OPINION

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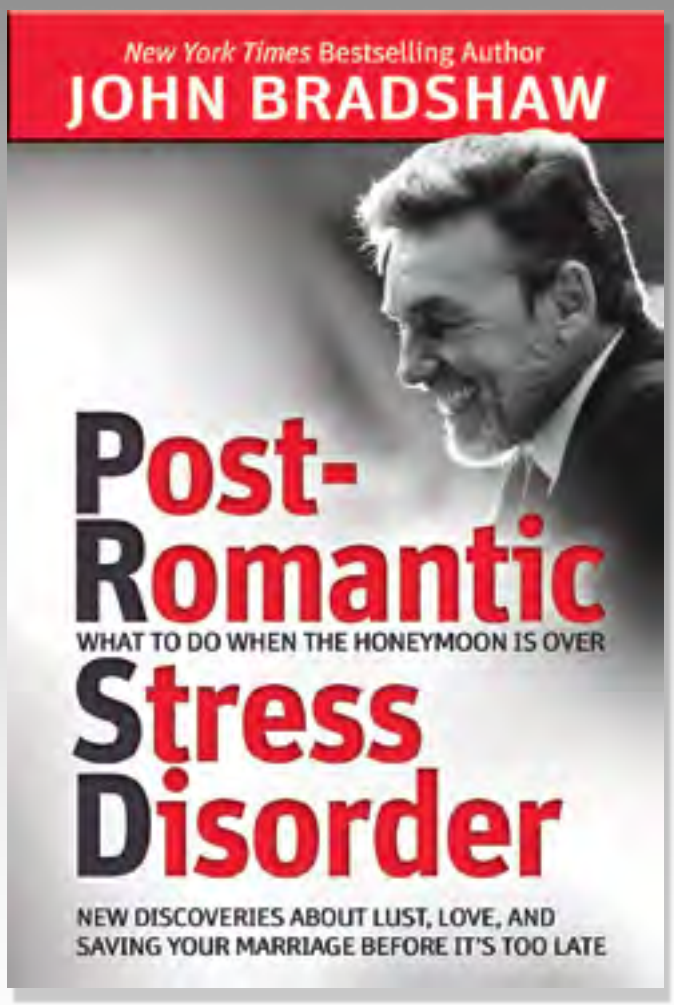

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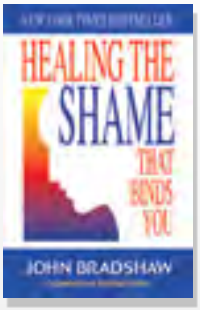

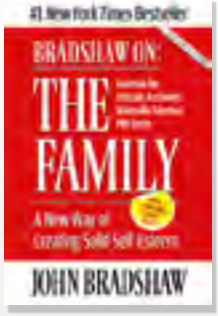

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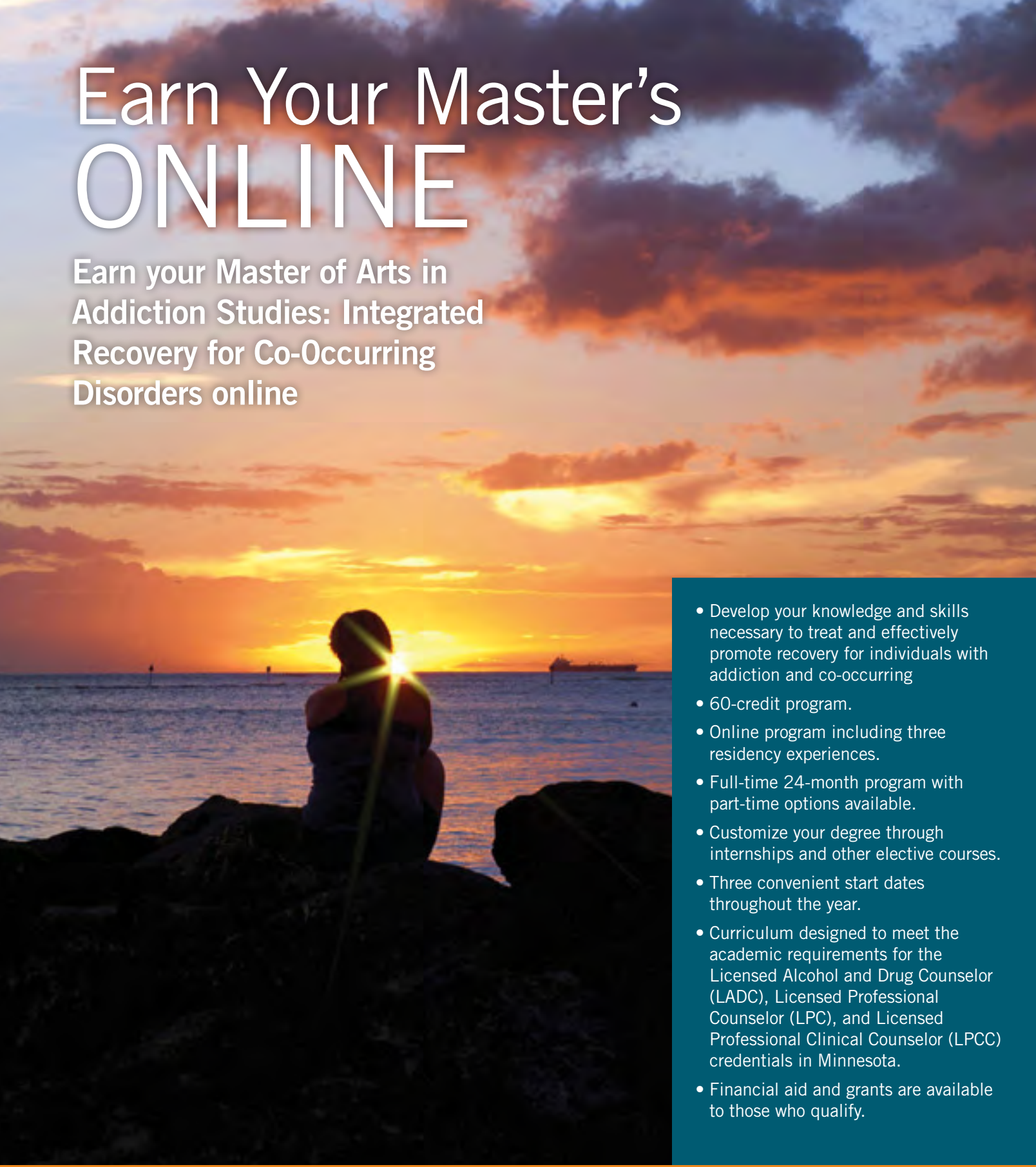

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Holidays

In about a month another year will end. Traditionally, some people like to look back on the year and some like to look toward the future. That seems to be an American trait; we are always looking at anything but the present. However, this brings us to getting through the holidays. They will soon be present. It seems that there are thousands of articles each year on how to "get through" the stress of the holidays. It is amazing to me that in American culture we find the time for gratitude, family togetherness, giving, receiving, and happiness to be so stressful. Think about it. Have we become so high-strung that we can't even enjoy ourselves?

Yeah, yeah, I know—I don't know your dysfunctional family. As a matter of fact years ago I myself suggested that card stores should have a "dysfunctional family" section. Just think of the sayings inside of those cards: "The holidays bring back such family memories—frustration, despair, and rehab are some of them" or "Thank you for always being there for me—obviously I am still in denial" or how about "Thanks anyway."

Perhaps the expectations for the holidays are always too high. We need to be more realistic. Functional families—dare I use the phrase "happy families"—are not functional all the time and dysfunctional families are rarely dysfunctional all the time. Instead of having suggestions that reflect only positive thoughts, techniques, and behaviors, maybe we should have more realistic suggestions for spending time with average families and friends. After all, there are probably some people in your family that you just don't like. The idea of being around them is second only to a root canal. I can guarantee you that at some holiday dinners this year someone at the table will be texting—they just don't want to be there. Therefore I can't resist offering some realistic suggestions for the coming holidays.

- Take your copy of the DSM-5 to your family gatherings. It will help you to understand your family better and allow you to practice your diagnostic skills.
- Don't tell people to "Have a happy holiday," it creates too much pressure. Maybe we should just say, "Have a holiday!"
- Don't try to keep up with all of the correct first and last names of everyone on your holiday card list. Just address all of your cards to "Occupant."
- Don't complain about twelve consecutive hours of football on television on Thanksgiving Day. Without it people might actually have to talk with each other.

Besides all of this I still believe in the moments that make holidays special. I still believe in the opportunity to realize the importance of some of the people in our lives. I still believe in the power of loving friends and family and I am grateful they are in my life.

Have a holiday!

Robert J. Ackerman, PhD
Editor *Counselor*,
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It's All about Attachment

Ronald Mah, MA, PhD, LMFT

Why do we pick up a crying baby?

The baby is in distress over discomfort, hunger, being startled, and other reasons. Babies who are in distress and not attended to will slide into despair. The difference can be heard in their cries. Babies do not know how to self-soothe. So, we pick up the baby to soothe him or her so that he or she does not go into despair, which could potentially ignite a whole other set of emotional and psychological issues.

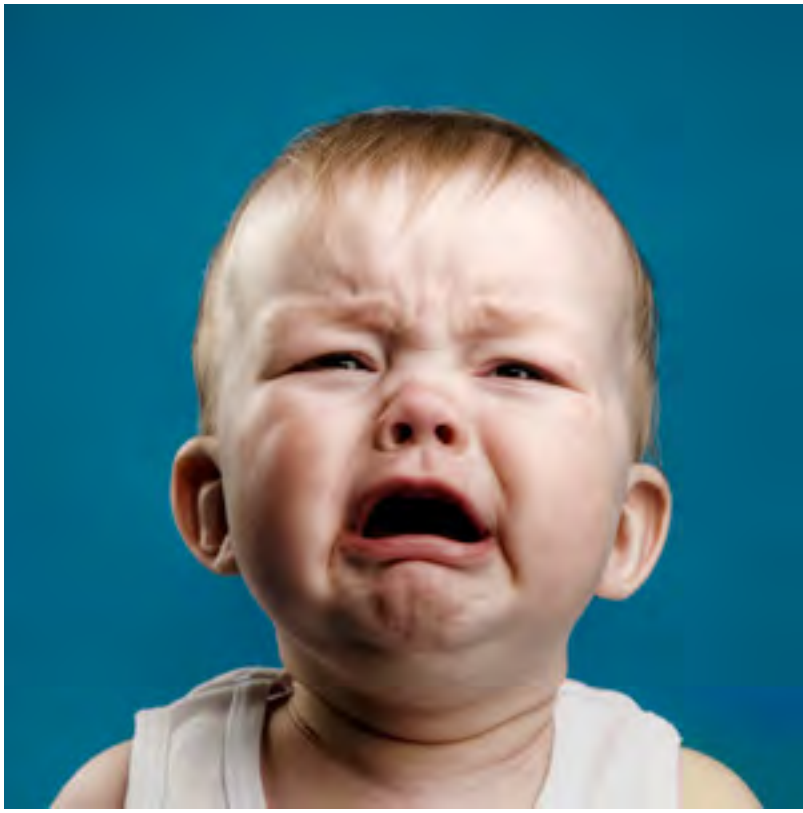
We pick up crying babies because as we soothe the baby, the baby learns how to self-soothe. Babies eventually learn to rock themselves gently the way we rock them. They eventually learn to caress themselves around their face and body, the way we caress them. They also eventually learn to murmur in the same tone, but in baby language, the gentle nurturing sounds that they have heard from us. Babies learn how to self-soothe by being soothed by loving caretakers.

Babies that are soothed learn behaviors that they eventually use to soothe others as they grow older. Babies that do not learn how to self-soothe become children, teenagers, and adults who do not have the skills to self-soothe or to soothe others.

Children who do not know how to self-soothe will act out to gain the fourth cousin twice removed of nurturing—that is, negative attention. They take the negative attention because that is all they feel they can get. We need to celebrate their acting out, because their acting out is a cry for help, which is also a cry of hope. Babies who stop crying have lost hope, something that can result in failure to thrive syndrome. Children who stop acting out may also slide deeply into depression.

So, why is this article being written for alcohol and drug abuse counselors or professionals who work with clients with other compulsive and addictive self-destructive behaviors? How will the principles stated in this article be useful in working with such clients?

The answer is because teenagers and adults who do not know how to self-soothe will use alcohol, drugs, sex, food, self-injury, and any number of other dysfunctional behaviors in order to self-soothe. If they lose hope, they may also fall into patterns of short-term gratuitous or hedonistic behaviors that can be self-destructive. Long-term goals or dreams become irrelevant with life experiences and views of hopelessness and helplessness.



Teenagers and adults who do not know how to self-soothe will get into a relationship with a professional, or a family member or friend, and demand that we always perfectly soothe them when they are in need. If for some reason we fail to soothe them when their distress spirals immediately into despair, they will lash out and punish us for the perceived betrayal. This can be borderline personality disorder tendencies in action and can become endemic in problematic couples and other relationships. Conversely, they may not know how to soothe their family members or significant others or friends effectively or appropriately. Other personality disorders may arise from the same issues.

Parents who do not know how to self-soothe will overcompensate soothing for their children as they seek to prevent their children suffering the despair they experienced, often despite their children not feeling despair. The consequence of this may be narcissistic, entitled, and spoiled children who proceed with problems into second (their

own intimacy relationships) and third generations (their children). This can contribute to the development of another generation of addiction-prone individuals.

Addiction, including alcoholism and drug addiction, may have many roots. Not the least of these is the attachment anxiety and the attachment despair one may experience from feeling insignificant, abandoned, and alone in the world. As a psychotherapist I advocate that my clients must learn four things.

Learn to be Alone

As much as good people—friends, family, fellow Twelve Steppers, church members—can give support, there inevitably will be times when a person is alone. Being alone is not intrinsically horrific, but can be quite wonderful if a person is good with him- or herself. It is important for people to learn how to be alone comfortably.

Learn Not to be Lonely

As previously stated, being alone can be great—a time to reflect, to consolidate or to commune with the inner soul. However, some individuals struggle to be alone without being lonely. They need to learn that being lonely isn't the only way to be alone.

Learn Not to be Desperate

When loneliness happens, people need to learn how to be lonely without getting desperate. As attachment anxiety or attachment despair trauma is retriggered, and/or real and existential fears and anxieties amplify when alone and lonely, some individuals become desperate and that can cause even more problems.

Learn Not to Make Bad Choices

Since the cycle and sequence of this dynamic is often powerful and not readily amenable to conscious restriction or muting, people need to learn how to be desperate without making bad choices. Bad choices that occur as an attempt to self-soothe include alcohol, drugs, sex, porn, spending, toxic relationships, and other destructive behaviors. It is not being alone, lonely or desperate that makes life crazy and unmanageable; it's the bad choices made when desperate.

Being able to avoid bad choices is not the same as becoming able to make good choices. The inability or difficulty in making good choices is a later clinical or life challenge, a later focus of therapy or personal process. It is the consequences of bad choices and prior bad choices that make a person's life crazy and out of control.

How does someone become desperate and not make bad choices? It's about practice; a person must practice feeling the desperation and not making bad choices. Avoiding the desperation eventually fails to work. Essentially or to a large degree, alcohol, drugs, and other compulsive behaviors can be attempts at avoiding feeling desperation. People need to perhaps not make good choices yet, but definitely not call their dealer, go to the liquor store, download some porn or overeat. They must practice suffering through it. Suffer and survive, and then suffer some more and still survive. Then do it again. However, when in that place of anxiety, desperation, traumatic intensity or profound loneliness, the ability to self-soothe is essential.

So, why do we pick up a crying baby? We do this because it is how they learn that in the big wide world, there is someone who cares that he or she is in distress. Additionally, we do this because this is the fundamental behavior of all those wonderful attachment theories! A cry of discomfort is a cry of need. Crying out and acting out are the cries to caregivers—both personal and professional—that need to be responded to.

That is why we pick up a crying baby and why we're talking about babies to alcoholism and drug abuse counselors. Even though we now know the "why," the work of "how" remains difficult and challenging. Hopefully this perspective and these principles resonate with all of us, the addiction counselors, and with the addicted individual to empower more effective work and processing. Give yourselves a hug!

Ronald Mah, MA, PhD, LMFT, *practices in San Leandro, CA. With an extensive background in education and multicultural and social services, and authoring books in discipline and behavior, he individualizes therapy according to logical emotional, cognitive, social, spiritual, familial, and cultural roots.*

Drugs and Rock: Music from the Heroin Songbook

Maxim W. Furek, MA, CADC, ICADC

The volume of books, poems, and stories devoted to opiates is staggering in scope. Famous literary personalities of the nineteenth century included Thomas DeQuincey, who wrote *Confessions of an Opium Eater*, and Samuel Taylor Coleridge, who wrote *The Rime of the Ancient Mariner* and the laudanum-inspired *Kubla Khan*. At one point, Coleridge was using a gallon of laudanum—a mixture of alcohol and opium—per week (Avis, 1990).

Heroin, a semisynthetic substance derived from morphine by simple structural modification, was first created in the 1870s, shelved, and then rediscovered in 1898 by Heinrich Dresser, a chemist for the Bayer Company of Germany. Heroin was initially marketed as a remedy for tuberculosis, laryngitis, and coughs. It was also ironically touted as a potential cure for morphine addiction (Hodgson, 1999). Between 1899 and 1905, at least 180 clinical works on heroin were published around the world, and most were favorable, if cautious. In 1906, the American Medical Association approved heroin for medical use, though with strong reservations about a "habit" that was "readily formed" (Askwith, 1998).

But perhaps even more fascinating have been the apparent correlations forged between heroin and music, a trend that has continued over the decades and remains with us today.

The History

Heroin became popular after World War II with jazz and bebop musicians. Prominent drug arrests of this period involved Charlie Parker, Thelonious Monk, and Billie Holiday. More recently, Ray Charles' addiction and recovery was explored in the book *Brother Ray* (Charles & Ritz, 1978). Charles admitted that his road to addiction began with curiosity:

> *Now in my case it happened because I wanted it to happen. That's all there is to it. Didn't take me long to figure*

> *out that before a gig, the cats might be doing something besides smoking reefer. Or if we were at someone's house, I'd hear them doing something in the kitchen. Before long, I discovered that they were cooking up horse, and I wanted to try some for myself* (Charles & Ritz, 1978).

Decades later, heroin impacted on Generation X's music as provocative subject matter that introduced the once taboo drug as a mainstream commodity. The 1990s, an era of despondency and isolation begat a decade of heroin use (Lowry, 1996) as heroin became a serious problem in the Pacific northwest, killing grunge rockers in "epidemic proportions" (Cohen, 2002). During the 1990s, there was an increase in heroin overdoses in the United States, but not as dramatic as in Seattle and Portland. Seattle experienced a 134 percent increase in overdose deaths from 1990 to 1999. The deaths of Nirvana's Kurt Cobain, Alice in Chains' Layne Staley, and the Smashing Pumpkins' Jonathan Melvoin illustrated the perils associated with the dirty powdered substance.

Heroin has tortured the lives of countless musicians and contributed to innumerable deaths among this group. Musicians known to have abused heroin include Tim Buckley, Eric Clapton, Dr. John, Pete Doherty, Boy George, Tim Harden, Jimi Hendrix, Janis Joplin, John Lennon, Courtney Love, Jim Morrison, Lou Reed, Keith Richards, Steven Tyler, and many others.

In an ironic twist there emerged a strange celebrity cult of former heroin addicts who were able to quit the drug. *The Basketball Diaries'* author Jim Carroll, after conquering his sundry demons, arrived as a celebrated poet-playwright with his own rock band, as did the iconoclastic Lou Reed. Motley Crue's bassist Nikki Sixx watched his tell-all memoir *The Heroin Diaries: A Year in the Life of a Shattered Rock Star* land on the *New York Times* best-seller list (Sixx & Gittins, 2007). Note too that author Irvine Welsh, on the other side of that warped and twisted coin, had been forced to defend accusations that his book *Trainspotting* was somewhat less authentic because Welsh wasn't a heroin addict (Haq, 1996).

The Songbook

The following list of songs is a brief attempt to explore the varied effects of heroin and related opiates through a narrow musical lens. It is my hope that the information offered would be utilized as a means of understanding and, in some small way, of resolution of this horrible and ongoing problem that persists at epidemic levels.

1940: "Junker's Blues"

Champion Jack Dupree's song, steeped in the blues tradition, appears to be a family affair. He sings, "My brother used the needle / and my sister sniffed cocaine / I don't use no junk / I'm the nicest boy you've ever seen." The song mentions the notorious Angola prison farm in Louisiana, but does not mention the Harrison Narcotics Act of 1914 that viewed heroin addicts as criminals and incarcerated them.

1967: "Heroin"

Lou Reed, The Velvet Underground's innovative singer/songwriter may have initiated the heroin cult and the punk rock movement in one single creative moment. "'Heroin' wasn't pro or con," Reed said. "It was just about taking heroin from the point of view of someone taking it. I'm still not sure what was such a big deal. So there's a song called 'Heroin.' So what?" (Orlando, 2009). Drummer Moe Tucker disagreed of the controversial release, stating, "I consider it our greatest triumph" (Orlando, 2009).

1969: "Cold Turkey"

In former-Beatle John Lennon's accounting of heroin withdrawal he pleads for salvation from this chemical horror. Lennon screams out, "Oh I'll be a good boy / Please make me well / I promise you anything / Get me out of this hell" in a reminder of the narcotic's chilling hold. The song was Lennon's testimonial of pain after kicking his brief heroin habit. In a *Playboy* interview Lennon explained that, "'Cold Turkey' is self-explanatory. It was banned again all over the American radio, so it never got off the ground. They were thinking I was promoting heroin . . . they're so *stupid* about drugs," he said (Sheff, 2010, p. 215).

1971: "Sister Morphine"

This Rolling Stones foray into the dark underbelly of ambulance rides, hospitals, and morphine addiction is from their *Sticky Fingers* LP. Marianne Faithful shares songwriting credits with Mick Jagger and Keith Richards on this melancholy tune that asks, "What am I doing in this place? / Why does the doctor have no face?"

1972: "King Heroin"

James Brown was able to easily transition from song and dance man to political activist. In "King Heroin," Brown delivered a political speech to his constituents wrapped around social commentary and a strong antiheroin message. Although lacking in slick metaphors and prose, the song is straightforward in its realism. In the song Brown has a dream where he sees heroin as "a real strange, weird object." This 1970s example of soft-spoken rap is a blatant social protest against the seductive white powder of heroin. In a mix of soulful jazz and politics he says, "I can make a man forsake his country and flag / make a girl sell her body for a five-dollar bag." And then later a stark warning, "Mount the steed! / and ride him well / For the white horse of heroin / Will ride you to Hell!"

1974: "Beware the Man (With the Candy in His Hands)"

Recorded by The Dramatics and featured on their LP A *Dramatic Experience*, this was among the antidrug commentary written and produced by Tony Hester, a drug addict and close friend of the group. "Beware of the Man (With the Candy in His Hands)" has its "odd monster/pusher sentiment only redeemed by Tony Hester's great and innovative production," according to Jason Elias's review (n.d.). Hester's career was cut short after he was robbed and killed on the streets of Detroit.

1979: "Comfortably Numb"

This song is believed to be the best of the Pink Floyd songs, with one of rock's finest guitar solos thanks to lead guitarist David Gilmour. According to *Rolling Stone*, the lyrics came from Roger Waters's drug experience prior to a Philadelphia concert. Suffering from hepatitis, Walters was injected with sedatives by a local doctor. "That was the longest two hours of my life," Waters said, "trying to do a show when you can hardly lift your arm" (Ladd, 1980).

1988: "Jane Says"

Jane's Addiction was named after heroin addict Jane Bainter, who was a housemate of the band. This antidrug message follows Jane, caught in the web of addiction, who articulates the impossible dream of escaping her narcotic prison. "Jane says / She's going away to Spain / When I get my money saved / She's gonna start tomorrow / I'm gonna kick tomorrow" she promises.

1994: "Pool Shark"

Bradley Nowell, founder of the ska-punk band Sublime, rationalized that experimenting with heroin might trigger his musical creativity and get him a record deal. Nowell's "experiment" evolved into addiction. "Pool Shark," from the CD *Robbin' the Hood*, addressed his dependency: "Take it away but I want more and more / One day I'm going to lose the war." Nowell's lifeless, twenty-eight-year old body was discovered in San Francisco's Ocean View Motel, another victim of a fatal heroin overdose.

2003: "Leave Drank Alone"

In what may have been a desperate cry for help or a warning to his peers, this Big Moe single was an obvious realization that the time had come to say goodbye to lean syrup, also called "purple drank," which is a mixture of Prometh cough syrup and alcohol. With its straight R&B delivery, the vulnerability in the song is readily apparent. Big Moe died at the age of thirty-three, possibly the victim of his "purple drank" lifestyle. "It's tragic what happened," said rapper Crisco Kidd about Moe's death. "Maybe his death tells us it's time for everyone to put their cup down" (Peralta, 2007).

2008: "Rehab"

English R&B singer Amy Winehouse, stalked and tormented by the unrelenting paparazzi, watched as her struggles with drug and alcohol addiction, eating disorders, cancelled tour dates, and ensuing legal troubles were all shamelessly revealed to the tabloid-crazed public. Ironically, songwriter Winehouse's first North American hit "Rehab" was a #7 single in the UK and, in her first Grammy appearance, won the Grammy for 2008 Record of the Year.

These songs represent several main themes including pain, suffering, and denial. In addition, several controversial songs were mistakenly assumed to have prodrug themes, while several hip-hop tracks promoted the joys of Prometh syrup within a unique subculture. While a lot of the songs about heroin are songs of warning, there are some that are songs of hope. C

Maxim W. Furek, MA, CADC, ICADC, *is director of Garden Walk Recovery and a researcher of new drug trends. His book,* The Death Proclamation of Generation X: A Self-Fulfilling Prophesy of Goth, Grunge and Heroin, *is being used in classrooms at Penn State University and College Misericordia. His rich background includes aspects of psychology, mental health, addictions and music journalism. His forthcoming book,* Celebrity Blood Voyeurism, *is a work in progress. He can be reached at jungle@epix.net.*

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Partners of Sex Addicts: The Forgotten Ones

Alexandra Katehakis, MFT, CSAT, CST

Imagine meeting the man or woman of your dreams and forming a monogamous bond with that person. Perhaps you get married and have children, or move in together. You tell your friends and family that you've met "the one." You build a life together, creating routines, sharing experiences, and making love. You invest in the relationship, allowing yourself to be vulnerable, to trust, to open up, believing in your future together.

Then one day, a crack appears in the beautiful veneer of your union. Maybe you notice your partner deleting text messages or catch him or her in a small lie. You don't think much of it, and consider that you're probably overreacting. Then something slightly more alarming occurs. You see a receipt for a night at a hotel when your partner was supposed to be at his or her parents' house. Or maybe you notice your partner is constantly making excuses when you try to be sexual.

The lies and the deception become a kind of perpetual haze, making it difficult to see even a few feet in front of you. Self-doubt begins to riddle your thoughts like a virus. You second-guess yourself constantly, unable to come to terms with all the inconsistencies in your partner's behavior. He or she is often late, distracted, and strangely distant. Now it's your partner's turn to dismiss your concerns, saying, "You're making a mountain out of a molehill."

You try harder to make things work. You plan a special getaway, make a gourmet meal or spoil your partner with extra affection. Maybe you even do things you feel ashamed of just to keep your partner sexually interested. Maybe you become depressed and anxious, unable to sleep or concentrate. You become obsessed with uncovering the truth, without having any conscious idea of exactly what truth you're looking for. You follow your partner, spy on him or her at work or lurk around your home trying to overhear conversations. You try to hack into his or her computer just to get some answers. You feel like a crazy person and question your own sanity.

Suddenly the crack widens into a gash, threatening to split the very foundation of your relationship. At this moment, the unthinkable happens. You discover that this person you loved with every fiber of your being is what many websites are calling a "sex addict." Although you had doubts and suspicions, you are now face to face with an event that you cannot ignore: your partner has contracted a sexually transmitted disease, has been arrested or you have been confronted in person by one of your partner's lovers. The shock is devastating. In one indescribably painful moment, everything you believed in or cared about is shattered. Trust has completely evaporated without a trace. You are disoriented, alienated, and utterly lost. You may feel you have nowhere to turn, as everyone you know still views the sex addict as a loving father or mother, an honorable boss or a loyal friend. You alone now bear the burden of the truth about your partner. The sense of betrayal is boundless as you replay the past in your mind over and over, asking yourself how you could have been "so stupid." Perhaps your anger boils over and you consider revenge, becoming enthralled with ways to punish your partner, even while you desperately yearn for his or her love. Your own family of origin issues may begin to plague you, as you are forced to recall your father's cheating or your mother's emotional abandonment.

But it's not over yet. Now that the sex addict has been caught, he or she decides that it's therapeutic to make a full disclosure. Just when you thought you had seen the worst of the pain, you now are cast into a deeper hell than you even thought was possible. As the years of cheating, paying for prostitutes, abusing porn, same-sex affairs, and fetishes come to light, coupled with the financial tolls, you can truly withstand no more.

At this final, precarious precipice, you throw yourself into the arms of the recovery community, diving into workshops, therapy, and support groups. Only instead of being embraced, nurtured and witnessed, you are told that you are a "coaddict." You are called "codependent." Even though these labels have never described you, they are now thrown your way with regularity, emphasizing the language of personal weakness. This final stage is the ultimate betrayal, for where else can you ever find understanding if not in the arms of the therapeutic community?

You've just experienced a thin slice of what it's like to be the partner of a sex addict, which is why *understanding* the partner's experience isn't enough. The onslaught of traumatic emotion that's unleashed due to the attachment system taking a beating can derail even the most seasoned therapist. Feelings of anger, fear or revulsion toward the partner will leave the therapist unable to activate his or her own empathy centers. Unless we can recognize the partner's affect as a traumatic reaction to betrayal and put ourselves in *their* shoes, they will forever remain the forgotten ones.

Fortunately, a major paradigm shift has occurred in treating the partners of sex addicts. We as therapists now recognize the extreme vulnerability of this population, and we are moving towards a model that places empathy, compassion, and the rebuilding of trust as its greatest goals. Rather than pathologizing the partner, we are learning first and foremost to tolerate and validate their pain and grief, while also helping them to process the momentous emotional, social, financial, and spiritual losses.

The concept of relational trauma (RT) has finally emerged to describe the devastating, PTSD-like condition of the person whose primary relationship bonds have been decimated. While the word "trauma" has generally referred to events where lives are at stake, such as in the cases of war, rape or disaster, relational trauma addresses the death or irreparable injury of a primary bond. A loved one who was once considered integral to a person's sense of security, happiness, and well-being has now become the source of pain and suffering. To add insult to injury, the partner of the sex addict often has his or her own unresolved childhood trauma that gets activated by the discovery of betrayal. No matter the circumstances, this kind of shock cannot be anticipated or absorbed. The crisis becomes an existential one. If everything the partner knew about his or her significant other was false, what else might be in the dark? Even life itself seems untrustworthy, as all perceptions and judgments become suspect in the aftermath of the betrayal. Furthermore, genuine life-threatening events may be imminent, such as contracting an STD, losing one's home or having one's children exposed to dangerous situations. The trauma may also be worsened by the partner's isolation, limited personal finances or the amount of access available to getting therapy.

The coaddict model of coping with a sexually addicted partner is based on the Al-Anon Twelve Step recovery program, which diagnoses alcoholism as a "family" disease, implicating everyone involved with the addict. While the purpose of this model is to help the family and friends of alcoholics examine and improve their reactions to living with a drinker, many partners herded into spin-off groups like S-Anon feel indignant about having to declare their lives "unmanageable" or publicly identify as someone with a personal shortcoming by raising their hand at a meeting. For them, the RT recovery model is far more comforting and affirming.

Transcending Post Infidelity Stress Disorder (Ortman, 2009) details the PTSD-mirroring stages of relationship trauma, which include discovery of the betrayal, an overload of fear and anxiety, uncontrollable replaying of past injuries, and a sense of shame, avoidance, emotional withdrawal, and rage. While there are other available books on RT, including *Your Sexually Addicted Spouse* (Steffens and Means, 2009) and *Facing Heartbreak* (Carnes, Lee, & Rodriguez, 2012), the predominant literature on the topic remains of the coaddict variety, and much more needs to be written on the partners' behalf.

Going forward, the partners of sex addicts will need vast amounts of healing as they strive to integrate their experience and regain a sense of trust in humankind. The therapist's role is critical at this juncture, because in some cases, he or she may be the only one who is capable of validating their trauma. The partner's friends and family, while meaning well, may all have an agenda, whether it's to protect their own from further harm or to remain neutral as an ally of both parties. The therapist can be the North Star in all this confusion, providing empathy and emotional regulation to someone who has experienced unimaginable heartbreak. In choosing the right therapist, a partner should first consult with the prospects to determine their specialized knowledge and training around sex addiction, and their experience with relational trauma in particular. The therapist should be able to suggest practical, concrete steps for emotional and physical safety, dealing with the disclosure process and the aftermath, tools to determine appropriate boundaries concerning information-gathering about the past, tools for developing a robust support system, and of course suggestions on how to practice rigorous self-care in terms of managing feeling states, sleep, exercise, and nutrition. In this way, a good therapist grounded in the RT framework can assist the partner with the move from victimhood to victorhood, emerging from the rubble as a stronger, wiser human being.

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Powerlessness?

Rev. Leo Booth

The truth is that the question of powerlessness, being powerless, and staying powerless in our relationship to the awesome power of God is ancient. From the beginning of time, when early humans uttered their first "Give Me" prayer, the powerlessness of the human condition was *generally* accepted. Thus followed these statements:

- Make God happy with sacrifices and He will spare you or give you abundance.
- We are dependent upon God for everything; not to accept this is ego.
- Things happen in God's time. He has done and is doing what we cannot do for ourselves.

Since ancient times, in all religious and theocratic cultures, this seems to have been the general feeling. Indeed, a popular definition of humility has been the idea that we submit absolutely to God's power, and we are servants of His desires and wishes. In the words of the prophet Isaiah, "Here am I, send me" (Isaiah 6:8, Good News Bible). God forbid, literally, that we should make up our minds and make decisions about what we should do.

What We Hear in Alcoholics Anonymous

This concept of powerlessness is fundamental in Alcoholics Anonymous (AA) thinking; indeed it appears front and center in the first Step: "We admitted we were powerless over alcohol—that our lives have become unmanageable" (Alcoholics Anonymous World Services, 2002, p. 71).

And although we meet every religion and culture in the recovery rooms, the idea of "I can't, God can, will I let him?" is prevalent amongst the members. Indeed people who have been sober many years are often heard to say "I'm powerless over alcohol" as if their years of sobriety and following a spiritual path have not nurtured any power.

Also, although alcoholism is accepted in the medical world as a disease, there are still many alcoholics who see themselves as bad—not quite degenerates, but close to it. I've heard the following in AA rooms:

- "If you see my lips moving, then you know I'm lying."
- "I don't deserve this recovery. I did nothing to get it or maintain it; it's only through God's grace that I remain sober."
- "I was once a drunken thief. Now I'm a sober thief."

Some of these statements are intended to be humorous, but I think there is still an element of guilt and shame. This feeling of being irresponsible is reinforced by Steps Four, "Made a searching and fearless moral inventory of ourselves," and Five, "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs" (Alcoholics Anonymous World Services, 2002, p. 71).

Do People Believe This?

In many ways the treatment for alcoholism and the Twelve Step program present for most people a new way of living, alongside new and challenging concepts. Regular folk had probably not read the writings of William James or Emmet Fox, and they probably didn't know the Oxford Group. Yes, religion they had probably experienced, but hardly the study of

religion and philosophy. In addition, spirituality would be a completely new and confusing topic; confusing in the sense of distinguishing it from religion. It's enough to say that the ordinary person, on entering recovery, has a lot to learn, digest, and comprehend. Hence the need for study programs that focus on *The Big Book*, Twelve Steps, and Twelve Traditions.

Yes, they can talk and share about their history of drinking and what happened to them, but to place it in the context of an AA philosophy is never easy, even for accomplished speakers. Here's my point: Most people probably don't say exactly what they feel or mean. In an effort to remain humble they have a tendency to put themselves down, emphasizing what God is doing in their lives rather than what they have created and achieved. The theme ends up being that only through God's grace are they able to achieve anything.

A Case for Pelagius

Notice that throughout this article I have said what was and is *generally* believed; there are always exceptions. There have always been a few people who understand the meaning of powerlessness, especially for the alcoholic, in a different way to the general consensus. I know I'm one of them.

Recently on my Facebook I blogged the following:

> *Powerlessness is a characteristic of being an alcoholic, not a characteristic of being in recovery. The promises would never be achieved if we remain in a permanent state of powerlessness. When we connect with God or H.P. we experience power and a profound willingness to take responsibility for our lives, alongside carrying the message to those drinking alcoholics feeling powerless.*

Let me introduce you to another thinker who has a different concept and understanding of powerlessness called Pelagius. This is taken from my book *The Happy Heretic:*

> *He was born around 354 AD in Wales, Britain. He was educated in both Greek and Latin, a monk but not a cleric; he was never an ordained priest. In his early years, he was admired by no less a person than Augustine of Hippo, who called him "a saintly man." When he moved to Rome, he became concerned about the moral laxity in the city, believing it was partly the result of Augustine's teaching concerning divine grace. Pelagius was concerned about the emphasis that Augustine placed upon God's grace—the idea that since the Fall of Adam, every good thought or action was dependent upon God. We could do nothing on our own. There was no teaching that affirmed the need for our response. There was little teaching concerning human responsibility; that we need to be accountable for our behavior. He was particularly disturbed by a famous quotation from Augustine, "Give me what you command and command what you will."*
>
> *Pelagius believed that this saying discounted free will, turning man into a mere automaton. He soon became a critic of Augustine, disagreeing with him concerning original sin and the working of God's grace in perfecting salvation. Pelagius argued that if human beings could discipline themselves in the way exemplified by Jesus, then they could remain perfect. He believed that grace needed to be connected with human choice* (2012, p. 7–8)

For me, the spiritual awakening that is promised in Step Twelve is the awareness that I'm not a bad person, I'm not unlovable, and I'm certainly not powerless. But I didn't know this when I was drinking. What I became in my alcoholism is not who I am. This is, and was, a powerful awakening in my life. My journey, that encompasses the Twelve Steps, is into the awesome fullness of what God created. I'm privileged by my choices to enter into a partnership with God and create a better life for myself and those around me.

Now *that* is power!

***Leo Booth**, a former Episcopal priest, is today a Unity minister. He is also a recovering alcoholic. For more information about Leo Booth and his speaking engagements, visit www.fatherleo.com or e-mail him at fatherleo@fatherleo.com. You can also connect with him on Facebook: Reverend Leo Booth.*

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The High Cost of Anger, Part II

John Newport, PhD

What was originally intended as a two-column series on the high cost of anger has morphed into three columns. The first installment took a detailed look at the costs of uncontrolled anger affecting our overall health and well-being, including sobriety maintenance. This column and the final installment deal with effectively managing our anger. The particular focus of this column is on prevention; staying calm in the midst of stressful encounters and keeping our expression of anger or frustration at a healthy level.

The first line of attack in keeping our anger under control is learning to maintain a baseline level of calmness by taking care of ourselves and effectively monitoring our emotional expression. The following suggestions are presented to address this important area.

Maintaining Sound Nutrition

During our days of using and abusing, we invariably let healthy eating habits fall by the wayside. In recovery it behooves us to adopt health-conducive diets and avoid alcohol, while minimizing other nutritional stressors such as sugar, caffeine, fried foods, and highly processed foods.

A recent study headed up by investigators at Ohio State and the University of North Carolina at Wilmington sheds light on the role of low blood sugar levels as a contributing factor in many marital spats (Borenstein, 2014). In this study, participating couples were monitored nightly for three weeks in terms of their levels of aggression, as indicated by the number of pins stuck in a "voodoo doll" representing the partner's spouse. The researchers found that the lower the blood sugar levels, the more pins were pushed into the doll. In fact, people with the lowest scores pushed twice as many pins into the dolls as those with the highest blood sugar levels! Bushman, the study's lead author, says there is a good physical reason to link eating to emotion: while the brain accounts for only 2 percent of our body weight, it consumes 20 percent of our calories. Strange as it seems, the authors advise couples to avoid fighting on an empty stomach, adding that while a candy bar might be good before discussing a touchy subject, fruits and vegetables are a better long-term strategy.

Regular Exercise

Vigorous exercise is helpful in keeping calm in stressful situations. Among other things, exercise releases endorphins, the "feel good" hormone that stimulates the pleasure center of the brain. Cumulative stress and frustration edge us toward the flight or fight response, making us uptight both physically and mental-emotionally as cortisol is released into our bloodstream, triggering rapid heart beat, heightened blood pressure, and increased muscular tension. Exercise can serve as an antidote through helping us release from our bodies the toxic residue associated with accumulated stress and frustration.

Adequate Rest and Sleep

We all know how irritated we can be when arising from a night of restless tossing and turning. I am particularly aware of this, as clashes with my spouse often occur on mornings when I am sleep deprived, which in her words brings out the "grouchy bear" in me.

Take an hour or so before bedtime to wind down and mellow out, as going to bed with an overloaded mind is a major cause of insomnia. Boycott the Eleven O'Clock and opt for a good comedy or relaxing reading.

Adopt a Mind-Quieting Ritual

In our fast-paced, high stress society many of us find it helpful to work a mind-quieting ritual into our daily routine. I have been practicing a popular form

of meditation for close to forty years and can attest to its benefits in terms of emptying my mind of stressful thoughts and fostering an underlying sense of serenity. If sitting meditation is not your cup of tea there are many other practices available. These include walking meditation, spending time outdoors quietly appreciating the beauty of nature, relaxing reading, contemplative prayer, and best of all, simply cuddling with your partner before drifting off to sleep.

Helpful Tips from the Buddha

The Buddhist traditions embody many tenets that can help us calm our restless minds. Buddhist teachings focus on eliminating suffering, and an agitated mind is a major cause of suffering. The Holy Middle Path reduces our proneness to agitation through encouraging us to practice moderation in all things. Each morning I read two affirmation cards: one that states "I walk the Holy Middle Path with honor, integrity, and compassion" and one that states "Right thoughts, speech, and action, all grounded in right and honorable intention." For further information on this topic I highly recommend two books by contemporary Buddhist teacher Thich Nhat Hahn titled *Present Moment Wonderful Moment* (1990) and *Taming the Tiger Within* (2005).

Cultivate an Attitude of Gratitude

We're all familiar with the old saying "Is the glass of water half empty or half full?" How do you view your glass of water? If we view our glass as half empty, we probably tend to focus on what is lacking in our lives, which increases our experience of frustration and anger. We can benefit through cultivating an attitude of gratitude and focusing on the abundant aspects of our lives and the world around us that are infinitely more than half full. An excellent resource here is a *Daily Word* article by Brother David Steindl-Rast titled "Living Life in Gratitude." To obtain a copy, call Unity Customer Service at 1-800-669-0282 and ask for their Archives Department. Trust me, it's well worth the nominal retrieval fee.

Hopefully these pointers will prove helpful in preventing excessive outbursts of anger and the toll these outbursts take on our psyches, bodies, and relations with others. As always, feel free to share this column with your clients. The third and final installment will deal with nipping our anger in the bud and repairing the damage in those hopefully rare moments when our anger gets the best of us. Until next time—to your health!

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Becoming Balanced

Sheri Laine, LAc, Dipl. Ac

Curare is the Latin term for both caring and curing. As we "care" for ourselves, the positive vibrations radiating from us flow to others around us. They feel our vibration. They want our "cure."

The more balanced we are, the easier it becomes to sense when our *EnerQi* is off. *EnerQi* is a term I have coined that refers to the energetic vibration we radiate and carry with us. This vibration is affected by the lifestyle choices we make.

The decisions we make every moment of every day influence the balance of our own *Qi* and *EnerQi*. When you are in tune with your body's needs, maintaining equilibrium becomes quite straightforward.

We see the nature of balance and imbalance when we observe the circumstances that unfold in our lives due to our behaviors. Since we are all interconnected, our actions, decisions, thoughts, words, and emotions not only affect us, but those around us. Positive, uplifting, and engaged openness with ourselves and with others serves as a counterbalance to the sometime negative effects of the everyday world that we all share.

This type of approachable behavior makes us softer, a bit rounder in our humanness. It wakes us up to the grander scheme of a better world we are helping to create, and want to live in.

Making eye contact when others are speaking, stopping to help a stranger in need, asking the barista or shop clerk how their day is going is a gift you can give over and over again. Actions like these are selfless and caring—they are random acts of kindness.

The opportunities, ideas, and ways to give to others are endless. As you give, in small or in big ways, you will observe a shift in what you receive within your own life. Situations change, perspectives shift, relationships transform.

By tuning into yourself and others you become empowered to make stronger, healthier, and more powerful decisions.

It is a given that when your *EnerQi* is vibrating with a strong electromagnetic current, you will attract these like energies to yourself. It is a central law of the universal flow of attraction and health. Your thoughts are big, energetic, forceful magnets that become your reality.

You will discover as you begin to live a more balanced life, you will create and experience more vibrant health, joy, laughter, love, and happiness in all areas of your life.

Although I have discussed the concepts of Oriental philosophy in previous columns, they bear repeating as they are such an important concept to overall health, equilibrium, and ongoing wellness.

All living organisms operate within a constant dynamic flow between yin and yang—hot and cold, night and day, dry and wet. When looking at the symbol for yin and yang, one of the first things to notice is that they are round with two symbols enclosed within. There are no sharp edges or angles; everything circulates around the yin and yang symbol. One half gives way into to the other.

Yin and yang depend on each other for balance, harmony, and wholeness. Each contains a round circle of the opposite color, representing the opposite energy within its center. Because they are interdependent, yin and yang are both conduits of magnetized energy for one another, and for themselves. They feed off each other's actions and reactions.

Acupuncture, done with metal needles, serves as a conduit to assist in the equalization of this magnetized energy. Through acupuncture, new blood, oxygen, and vitalized *Qi* will flow to your brain, organs, and meridians enhancing your immune system.

With a new year almost upon us, begin exploring interesting ways within your own life to translate and include the concept of yin and yang energy. Then take those insights out into the world around you.

Life abounds with possibility and contains a myriad of options from one moment to the next. Every day you have the unique opportunity and privilege to choose the life you want to lead, along with the power to make the decisions that will take you to those places.

Namaste. C

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.*

Depression and Substance Use Disorders

Dennis C. Daley, PhD

Hall of Fame centerfielder for the New York Yankees Mickey Mantle (who was my childhood hero), the brilliant entertainer Robin Williams, and astronaut Buzz Aldrin all suffered from depression and a substance use disorder (SUD). Sadly, Robin Williams's life ended a few months ago when he committed suicide, the risk of which increases significantly with depression. When a SUD is also involved, the risk is even greater.

This combination of disorders is common among individuals in treatment. About one in three people with a SUD will experience clinical depression during their lifetime. Studies show that individuals with a current or lifetime depression are two to seven times more likely to have a SUD. Studies also show high rates of depression among clients with a SUD, especially women. While depression is common with SUDs, it is also common with anxiety disorders, posttraumatic stress disorder (PTSD), eating disorders, personality disorders, nonsubstance addictions, and other disorders.

Depression and Effects

There are several depressive disorders in the DSM-5, but the most common are major depression (single episode or recurrent), persistent depressive disorder (previously called dysthymia in DSM-IV), and substance- or medication-induced depressive disorder. Depressive disorders affect over 15 percent of the population, with major depression being the most common. The groups with the highest rates of depression are American Indians and Alaskan Natives, women, and young adults between eighteen and twenty-five years of age.

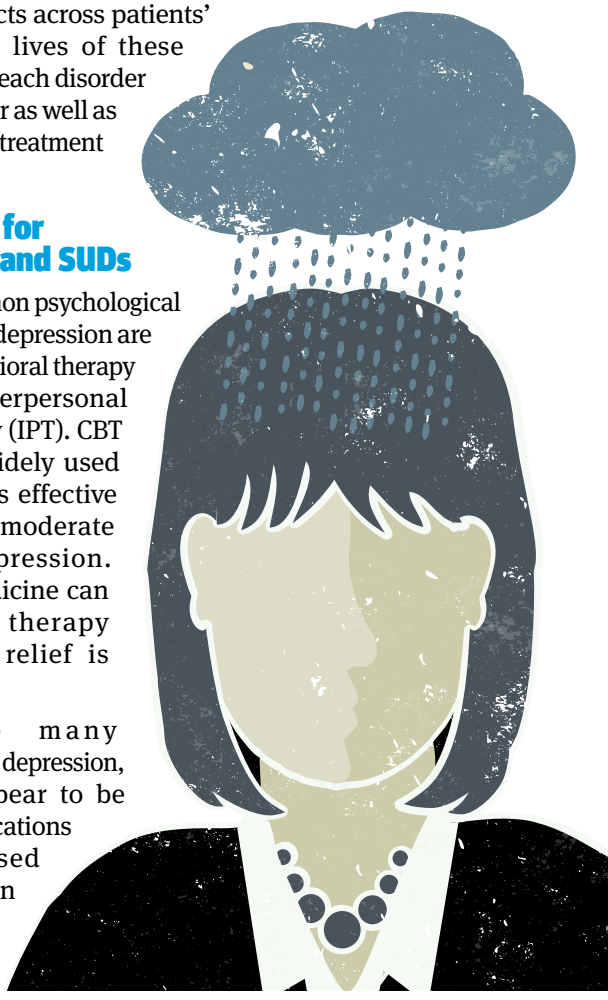
Depressive disorders are separated from bipolar disorders in the DSM-5, but many people with bipolar illness experience depression. Common features across depressive disorders include:

- Feeling sad
- Feeling empty
- Irritable mood
- Feeling worthless
- Excessive guilt
- Hopelessness
- Sleep and/or appetite disturbance
- Low energy
- Agitation
- Retardation
- Diminished ability to think or concentrate
- Indecisiveness
- Recurrent thoughts of suicide

Even with improvement, some clients have symptoms that persist and become chronic.

Survey Results

Over seven hundred behavioral health professionals who completed surveys identified depression and SUDs to be an issue of high interest to them. I believe the reasons for this are the high rates of these disorders in behavioral health care settings; the increased risk for suicide associated with depression and SUDs; significant negative impacts across patients' and families' lives of these disorders; and each disorder affects the other as well as the response to treatment or recovery.



Treatments for Depression and SUDs

The most common psychological treatments for depression are cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT). CBT is the most widely used therapy and is effective with mild to moderate cases of depression. However, medicine can supplement therapy if sufficient relief is not achieved.

There are many medications for depression, but none appear to be superior. Medications are often used in conjunction with therapy or counseling.

Electroconvulsive therapy is effective with severe cases of depression that do not respond to other treatments, or if medications cannot be taken. Light therapy is safe, effective, and well-tolerated with seasonal depressive disorder.

Effective psychosocial treatments for SUDs include individual—CBT, individual drug counseling, Twelve Step facilitation, motivational incentives, and others—group, marital, and family therapies, as well as therapies that combine these approaches. In addition, there are FDA approved medications for opioid, alcohol, and nicotine dependence. Medications for opioid and alcohol dependence are usually used in combination with psychosocial treatments and mutual support programs.

Strategies to Help Clients

When possible, provide integrated care and address both disorders. The initial focus is usually on stabilizing the client from acute symptoms of depression, facilitating abstinence from substance, and addressing problems that contribute to, or worsen, these disorders. For those in psychiatric hospitals due to the severity of depression, or in rehab due to an addiction, a key issue is linking the client with follow-up care after discharge. Other ways to help include:

1. **Assess depressed clients for SUDs and assess clients with SUDs for depression.** A thorough evaluation determines diagnoses and can be used to develop an integrated treatment plan. Clinical interviews and pen and paper inventories (e.g., Beck Depression Inventory, Hamilton Rating Scale for Depression, Drug Abuse Screening Test, etc.) can help identify these problems and their severity. Be sure to assess for bipolar disorder if depression is the main mood disorder present.
2. **Provide information and address questions related to either disorder.** Clients benefit from understanding symptoms, how disorders interact, treatment options, and recovery programs. For example, maintenance treatment of recurrent major depression is different than that for a first episode of major depression. Alcohol or marijuana use raises the risk of relapse to cocaine.
3. **Assess suicidality (intent, methods, reasons, protective factors).** Most people who attempt or complete suicide are depressed. Risk factors include a recent loss (relationship, job, health), prior attempt or current plan, lack of support, inability to accept help, suicide by a significant other, and the burden of chronic depression. You may reduce suicide if you help the client catch signs of psychiatric relapse early; discuss suicidal thoughts, feelings or plans; seek safety if there is an imminent risk of suicide; avoid substance use; have activities to calm or comfort self; review reasons for living; call a confidante, professional or crisis line; go to the ER or build on protective factors like spiritual beliefs, social support or meaning in life.
4. **Provide information and options for medications to clients with more severe forms of depression or dependence on opioids, alcohol or nicotine.** Facilitate an evaluation with a physician, monitor adherence, and discuss the potential impact of substance use on medications as well as recovery. For clients with depression that is part of a bipolar disorder, lithium reduces the risk of suicide.
5. **Address the SUD.** Facilitate abstinence and monitor substance use since the efficacy of medications is affected by substances, which can lower the client's motivation. Help clients understand and manage obsessions and cravings for substances, resist social pressures to use, manage feelings that could impact on relapse, establish and use a support network, and know the potential impact of depression on recovery from a SUD.
6. **Promote recovery.** For more severe depressions or addictions, recovery is a long-term process that requires commitment, hard work, and the use of skills to manage the challenges of recovery (e.g., refuting distorted thinking that contributes to depression, asking others for help or support).
7. **Focus on managing emotions and moods.** Clients benefit from learning to discriminate feelings of depression from a clinical disorder, especially in the early phases of recovery when depression is common. Some need help with anxiety, anger, boredom, grief, loneliness, guilt or shame. Inability to manage negative emotions is a cause of relapse to SUDs. Clients can also benefit from focusing on positive emotions such as gratitude, forgiveness, and love. Using a daily log to rate depressive symptoms or other emotions helps the client increase awareness of moods and emotions, the context in which these occur, and what coping strategies are most effective. Clients with persistent mood symptoms that never totally remit can use a daily log to see improvements over time or identify any significant worsening of depressive symptoms.
8. **Change inaccurate, faulty or "stinking" thinking.** CBT and related interventions help clients understand and challenge distortions such as expecting the worse outcome, awfulizing or disqualifying the positive. Helping clients challenge addictive, also called "stinking," thinking such as "I need alcohol or drugs to have fun," "Recovery is a drag," or "I had a drink and blew my recovery so why even bother" can help sustain recovery.
9. **Involve the family.** Families or significant others can provide support, provide input to professionals, and help themselves through expression of their own needs. They may also get involved in treatment and/or recovery for themselves (e.g., Al-Anon, Nar-Anon, NAMI groups) to learn ways to cope with the disorders and manage their own reactions.
10. **Evaluate and enhance relationships.** Helpful interventions include identifying and resolving

interpersonal problems, improving social skills, addressing role transitions, and building a support network. Some clients need help learning how to ask others for help or support.

11. **Facilitate lifestyle change.** Participating in pleasurable activities, developing new leisure interests, using a daily or weekly plan, exercising regularly, meditating, and using relaxation techniques all can aid recovery. Some will need help with sleep, hygiene or money management—especially those with bipolar illness.

12. **Facilitate involvement in mutual support programs.** You can educate and provide options for mutual support programs (MSPs). While Twelve Step programs are the most widely available and used, some clients prefer other options, including online meetings. Explore common resistances to engaging in MSPs. When possible, link the client to specific groups or individuals in recovery who can facilitate their use of MSPs.

13. **Address relapse and recurrence.** Outcome studies show high rates of relapse to SUDs and recurrence of depression. For SUDs, the risk of relapse is higher during the initial ninety days of recovery and within the first year. About half of individuals with major depression will have a recurrence. Strategies to reduce relapse risk include monitoring and addressing adherence problems when they arise; identifying and managing high-risk factors and early signs of relapse; and preparing the client to take quick action should depression return or worsen or substances are used. Clients with more severe addictions and/or recurrent major depression benefit from long-term involvement in professional care and MSPs.

14. **Address sleep problems.** Some clients have difficulty falling or staying asleep or have early-morning awakening, any of which can adversely affect attention and concentration, cause fatigue, anxiety or irritability. Strategies to improve sleep include using relaxation or calming techniques prior to bedtime, reducing time in bed, getting up at the same time each day, not going to bed unless sleepy, not staying in bed for longer than a half-hour if one cannot sleep, changing thoughts and beliefs that contribute to difficulty sleeping, and not using alcohol or caffeine prior to going to bed. If these do not work, medications may help. Benzodiazepines are usually contraindicated for clients with SUDs due to their abuse potential.

Observations

- The combination of depression and a SUD often responds well to treatment, especially when it is integrated and focuses on recovery from both disorders.
- Clients may experience depression when they stop using substances. For many, this improves as sobriety progresses. For others, depression worsens after they stop substance use.
- Clinical attention needs to be paid to suicidality given the high rates of attempts and completions among depressed individuals.
- These disorders create distress and problems for families and significant others, yet many programs or clinicians do not include family and significant others in the treatment.

Questions to Consider

- If you work in a psychiatric setting, do you screen clients for substance use to determine if a problem exists and if so, do you focus on both disorders?
- If you work in an addiction setting, do you screen clients for clinical depression and if a problem is assessed, do you focus on both disorders?
- Given the risk of suicide, do you routinely assess suicidality with your clients?
- Do you address the impact of these disorders on the family, or work with clients to address family issues? C

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You Need Critical Thinking, Part II

Michael J. Taleff, PhD, CSAC, MAC

This is the second part of a two-part series on the need for critical thinking in the addiction field. In Part I we described some general, but noteworthy biases that contribute to bad thinking. For this column, we review several fallacies which addiction counselors fall into, review strategies to offset those fallacies, and present the basic mechanics of critical thinking itself. Don't worry, it's really easy.

The important goal of this two-part column is to emphasize the responsibility of addiction professionals to think better in order to make better clinical assessments and treatment selections for our clients.

Fallacies

Fallacies are deadly hazards of the mind. Consider them termites that infest our thoughts and just eat away at the foundations of clear thinking. Essentially they are mistakes, omissions, false beliefs, and have everything to do with making arguments defective and supplying wrong conclusions (Gambrill, 2006; Taleff, 2006). There are hundreds of recognized fallacies out there. Over the decades I have observed some favored fallacies found in our field. It is to those we now turn.

Authority Fallacies

Arguably, the most frequently observed fallacy in our field is the authority fallacy. It is a claim made by a notable "expert" in our field, be it an author, supervisor, counselor or any number of others who make claims without data support. Now anyone can make a claim, but if the claim has no substance to it, no research to back it, it leans dangerously toward being an authority fallacy. The point is that without facts, claims made by any number of folks in our field are hollow. They're just someone's opinion. What adds an additional negative feature to the authority fallacy is that the people who make a claim expect you to trust them without the research. That presents problems because it's just their word and not much else. Opinions are fine, but how do they hold up under the heat of research?

The other big problem with this fallacy is that an audience, reader or colleague who listens to this stuff often takes such nonsupported beliefs or opinions as genuine. Why? Because it was made by "authority figures" who sound like they know what they're talking about. Today the vast amount of addiction data in existence will always supplant any expert's unsubstantiated claim.

Authority Fallacy Variants

There are some variations included under the authority fallacy. One includes the "bandwagon effect" or appeal to the many fallacy. Here the fallacy is built on consensus, or "everyone is doing it." For instance, let's consider this fallacy in relation to plugging a new counseling theory. The fallacy thinking is "if everyone is buying into this, there must be something to it." A significant problem with this fallacy is that there are always new counseling theories out there, but sometimes such ideas have little if any empirical support to back up their claims. The authority element of the bandwagon effect is that many buy into such effects without much thought. And, as some of you know, a number of addiction counseling theories have come and gone over the decades. The ones that are gone are the ones that didn't have the research support.

Another authority fallacy variant is the appeal to tradition fallacy. Here the authority comes from the dogmas and canons in our field. These dogmas have been around so long they take on the aura of authority. You often see it when questioning a traditional treatment program. The question posed is, "Why do you do treatment this way?" The tradition fallacy response is "That's the way we have always done it" or "That's the way treatment is supposed to be done." It has a very authoritative tone and sometimes one that is a bit

condescending. Well folks, always question such programs, especially in this day and age. Programs used to be built on tradition, now they need to be built on research.

Strategies to offset these pesky authority fallacies include finding the data to confirm what an authority has stated, looking for vested interests, and not taking things at face value (Taleff, 2006). Lastly, should you opt to purchase an authority's book, first look to see if there are references, particularly research references. Be cautious if no such references exist.

Generalizations

Neck and neck for what I believe is the most abused fallacy in our field is the one called "generalization." This fallacy attempts to argue a claim with little or no data or evidence to back up the claim (Taleff, 2006). Basically, it spouts off a notion, theory or conclusion with nary a nod to proof or a consideration of other variables. Some refer to this as "jumping to conclusions." The point is that generalizations are inaccurate and they come in different flavors.

The first notorious generalization is called the hasty generalization. If a generalization draws meaning from little or no evidence, then the hasty version is the most barefaced version. Clinically, you sometimes see this when addiction professionals glance at a new client admission, then turn their head toward you, and then pronounce that this new admission, whom they have never seen, let alone talked to, is a down-in-the-dirt addict if they ever saw one. The oft used justification to support this hasty generalization is "What would a person be doing here if they didn't have addiction problems to begin with?" However, this line of thinking is putting the cart before the horse. Taking time to do an assessment is where the real determination is to be made, not in a three-second glance. All the hasty generalization does is to add needless bias to evaluations, which blurs good clinical work. It also comes dangerously close to prejudice.

The next generalization is called the exclusive generalization. An illustration explains this best. Go to a book store and scan the self-help section. You will find a number of addiction books that try to claim that one or two elements in a person's life are responsible for the onset of addiction, be it anger, poor self-esteem or something else. While appealing, such books exclude any number of other variables that can account or add to what really are the reasons for a person's addiction. They exclude important variables and jump to *the* conclusion that whatever has been written or stated is the reason for an addiction. Sorry to say this, but there are no simple answers to addiction onset.

The tactic to address the generalization fallacy is not to buy into such conclusions. As with the authority fallacies, claims without good solid data are just empty claims. If you want to find good claims, find those with good research. Besides the recommendations listed above, what else can good addiction professionals do not to fall into these and a host of other fallacies? In a nutshell, learn the fundamentals of critical thinking.

Critical Thinking 101

While there are some challenging terms in and about critical thinking, the mechanics are quite easy. All the modest terms you need to know amount to about three words: premise (reason), conclusion (claim), and argument.

First, think about the terms "conclusion" or "claim." In our field, people are forever making claims about this or that. For example, "Our program is better than the one in the next county" or "This treatment is better than that treatment." Bold claims, but to all such claims one has to ask, "Where's the evidence?" or as they say in critical thinking, "What are the premises or reasons?" Consider that every claim made to a potential client concerning your program, or even about your own capabilities, needs to have strong, reliable, robust, and trustworthy premises or reasons to back up that the claim.

Put premise and claim together and you've made an argument. Arguments are not, as some believe, spats or quarrels, but a method to assess the truth of some claim. A premise or reason supports a conclusion or claim.

That's it. Those are the essential mechanics—nothing difficult. Consider that any client interpretation or diagnosis you make, or choice you make for a particular treatment is simply an argument, as in the above form. The big issue is how robust are the reasons for the interpretations, diagnoses or treatment selections you make. Inadequate premises and reasons are generally where clinical problems arise.

A Few Tips

So, how do the mechanics of critical thinking relate to the biases and fallacies we reviewed? Well, good critical thinking doesn't let the biases and fallacies get away with their shenanigans. Recall that biases and fallacies twist good clinical thinking. Critical thinking aims to minimize such influences. Now comes the part that requires a little work. Realize you and I are prone to biases and fallacies. They exist and we may not even know when we fall prey to them. That reorganization process is going to take time to bear fruit. Next, consider spending some extra time assessing the way you come to your clinical claims or conclusions. What helps is the all-powerful question. That means asking yourself, "How did I get to this conclusion?" and "How good are my reasons?" Questions are especially helpful if you're prone to make snap judgments, or you find that you constantly cram all your clients into a single classification. Such actions are generally a sign you have fallen for a fallacy or just tripped over a bias. Don't let them do that to you. C

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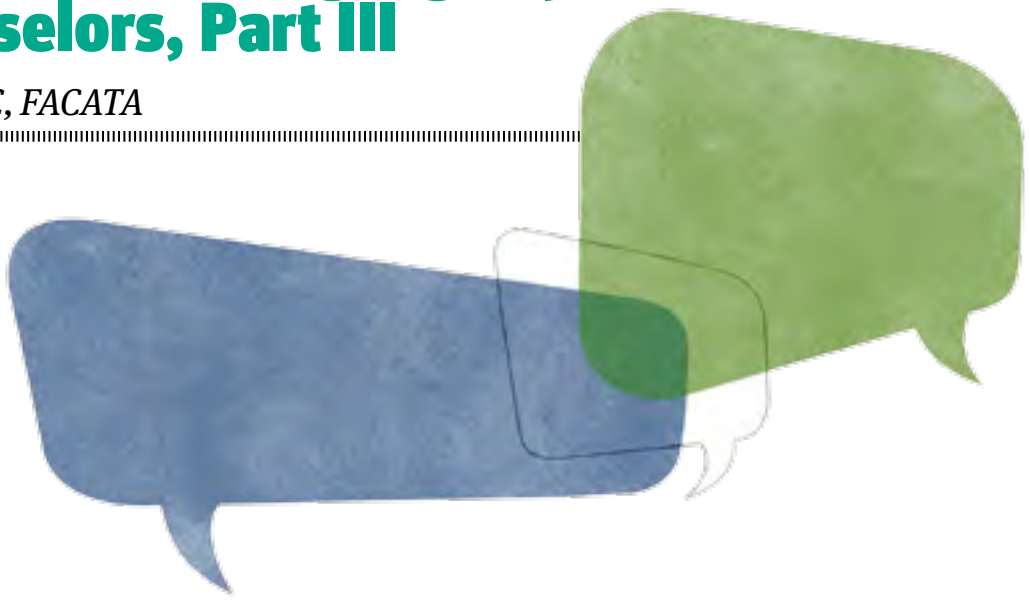
The Use and Misuse of Language by Addiction Counselors, Part III

Gerald D. Shulman, MA, MAC, FACATA



This is the final column in a three-part series examining language and the correct and incorrect uses of terms related to addiction treatment.

"Last Use" (of a Substance)

This term is included because of the frequency with which it is calculated inadequately when performing a substance use assessment. Most frequently, information in the assessment section of clinical records pertaining to recent use of substances will list only the day of last use for each substance. However, for substances with short half-lives, it is critical to list the time of day as well as the day of last use. For example, when assessing for potential withdrawal problems in a patient with a severe alcohol use disorder, there is a significant difference between documenting last use of alcohol as yesterday if at 12:01 AM vs. yesterday if at 11:59 PM.

"Impaired Driving"

Previously, "impaired driving" commonly referred to a blood alcohol level of 0.08 percent or greater and was often referred to as "drunk driving." However, the causes of impairment are increasing because of the use of drugs (e.g., opioids, cannabis, benzodiazepines) alone or in combination with one another or with alcohol. Since impairment does not begin at 0.08 percent BAC but with the first use of the substance, it is my opinion that using 0.08 percent BAC to determine impaired use is too high. Driving is considered to be impaired at a low of 0.0 percent in Nepal with other countries in Africa following suit with most countries in the European Union at 0.05 percent and a few at 0.02 percent.

"Mental Health Problems"

This all-encompassing term includes those people who have mild and transitory problems (e.g., grief over loss of the substance in early recovery because of giving up the substance), those with mental health signs and symptoms of insufficient number or severity to meet the diagnostic criteria for a mental health disorder (e.g., subclinical or subthreshold), and those individuals who display sufficient signs and symptoms to meet diagnostic criteria for a mental health disorder.

"Mild," "Moderate," and "Severe"

"Mild," "moderate," and "severe" refer to levels of severity found with all diagnoses in the DSM-5. For a substance use disorder, "mild" means meeting two or three of the eleven criteria, akin to the DSM-IV's substance abuse diagnosis; "moderate" means meeting four or five of the eleven criteria; and "severe" means meeting six or more of the eleven criteria, akin to the DSM-IV's substance dependence diagnosis.

"Motivation"

A desire or wish to achieve some end. Clinicians sometimes describe patients as "not motivated" because they may not yet wish to stop their substance use. In reality, all patients who present for assessment or treatment are motivated, but they might not be motivated for abstinence or recovery. They may be more likely motivated to avoid imprisonment, retain or regain custody of their children or keep their jobs. These types of motivation can become the pathway to motivation for recovery.

"Opiate" & "Opioid"

Opiates are naturally occurring narcotics (e.g., codeine) while the term "opioids" refers to both naturally occurring and synthetic narcotics (e.g., oxycodone).

"Premature Discharge"

"Premature discharge" is a term usually used to indicate discharge prior to the anticipated time. That time is usually determined by a projected discharge date in a fixed length of service treatment program.

"Problem Drinker"

This term has no agreed-upon meaning. It may be used to describe drinking that is not severe enough to reach diagnostic levels and also all levels of pathological use of alcohol without regard to diagnosis. In addition to having no agreed-upon definition, it appears to

characterize addictive alcohol use as if it is under the individual's control. Most unfortunately, it is sometimes used to describe a research cohort, thereby rendering the findings useless in applicability to an alcohol-disordered population.

"Recidivism"

"Recidivism" is a criminal justice term used to describe reoffense, a return to criminal behavior. It should never be used in place of relapse to describe a return to the use of substances. Such use reinforces the perception that substance use disorders are criminal behaviors instead of health care problems. No one would consider using the term "recidivism" to describe a relapse in any other chronic illness (e.g., "recidivism" in diabetes or hypertension).

"Recovery"

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), recovery from mental disorders and substance use disorders is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (2012). It is a process by which people with a substance use disorder achieve remission—meaning they no longer meet diagnostic criteria—and then develop their full potential. People unknowledgeable about addictive disorders or who view substance use disorders as an issue of morality may incorrectly describe this phenomenon as "reform."

"Recovery" vs. "Discovery"

It is not uncommon for clinicians to try to assist their patients to recover from a disorder with which they do identify and about which they have no understanding and/or acceptance. For such patients, a more appropriate interim goal is "discovery," first developing the awareness that they have the problem.

"Relapse"

"Relapse" refers to a return to the active disease state, as in cancer. With substance use disorders it is usually characterized by out-of-control use and possibly significant negative consequences. Relapse is distinguished from "lapse" which is a brief duration, low consequence return to use, often with a desire to return to abstinence. A lapse is often referred to as a "slip" in Twelve Step recovery terminology.

"Remission" vs. "Recovery"

"Remission," as used in the DSM, implies that the individual no longer meets the diagnostic criteria for the disorder. "Recovery" on the other hand, is a far more all-encompassing term; it includes emotional and spiritual growth and for many it means attaining a type of existence not even realized before the onset of the disease. When speaking to utilization reviewers, use the term "remission," which they are likely to understand, rather than "recovery," which they may not.

"Resistance"

This is a state of mind characterized by ambivalence about a course of action, which is often used too narrowly to describe opposition to engaging in treatment. We have come to understand from learning theory that a behavior which is not reinforced is not continued. Said another way, whatever the negative consequences of the substance use, the user derives some positive gain. It is important from a treatment perspective

to search for those positive gains in order to help the patient find other ways to achieve the pay-offs associated with the substance use. A man might find that the only way he can comfortably talk to or pick up a woman is in an alcohol-connected environment, such as a bar, where both he and the object of his quest are drinking. A woman might find that the only way she can get her husband's attention is by being "sick" (e.g., experiencing problems as a result of her substance use that demands his notice). It is characteristic of Proschaska and DiClemente's precontemplation Stage of Change.

"Signs" vs. Symptoms"

A "symptom" is generally subjective, such as when a patient complains about fatigue or insomnia which can only be detected or sensed by the patient—others only know about it if the patient tells them. A "sign," on the other hand, is objective as the results of a breathalyzer

or tremors and can be recognized by a doctor, a counselor, family members, and the patient.

"Substance-Related Disorders"

This is a term used to describe both substance use and substance-induced disorders as defined by the DSM-5. Substance-induced disorders are those caused by the substance use and include intoxication, withdrawal, and mental health disorders.

"Substance Use Disorders"

This is the term used to describe substance abuse and substance dependence disorders as defined by the DSM-IV or substance use disorders of varying severity as defined by the DSM-5. This is discriminated from "substance-related disorders" which includes both substance use disorders and substance-induced disorders.

"Success/Progress"

Treatment success or progress should be defined or measured by a reduction in the severity/intensity, the duration, and the frequency of symptoms rather than the "all or nothing" view of symptoms or no symptoms that is often associated with the concept of abstinence-based treatment. For example, if an individual diagnosed with a severe alcohol use disorder, who has been unable to achieve a single twenty-four hour period of abstinence in the three years prior to treatment, was able to achieve a year of abstinence with the exception of a five-day drinking episode in the year following treatment, it would be difficult not to consider this a success, even though the ideal would have been for the patient to have had no drinking days at all. Another example of such success would be the person with schizophrenia who after treatment still hears voices, but no longer has to do what the voices tell him to do and does not have to be rehospitalized.

"Tolerance"

"Tolerance" may be defined as a state of progressively decreased responsiveness to a drug as a result of which a larger dose of the drug is needed to achieve the effect originally obtained by a smaller dose.

"Treatment Completion"

The phrase "completing" treatment implies a fixed course of treatment, only applicable to an acute illness. When applied to chronic illness, treatment usually consists of a period of primary treatment followed by the management of the illness to maintain stability (think diabetes). An individual with a chronic illness never completes treatment, since completion implies the illness is not chronic and there is no need to manage the illness after the completion of primary treatment.

"Withdrawal"

This relates to the group of symptoms that occur upon the abrupt discontinuation or decrease in intake of medications, recreational drugs or alcohol to which the individual has developed physiological dependence. Withdrawal is dose dependent and varies based upon the drug consumed. The result of untreated, severe withdrawal to drugs such as alcohol, barbiturates, and benzodiazepines can result in very serious consequences including death. Withdrawal is different from a hangover, which consists of a constellation of symptoms of toxicity from consuming large amounts of the drug, usually associated with alcohol.

This concludes this three-part column on language. My hope is that they have clarified, explained, simplified, and corrected the language that we as clinicians use every day, and that I have opened our awareness to some new information. We have an opportunity to help people understand that what we deal with on a day-to-day basis is a disease, we can reduce the stigma, and we can further develop a common language. C

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Rural Adolescents: Let's Not Forget about Them

Fred J. Dyer, MA, CADC

The motivation for this article stems from three factors: my experiences as a young boy in the late 1950s and early 1960s on my grandparents' farm in Marvel, Arkansas, where I had the hard work experience of farm life; my work as a trainer and consultant on adolescent issues with agencies all over the country; and my appreciation for the opportunity to contribute monthly columns for *Counselor*.

Rural America is often personified by tranquil images of pastoral landscapes dotted with languid red-and-white and brown-and-black cows, where peace-loving, trouble-free residents wander to nearby creeks and ponds to fish. Nevertheless, studies that focus on rural substance abuse identify a changing image of rural life. Published in 1994, *Rural Substance Abuse: State of Knowledge and Issues*, was a collection of scholarly research and discussion of substance use among American youth and migrant farm workers, health consequences and interventions, and prevention and treatment strategies. Contributors to the monograph agree that the popular image of an idyllic rural life amidst rolling hills and white picket fences with minimal social problems such as substance use is not accurate.

Several years later, *No Place to Hide: Substance Use in Mid-size Cities and Rural America* (2000), a study commissioned by the US Conference of Mayors, reported that rural teens were using alcohol and illicit drugs at a higher rate than urban teens and that for young adults and adults illicit drug use rates were comparable across rural and urban settings. In a report from the South Carolina Rural Health Research Center, Mink et al. (2005) presents evidence for elevated rates of drug use, including methamphetamines, among rural youth. The evidence from the report concluded that, despite these trends, mental health workers in rural schools receive less training and are available for fewer hours than in urban schools. Additionally, according to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 2005 National Survey on Drug Use and Health, young people in rural areas are more likely than big city youth to indulge in binge drinking. Methamphetamine and oxycodone use is also a big problem.

Given the enormity and challenges of addressing alcohol and drug use and mental health problems of youth in rural areas, clinicians, public health specialists, mental health workers, school counselors, and teachers must understand the many factors that make providing substance use prevention and treatment services in rural areas so difficult before delving into solutions. SAMHSA's *TAP 28* (2004) describes many of those factors:

Poverty

Inner city residents are not the only citizens facing economic hardship. Over the last two decades downturns in the farming, manufacturing, and mining industries have devastated many rural communities. Younger, more educated, and better-off residents have fled the countryside to seek opportunities in cities. What they leave behind are the older, poorer neighbors, jobs with low wages and no health insurance, and concentrated poverty passed on from generation to generation.

Influx of Drugs

Rural residents face a surge of drugs. In search of new markets, drug dealers from big cities have begun to target rural areas. Rural residents themselves have gotten into the game. Methamphetamine is easy to manufacture from readily available ingredients, and the isolation of rural areas helps manufacturers hide their labs.

Limited Treatment Options

Treatment facilities in rural areas are often scarce. In my work as a consultant throughout rural areas, I observed a scarcity of treatment facilities for substance use, in particular for adolescents. In addition, some rural treatment facilities lack the necessary expertise to address the problems faced by rural youth.

Logistical Difficulties

Even when treatment is available, rural residents may not be able to reach them. With the vast distances involved and the lack of transportation, residents typically need private vehicles to get to treatment. Additionally, a lack of affordable child care adds to the logistical difficulties.

Stigma

Cultural and social norms prevalent in rural areas can make it harder for people with substance use problems to seek help. Rural culture tends to emphasize individualism, self-sufficiency, religion, conservative beliefs, rigid norms, strong family ties, and distrust of others. Added to the community disapproval, rural residents who seek treatment for substance abuse face a lack of anonymity. Rural communities are often small and tight-knit, and people who are suffering from substance abuse problems face the added stigma of "outing" themselves as substance abuse clients if they present themselves at treatment facilities.

Recommendations for Servicing Rural Youth with Substance Use Challenges

1. Community interventions should attempt to draw on the existing resources of rural populations. For instance, residential stability (Bierman, 1997) and a strong sense of community in rural areas contribute to interpersonal ties among adults. Close relationships have the potential to increase adult social support and the monitoring of youth behavior. This can alleviate parent stress, thereby reducing substance abuse among youth and adults (Scaramella & Keyes, 2001).
2. The most effective interventions are likely to be those that are developed, tested, and evaluated in rural settings (Clark et al., 2002). Most prevention programs have not been implemented in rural America; one exception is the Fast Track Program (Bierman, 1997). In keeping with some of the findings of this report, studies of the effectiveness of such programs show that family processes are crucial for reducing substance use among rural youth.
3. Access to treatment services is a fundamental hurdle for addressing substance use in rural America. One method to decrease barriers to access is to focus on the role of the rural health provider as an active member of the behavioral health continuum of care. Rural providers should focus on detection and brief counseling rather than detection and referral.
4. Supporting formulized activities for youth, integrating drug abuse prevention and education into existing school-based health programs, investing in peer-focused prevention programs, and programs designed to improve self-esteem are feasible community-level interventions for reducing substance use among youth.
5. Understanding and operationalizing the risk-factor theory, which asserts that myriad factors contribute to the decision of youth to use drugs and alcohol, is essential. These factors include individual, peer, family, school, media, workplace, and economic conditions. Most successful treatment and prevention programs tend to operate at several levels, addressing multiple risk factors simultaneously.
6. Socioeconomic conditions, such as poverty and low educational attainment are linked to substance use. These factors are particularly onerous in rural regions, as these areas tend to experience lower socioeconomic conditions. Research suggests that use rates can be affected by programs not directly targeting them. For example, improvement in economic status, educational attainment, and mental health in general could reduce the numbers of people who decide to use substances or who use them excessively.

When states and cities fail to provide funding to help schools, when treatment services are scarce, when prevention programs are not available—causing services to not include the entire family— and when after-school programs such as Big Sister and Big Brother are cut, such factors cause some kids to continue to be marginalized because of where they live and what they do not have, and a blind eye is turned away from the inherent risk factors in rural areas.

Maybe John Mellencamp was right in 1982 when he sang, "A little diddy about Jack and Diane, two American kids doing the best they can."

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Ask the LifeQuake Doctor

Dr. Toni Galardi

Dear Dr. Toni:

I am thirty-three years old. I am a professional woman and I live alone. For two years I was addicted to prescription Xanax to get to sleep. I either didn't dream or didn't remember my dreams the entire time. After going into a treatment facility, I have successfully gotten off this dependency and have been in recovery for six months.

Recently, I began having what I would call nightmares. I have had a recurring dream in which someone gets killed. In the first dream there was a terrorist shooting everyone and then he aimed his gun at me. The last dream I had I dreamt that I had arrived at a workshop only to find out that the workshop leaders were going to kill each of us by the end of the weekend and we knew it was going to be a painful death. I agonized the whole time about how they were going to kill me, imagining being burned alive or having my head chopped off. At the end of the weekend they announce that this was all a ruse; they put us through this experience to see how we would prepare for our death. Then the dream ended.

I am curious as to what you think it means. You have mentioned in other columns that you do dream therapy so I just wondered what your take is. My therapist doesn't deal with dreams much. His approach is very "here and now" in this reality. I should add that I do remember seeing a documentary with the former psychologist and guru of sorts Ram Dass. He said that when he had his stroke, he didn't think of God. He just went into a lot of fear about dying or what was happening to him. The meditation practice I follow talks about a practice of being ready for your death at all times. So, what do you think, doc?

–Nightmare Maniac

Dear Reader:

First off, congrats on getting clean and getting help to get clean. Tranquilizers are tough to kick by yourself. Sometimes when dreams return early in recovery, they come back in a ferocious manner. One can speculate endlessly as to why that is, but I prefer to devote the time here to address potential meanings of your dreams.

Recovery brings a kind of death with it. We can no longer numb ourselves to our fears or emotional responses to life's stresses. It can also unleash the inner critic (terrorist) while we sleep in the form of nightmares. Given that the documentary about Ram Dass had a profound effect on you, perhaps there is a powerful message here in this new chapter of your life. How are you now living your new life every moment? If you knew you were going to die a painful death in two days, do you want to spend the last precious hours you have obsessing about how you will die or do you want to be as present as possible? Many spiritual teachers have said that our state of mind at the end of our life is most informed by our thoughts right now. So, what parts of you are you ready to let go of? What parts are you ready to let die?

We are dying every day. In my book, The LifeQuake Phenomenon, *I spoke of a practice I give my clients I call "Death Becomes You." I invite all my readers to do this one at least once:*

- *Imagine you've just been hit by a car or are a passenger in a plane that's going down and you know you're going to die. You have ten minutes. As you recall your life, what do you regret having done or not done? Think of three things. Now, how might that inform choices you make from now on? Is there someone you need to clean things up with or words that you've felt toward someone, but haven't said? Is there a life change you could make that would transform having any regrets at the end of your life?*
- *Now, imagine you are invisible at your own funeral. You have the opportunity now that you're disembodied to hear people's real thoughts. What do you imagine people will say about you after you've gone? What would you like them to say? Now write your most ideal eulogy. Imagine it being presented at the service. What do you need to let go of or change about yourself to live up to your ideal eulogy?*

May your dreams bring your soul homeward. C

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ROBERT WEISS, LCSW, CSAT-S

COMPLEX TRAUMA & INTIMACY AVOIDANCE

Evan, a highly successful, thirty-two-year-old mortgage broker, enters therapy complaining about a lengthy history of failed relationships. His romances nearly always start out well, with an intense physical attraction leading to great sex and a swift emotional escalation. However, after a few weeks or months he starts to feel smothered, and he begins the process of "checking out." He starts to negatively judge many of the things he initially thought attractive about his partner, he loses the desire to engage and be sexual, he stops returning texts and phone calls, he breaks dates, and he basically does what we all do when we feel ambivalent about a relationship. But the more he distances himself, the more tightly his girlfriends seem to cling. Eventually he breaks it off with them, but not until he's dragged them (and himself) through an emotional wringer. After his breakups, he completely loses his desire to date and to seek sex for many months. He continues to socialize; he merely stops dating and being sexual. In treatment, Evan worries that his prolonged periods of hyposexuality—the avoidance of sexual fantasies, desire, and activity—are unhealthy. He also wonders why he continually picks insecure, needy, demanding, and emotionally draining women as partners. "Is it me," he asks, "or is it them?"

Perhaps you've encountered a client like Evan. After a number of sessions these individuals typically reveal extensive histories of early-life trauma—neglect, abuse, abandonment, and the like—that clearly underlie their push-pull adult relationship attempts. In short, they seek sexual and romantic intensity and they know how to get the game going, but, thanks to their problematic early-life attachment experiences, they fear and eventually flee any sort of deep and lasting emotional connection. Interestingly, these intimacy avoidant, and at times sexually avoidant, clients tend to attract their mirror selves—men and women with their own early-life attachment trauma who miss obvious cues that the intimacy avoidant person is not emotionally available. Often these mirror-selves are active sex or love addicts. In short, the desperate yet ultimately nonintimate seduction of the sex or love addict entices the intimacy-phobic avoidant, drawing that person like a moth to flame. Unfortunately, these equally emotionally challenged partners can dance their romantic *pas de deux* almost endlessly without ever connecting in any meaningfully intimate way. So the likely answer to Evan's question is: "It's you, and it's also them."

What is Intimacy Avoidance?

Intimacy avoidant people fear the smothering sensation caused by enmeshment with another person. When these men and women are in a relationship that starts to feel too close they begin the process of distancing themselves and eventually creating or forcing a usually painful breakup. Sometimes they string their ill-fated relationships together one after another; other times they avoid romantic and sexual relationships altogether—usually for finite periods of time like a few weeks, a few months or a few years, though occasionally forever.

Common examples of intimacy avoidant people include:

- The spinster or confirmed bachelor who has many friends but avoids dating and being sexual with others, with or without excuses for this behavior
- The hard-working husband who rarely gets home in time to see his wife awake, let alone to interact with her in any meaningful way
- The dutiful mother who pours her entire self into childcare, neglecting the emotional and sexual needs of her husband
- The serial dater who bounces from one intense yet unfulfilling relationship to another, never allowing anyone to get too close
- The "annual" dater who gets into a relationship that seems promising, sabotages it when the connection starts to feel enmeshed, and then avoids dating and sex for many months afterward
- The modern couple—pairs who allow themselves to become more interested in and engaged with technology than each other
- The sex addict who is hypersexual and highly aroused by casual sex, but quickly becomes bored, distant, and nonsexual when a relationship turns intimate
- The abusive partner (physical, verbal, etc.) who uses anger and judgment to push others away
- The man or woman who loves and chases an abusive partner
- The addict (substance or behavioral) who escapes emotional connection—and therefore potential emotional discomfort—through use of intensely stimulating substances and/or behaviors

Nearly all intimacy avoidant men and women act as they do as the result of unresolved early-life attachment trauma and/or social anxiety that manifests in adult life as various forms of relational push and pull: *I want you close to me, but I can't tolerate the closeness. Then, after I push you away, I long for closeness, but not with you.* And so it goes.

What about Avoidant Personality Disorder?

Sometimes people confuse intimacy avoidance with avoidant personality disorder (AvPD). Certainly the two issues can look similar in some respects and even appear in the same person, but

they are definitely not the same thing. Personality disorders such as AvPD are considered to be relatively fixed and unchanging reflections of the self, whereas trauma-based intimacy avoidance can be treated in ways that result in profound life changes and the establishment of genuine, long-term, intimate connection. The DSM-5 summarizes AvPD with the following statement:

> *The essential [features are] a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation that begins by early adulthood and is present in a variety of contexts* (American Psychological Association, 2013).

Generally speaking, AvPD arises from the same underlying genetic and environmental factors as intimacy avoidance and sexual addiction. However, on the avoidance spectrum, AvPD is an extreme manifestation affecting arenas of adult life that include but are not even remotely limited to intimate relationships. For instance, individuals with AvPD will decline promotions at work because they fear new responsibilities will expose them to criticism, they avoid new activities and experiences of any kind because they fear failure and humiliation, they expect to be rejected in social settings so they avoid them like the plague, etc.

Certainly it is possible for intimacy avoidant people to also have AvPD, but the vast majority do not. In fact, many intimacy avoidant people are quite confident in most areas of life. They climb the corporate ladder, they have large groups of friends, and they display most of the other outward signs of success and happiness. They are simply avoidant when it comes to lasting romantic and/or sexual intimacy.

Early-Life Complex Trauma

Trauma is a word that psychotherapists tend to throw around a lot, especially since the inclusion of posttraumatic stress disorder (PTSD) in the DSM more than thirty years ago. That said, many traumatized clients have little to no understanding prior to clinical intervention of the fact that they've ever experienced any sort of psychological trauma. They simply don't understand what it actually is.

My dear friend and colleague, Dr. Christine Courtois, an internationally renowned trauma expert, likes to use the following definition when discussing trauma and its effects:

> *Trauma stands apart from normal events in its intensity and impact. It is often sudden, unanticipated, and out of the blue, making it all the more shocking. Trauma can include exposures and incidents that anyone would identify as overwhelming, such as physical or sexual assault, combat, major accidents, rape, domestic and community violence, child abuse, and terrorist attacks. It can also include exposures and incidents that are less easily identified, such as rejection, neglect, abandonment, bullying, and emotional abuse. Traumas can occur on a one-time basis, on a time-limited basis (as in an accident, a robbery, or a weather disaster), or repeatedly to the point of becoming chronic (as in child abuse and human trafficking). It is often hard for a traumatized individual to make sense of trauma from his or her everyday perspective* (Courtois, 2014).

Needless to say, Christine's definition is both broad and subjective, meaning trauma can involve any type of harm you can think of, and the way in which that harm is experienced is dependent on the individual. Consider a car wreck: A mother who has her children in the car is likely to be severely traumatized by the experience, whereas a guy who drives race cars for a living and has been in dozens of high-speed wrecks may walk away almost completely unfazed. One thing that is abundantly clear when it comes to trauma is that people who've been traumatized in the past can and often do experience a wide variety of symptoms and behavioral manifestations in the present—ongoing emotional discomfort, shame, low self-esteem, bad dreams, addiction, anger management issues, and an inability to form and/or maintain intimate relationships, to name just a few.

There are several basic types of trauma (Allen, 2005; Briere & Scott, 2006; Courtois & Ford, 2013; Courtois, 2014), including:

- Impersonal Trauma—natural disasters, accidents, illness, disability
- Identity Trauma—related to a person's inherent and mostly unchangeable personal characteristics, including gender, race, ethnicity, sexual identity, and sexual orientation
- Community Trauma—related to a person's membership in a community or group, such as a family, tribe, religion or political organization
- Interpersonal Trauma—acts of harm deliberately caused/committed by one or more people, usually with premeditation, including neglect, abandonment, abuse, assault or community violence

Again, the experience of trauma is always subjective. Nevertheless, certain traumas are typically more damaging than others. Among these is a specific form of interpersonal trauma referred to as attachment trauma (or betrayal trauma). Attachment trauma involves the abuse of an intimate relationship, most commonly either the parent/child relationship or the spousal relationship. In most cases, the greater the degree of attachment between the perpetrator and the victim, the more damaging the trauma is likely to be. This is because the betrayal occurs in the context of an intimate relationship, meaning the damage is caused by someone the victim wants and usually needs to love and trust. Exacerbating the situation is the fact that attachment traumas are usually chronic in nature, occurring and reinforcing themselves repeatedly over time, driving the damage ever-more-deeply into the victim's psyche (Allen, 2005; Courtois, 2014).

Nearly always, intimacy avoidant adults have suffered chronic attachment trauma during childhood via repeated physical neglect, psychosocial neglect (emotional and cognitive unavailability), emotional abuse, physical abuse, and/or sexual abuse (overt or covert) perpetrated by parents, siblings or other relatives. Additionally, chronic early-life attachment trauma can also occur at the hands of teachers, coaches, clergy, bullies, and others. It is possible for chronic attachment trauma to happen even when the individual is not directly victimized. For example, children who witness domestic violence may not have the abuse directed at them specifically, but they nonetheless suffer by living in a fear-based, unpredictable environment. Unsurprisingly, the greater the child's level of attachment to the victim and/or the perpetrator, the more traumatic this witnessing will be (Allen, 2005; Courtois, 2014).

Dr. John Briere, another renowned trauma expert, would likely add here that it is not so much the actual traumatic events that serve as the greatest indicator of ongoing adult emotional challenges, it's how those events were handled and worked through—or not—within the family and/or the community (Briere, 1992, 1996).

Childhood Trauma Influences Adult Attachment

In Evan's initial therapy sessions, he insists that his childhood was just fine—perfectly normal and probably better than most. He states that he has no interest in wasting time dissecting his early life, and that he instead wants to focus on his adult relationship issues. As therapy progresses, however, he reveals that his father was rarely home, working long hours as an attorney for the city—sitting in on evening council meetings, late-night planning sessions, and the like. He says his mother didn't seem to mind, as long as there was plenty of money for her to spend. She obsessed about the house, the yard,

her wardrobe, and her son. Evan says he can't remember a time she wasn't hovering nearby, watching him, even when he wanted her to simply let him be. She would ask for his opinion, while standing in bra and panties, about what she should wear, how she looked, and how frustrated she was that his father was gone all the time. Yes, he liked the special attention he got from her, but he didn't like that his friends and even his father called him a "mama's boy." In retrospect, he says, his relationship with his mother was "a little too close." He also admits that she was incredibly moody, swinging from manic happiness to angry depression and back again without any predictable cause. He wonders if that's why his father chose to work such long hours.

Evan's experience with his mother likely qualifies as covertly incestuous (Adams, 2011; Courtois, 2010), or at least as narcissistic parenting, both of which can and do play into adult-life intimacy disorders of all stripes, including Evan's penchant for intimacy avoidance.

This result rather closely follows standard attachment theory, initially developed by psychologist John Bowlby in the 1950s. Essentially, Bowlby found that when caregivers are consistently available and responsive in healthy ways, children typically experience secure attachment (Bowlby, 1988). In other words, children feel confident that home/love/family is a safe haven where they can reliably find comfort, security, protection, nurturance, validation, and assistance with emotional regulation. With this reliable refuge consistently available, the child can comfortably depart, wander, explore, experience, learn, and grow—returning on an as needed basis. Over time, children will naturally wander further away, for longer periods of time, eventually becoming separate individuals with positive self-esteem and their own identities.

Unfortunately, not all caregivers are entirely emotionally healthy; this is where problems arise. Caregivers who are absent, neglectful, intrusive, inconsistent, demanding, needy, anxious, depressed, impaired, addicted, and/or unpredictable in their response inevitably create conditions of insecurity in their children, causing those kids to become both externally focused and hypervigilant. This ongoing sense of uncertainty and doubt—the lack of safe haven—can be incredibly traumatizing, stunting a child's ability to explore, to learn, to experience, and to grow.

It is important to note that attachment styles tend to develop very early in life, and they tend to be relatively stable over the lifespan. So individuals who experience secure attachment as kids tend to also seek and find secure attachment in their adult relationships. Conversely, individuals who do not experience secure attachment in childhood tend to struggle with deep emotional connections later in life. This is absolutely the case with intimacy-avoidant people like Evan and probably most, if not all, of the "clingy" women he dates.

The good news is that attachment styles need not be permanently locked in. With effort and proper guidance, people who were not blessed with secure attachment early in life can learn it through therapy and/or other healthy and healing relationships, resulting in what is known as "earned security." In this way, intimacy-phobic individuals like Evan can overcome their childhood wiring and develop true intimacy and lasting emotional connection.

Treating Intimacy Avoidance and Other Manifestations of Early-Life Trauma

Intimacy avoidant clients, including sex and love addicted clients, are usually relatively functional in most areas of life, even though they are suffering from the aftereffects of chronic early-life attachment trauma that they have often not even identified as traumatic. Evan is a prime example. Successful in his career and attractive to women, Evan nevertheless struggles to form lasting attachments. Despite his reticence to admit that his upbringing was somewhat less than adequate, his disorganized attract-discard-avoid attachment style rather strongly suggests that his father's emotional neglect and his mother's enmeshment and inconsistence are underlying factors in his current relationship woes. As a boy, one parent was not present, while the other was smothering, had poor boundaries, and was highly narcissistic. Not exactly a safe haven for young Evan and not exactly surprising that he now struggles with intimacy.

It is important to keep in mind that trauma is subjective—colored by the ways in which a particular person experiences and processes a specific event or series of events. So the

amount of pain Evan experienced from his father's relative absence may or may not be significant to him today, with the same holding true with his mother's enmeshment and mood swings. The depth of the damage will only be revealed over the course of Evan's therapy. That said, his pattern of allowing women to get only so close before he pushes them away, along with his periods of sexual and romantic inactivity following breakups, strongly indicates the presence of a profound and sad attachment disorder that will not easily be overcome.

In treatment, it is important to ferret out intimacy avoidance patterns and their origins—most often some form of neglect, abandonment, emotional/physical/sexual abuse, and/or emotional enmeshment (such as covert incest) by a parent or another primary caregiver. Childhood experiences that commonly contribute to intimacy avoidance include:

- Being raised by a smothering or narcissistic parent whose needs supersede those of the child
- Being emotionally, physically, and/or sexually abused by a primary caretaker or sibling
- Growing up in a home where there is persistent and profound mental illness, addiction or both
- Witnessing the emotional, physical, and/or sexual abuse of a primary caretaker or sibling
- Growing up in a home where a sibling or parent has a profound emotional or physical impairment/illness (and there is no balance of attention and focus)
- Being physically, emotionally, and/or socially neglected or abandoned
- Being treated as a parent's confidante, companion or surrogate spouse (covert incest)
- Needing or being forced to fill an adult's role in the family, such as caring for siblings (especially in single-parent homes or addicted households)
- Being or feeling responsible for a troubled parent (an addict, an invalid, someone who is mentally ill)

Complicating matters is the fact that many intimacy-challenged survivors of chronic attachment trauma present with co-occurring issues—addictions, depressive disorders, anxiety disorders, anger management issues, chaotic lifestyles, and the like (Allen, 2005; Courtois, 2014; Delmonico, 1996)—that must be stabilized safely before underlying trauma can effectively be addressed. Essentially, clients need to achieve a modicum of stability, particularly in cases of addiction, before deeper and earlier issues can effectively be addressed. Nevertheless, education about early-life attachment trauma and its connection to the client's present-day intimacy avoidance should begin early on, if for no other reason than the need for contextual analysis and shame reduction (Courtois & Ford, 2013; Courtois, 2014).

After this initial "client safety and stability" stage of treatment, coping skills for dealing with the desire to avoid and/or escape the oppressive sensation of emotional attachment via intimacy avoidance—like Evan's tendency to form, abruptly end, and then avoid intense sexual/romantic attachments—can be developed, usually in conjunction with the deeper therapeutic work of reexperiencing, processing, and resolving the client's early-life attachment traumas. Usually this type of long-term healing involves some combination of social skills training, cognitive therapies, group therapy, social learning, and perhaps medication, similar to the treatment of complex (multilayered) trauma in general (Allen, 2005; Courtois, 2010, 2014; Courtois & Ford, 2013; Raja, 2012). C

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DISCOVERING THE FAMINE WITHIN:

AN INTIMATE LOOK AT COMPULSIVE SHOPPING AND SPENDING

ANGELA WURTZEL,
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"The term hunger diseases is used for all those states in which—because of narcissistic and oral needs—people are driven to consume objects—and/or to take possession of and to consume them—in an addictive manner."
—Raymond Battegay, *Hunger Diseases*, p. 4

Carrie called my office seeking therapy for spending too much money on clothes, household items, and anything she figured would be useful to her at some point in her life. She stated in this initial conversation that she knew there were other reasons to come to therapy and that her shopping habits were just the tip of the iceberg. Carrie and I spoke for a few minutes. I explained that I conduct long-term psychotherapy that addresses the underlying "hunger" associated with compulsive shopping. I told her that the process tends to take time, with an emphasis on helping people understand how the process of overshopping serves to shield oneself from perhaps more difficult experiences related to emotional development and interpersonal relationships. Carrie believed that this type of therapy could be useful to her and we scheduled an initial appointment to assess more specifically her attachment history, how therapy could be helpful to her, and her expectations.

When Carrie came in for her first appointment, I asked her why she sought therapy now. She responded, "My mother has had a particularly grand influence on me." Carrie explained that she had been considering her relationship with her mother and was thinking that she would like to be less like her because there are things about her mother that she is realizing hurt her. At the same time, Carrie said, "My mother is also my closest confidante. I tell her everything and she tells me everything." Carrie went on to say that she was at a point in her life to make some changes so that she could sustain an intimate relationship with a partner and eventually create a family. Our conversation brought up memories and times in Carrie's life when she remembered feeling deeply sad, sometimes anxious, and generally empty regardless of her successes as a student and now as a professional woman. Carrie is thirty years old and had never sought therapy until now.

Carrie is an example of a young woman who is accomplished in her life, but knows on a deep level that something is missing that would lend her life more meaning. Within sessions, it became clear that shopping helped Carrie feel less empty momentarily and once the satiation she experienced from the binge shopping episode halted, her voracious emptiness returned even more intensely. This cycle of shopping being a symptom *and* a solution confounded Carrie. She had never thought of herself as "impulsive," yet she described how she impulsively and compulsively sought out goods without conscious intention to stop an emotional experience. At the same time, Carrie held an intelligent rationalization for the products that she would purchase. Following her shopping binge she would feel relief, even a "sigh," she said, when she would get into her car after buying something. "I have a lot of things," she said, "and I still want more. Nothing seems good enough once I get it home. I secretly hope that once and for all I will find what I am looking for."

When Carrie finished describing her shopping process, she realized she had been repeating this pattern for many years and now in talking about her "shopping habits," she noticed how ingrained her behavior had been. She sat quietly for a few moments and I sat with her. She looked at me with some tears in her eyes and said, "I just can't imagine what I would do without doing this." For the first time she seemed to feel fear in thinking about the possibility that her shopping addiction might end. She continued, "I am thinking that I would really lose something and that I would have to be sad and grieve. I don't know if I could do that, feel all that." She started to softly cry. A few more moments in silence passed, and I sat with her, letting her lead the way during this tender and important insight. "I knew," Carrie continued through her tears, "that there was more to talk about and think about and eventually feel about in my life. I know that shopping, *per se*,

is not exactly my problem although I have made it my problem. It's like, what comes first, the problems or the shopping?"

At this juncture, Carrie was beginning to put into words the possibility that her deeper desires lay beneath her needing to consume through shopping. Her enormous longing for clothes had been masking an even stronger longing for warmth, recognition, and attention. Carrie had adopted a socially acceptable means—"retail therapy"—to do what she had not been able to do psychologically: manage a frustration born into her since her early childhood.

When Carrie was an infant, according to her mother, she was "fussy and refused her mother's milk," so her mother gave her to her aunt who had also just had a baby and was breastfeeding. Carrie breastfed not from her mother, but from her aunt, and was left with the belief that she was to blame because she would not take her mother's milk. Never did Carrie think that something may have been bad or sour or not soothing about her mother's milk until I mentioned this hypothesis in one of our sessions. Carrie's eyes welled up and she said, "Oh, no, I had not thought of that. Yet, it seems possible." Although Carrie did receive food, holding, and responsiveness, from her aunt, by which she was able to develop into a young woman with perseverance, she simultaneously experienced a traumatic rejection from her mother that is likely at the root of her psychological deficits. She is trying to strengthen those deficits through therapy. Carrie's shopping, then, has been a means through which she has been seeking things that would reinforce her and increase her significance.

In her paper, "The Psychic Economy of Addiction," Joyce McDougall takes from Winnicott's theory of the mother-baby pattern that lays the blueprint for how an infant will dispel tension one step further, suggesting that a "mother is potentially capable of instilling in her baby an addictive relationship to her presence and her caregiving functions" (2001). It is the mother who is in a state of dependency with regard to her baby, and the child is unable to identify with what Winnicott coined, "[a]n inner representation of a caregiving maternal figure that would have the capacity to contain and deal with psychological pain or states of overexcitement" (2001). As a result, the baby does not learn how to self-soothe and provide self-care when feeling tension. Carrie is an example of an adult child lacking the inner resources to regulate her emotional states and she, like McDougall hypothesizes, attempted to fill her empty self by seeking relief in the external world via an addictive process of shopping.

Carrie and I spent many hours discussing emotional regulation: the capacity to regulate internal emotional reactions through frustration tolerance rather than using an action or doing something to quell the emotions. Managing the urges to act while regulating emotions develops in early childhood

when an infant is repeatedly soothed by her primary caregiver and the infant incorporates these functions. When there are failures in this process or in the relationship, emotional regulatory skills are interrupted and underdeveloped. In his paper, "Out of Body, Out of Mind, Out of Danger," Philip M. Bromberg proposes Harold Boris's hypothesis regarding the regulatory process in relationship to eating disorders:

> *Eating disorders arise when dysregulation of desire is linked in infancy with the dysregulation of appetite. This leads to what he calls an unevolved state of mind in which one wishes and hopes to have everything all of the time—a state of mind that is labeled, in the vernacular, "greed." Greed is a state that attempts to eliminate the potential for traumatic rupture in human relatedness by replacing relationship with food—a solution that is largely self-contained and thus not subject to betrayal by the "other"* (2001, p. 72).

I would assert that this description of dysregulation could clinically apply to Carrie; even though her symptom and solution is shopping behavior, her underlying trauma is linked to desire and appetite. Furthermore, Carrie agreed that she may have truncated emotional regulatory skills. She remembered temper tantrums, escalating so much that she felt very out of control, while her parents just observed her without providing any containment or reparation. She recalled times when her mother failed to pick her up from school and dance lessons, and she would sit alone in the parking lot willing her mother to arrive. Other memories filled her, including packed lunches that included only lettuce sandwiches and juice, her younger sister calling her vicious names, and countless images of feeling deserted and alone. Carrie had minimal skills for managing her emotional states. She vacillated between major outbursts to complete numbing with nothing in between. She would either feel it all or nothing at all. Emotionally regulating in this manner helped Carrie to survive and manage, and when she was not able to contain herself completely, she resorted to seeking refuge outside of herself through the process of shopping. Putting these puzzle pieces together seemed therapeutic to Carrie and she started to create her own emotional regulatory system through the process of talking in therapy and practicing mindfulness. She sought out education in mindfulness, journal writing, and meditation—all of which aided her in building the stepping blocks of greater internal emotional regulation.

In a recent session, Carrie stated "I have felt sad for no reason. I was driving home from a visit with my family—it was a seemingly nice visit—and I thought to myself, *I am depressed. Really depressed. I need to go home and write down all of the thoughts I am having so I can tell Angela when I talk with her.* I got home and didn't write them down. Now, today, I am groggy and don't remember everything." Carrie described her evening with her family for her father's birthday and how her mother would only go to a restaurant with certain foods because she was currently experiencing stomach problems. Carrie chose a place that met her mother's dietary needs, rather than her father's celebratory occasion. Her mother, according to Carrie, "gorged her meal. Nothing was left on her plate and then she needed to leave because she had a stomachache." Carrie's father took her mother to Carrie's apartment to lie down and her father returned to the restaurant. "I was disgusted by her. Everything is about her." Over the course of this conversation, Carrie began to understand her deep sadness and depression that crept up on her as she left what seemed to be a pleasant evening with her family. During our therapy, Carrie has described her mother as intrusive and self-centered, and even though at this point in treatment Carrie has been able to separate and gain more autonomy, her mother's psychic impingements still impact her on a deep level. Carrie reported no urges to binge shop and was able to name her emotional feeling with words.

The process of making interpretations is delicate. A strong rapport and foundation must be established before making such assertions, however, the process of talking in a

"Her unconsicous response to emptiness and frustration automatically led her to self-soothing via shopping."

therapeutic environment sheds a light for both therapist and patient. With Carrie, her progression to make conscious her inner experience occurred steadily over time, and our work together offered her the space and time to make what was once dissociated digestible. I never wished to force feed her, which is what had happened with her aunt: a force feeding of the wrong food. Rather, I gave Carrie a mixed batch of food, some of which she wanted and some that she surely rejected. The experience of feeding has been weaved throughout our eight year relationship and Carrie has been able to understand and mourn for what she never had from her primary maternal relationship.

I resisted putting Carrie on a prescribed spending schedule and as a result Carrie's shopping changed within the first years of therapy because she took more responsibility for her income and expenses, and created a shopping schedule that fit her needs at different moments in time. However, Carrie had a scarce self-representation of herself and a thin foundation of what mattered to her. Our therapy began to center on her establishing *her* sense of self rather than what others expect and wish from her. Carrie's early attachment pattern predicted that she would respond to others' dependency upon her rather than the other way around. Carrie often told me stories of her relationship with friends and how she would let them stay with her with no end date, take their calls and text messages at any hour, and drop what she would be doing to attend to them, sacrificing her own needs and self. This left her empty and fulfilled in a curious way. She would not only be left with nothing from them, but also overwhelmed with all that she now had to do for herself that she put aside. Feeling frustrated, she realized that these were still times when she would compulsively shop. Her unconscious response to emptiness and frustration automatically led her to self-soothing via shopping. We discussed alternative ways to soothe and a new topic: how to establish boundaries and reciprocity in her relationships.

Carrie described herself as someone who lacks internal and external boundaries. It's as if her umbilical cord originated from her to her mother rather than from her mother to her. When we started discussing boundaries and potentially setting them, she responded more defensively than she had about any other topic we had talked about. "The idea of saying no to anyone just seems impossible. Saying no to myself caused me great fear, yet when I imagine saying to a friend that she can't stay with me or to not take a call or not call someone back is maddening. I feel like I would be playing games with them because I *can* let them stay with me." I listened and said that what she was saying made perfect sense, while at the same time it was the exact same thinking that had continued to lead her to make decisions that left her feeling incredibly empty, alone, and frustrated—a familiar feast of emotions for her to then manage insufficiently with shopping. I went on, "One way to help yourself is to protect yourself and your needs. In doing so, you will have to recognize what your needs are and that they may not match the needs of the others in your life." Carrie thought about this and added, "I will have to grieve again. I have a deep want in myself to be wanted by others and I won't get what I want either."

Carrie's need to be wanted by others illustrates her own narcissistic hole. Carrie then recounted a phone conversation she had with her mother that we have talked about many times over. Her mother called and rattled on for one hour and Carrie said almost nothing. Carrie said to me, "My mother was talking about the tree outside of her window. Her filing cabinets. Her paperwork. Nothing of interest to me, but I listened for one hour! I don't think she even asked about me." It was unusual for Carrie to admit out loud that her mother failed her in some way. After Carrie verbalized this, she sat still and her eyes gazed downward. She started to cry and after a few minutes said, "I just can't believe she isn't interested in me." I said, "I know, it's hard to believe she is not interested in you."

When Carrie and I continued to explore her mother's disinterest and intrusive phone conversation and her friend's impingements upon her, we realized how much these experiences parallel one another. We also concluded that Carrie had no power over her mother or her friends to behave in more interested, concerned ways and that only Carrie had the power to manage herself. The quest would be for her to develop boundaries that would still allow for her to maintain relationships with people while still being realistic and, most importantly, for her to seek out relationships that are based more on her needs. In the meantime, Carrie and I also noted that her shopping behavior was analogous to her desire to incorporate objects and people in similar ways. If she could possess them she would feel a strength she hadn't otherwise thought she could obtain. However, her strength truly lies in her boundaries.

At times exhausted, Carrie left these sessions feeling less confused and more realistic about what she was capable of accomplishing each week. She considered the idea of incorporating a weaning process rather than an all-or-nothing approach toward creating buffers and boundaries. Carrie and I talked about dependency, desire, wants, and needs, each being an integral part of the human experience that serves to satisfy us and aid us in having meaningful lives. Carrie invested herself in this process while at the same time bumped up against many walls of resistance, confusion, and fear. Every time she battled with herself, and also with me at times, she developed and created boundaries. Week after week, she spoke honestly and openly, and even though she may have wished for me to pave the way for her, it was more therapeutic for me to light the way and be witness to her creating her meaningful life. C

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BEST APPROACHES TO SUBSTANCE ABUSE PREVENTION

We all know that alcohol and drug addiction is a problem in the United States. According to the US Department of Health and Human Services (2008), the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) administered by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) found that "8.5 percent of adults in the United States met the criteria for an alcohol use disorder, whereas 2 percent met the criteria for a drug use disorder and 1.1 percent met the criteria for both" (p. 1). This survey ultimately observed the extent to which alcohol and other drugs are misused in the US. The NESARC survey found that individuals who exhibit drug dependency have a higher chance of developing disorders related to alcohol use. However, individuals who exhibit alcohol dependency are not as likely to develop issues with illicit drugs. The survey identified young adults ages eighteen to twenty-four as the population with the greatest issues related to concurrent alcohol and drug use disorders. Also, while examining specific populations, the survey showed that men are more likely to experience issues related to chemical dependency than women.

In terms of alcoholism specifically, the National Council on Alcoholism and Drug Dependence (NCADD) states that "17.6 million people, or one in every twelve adults, suffer from alcohol abuse or dependence along with several million more who engage in risky drinking patterns that could lead to alcohol problems" (n.d., p. 1). Clearly, alcohol is the most frequently abused chemical in the United States. Oftentimes, alcohol use disorders can be traced throughout family histories. Over 50 percent of adults report some sort of family history of negative impacts related to alcohol use. Additionally, over seven million youth have been reported to reside in a home that also houses at least one parent who demonstrates difficulty with alcohol use. In reference to drug dependence, as cited by the NCADD website, the National Survey on Drug Use and Health (NSDUH) found that nearly "Twenty million Americans aged twelve or older used an illegal drug in the past thirty days" (n.d.). Such a value accounts for approximately eight percent of the population aged twelve and up. It was also found that the recreational use or misuse of prescription drugs is on the rise; so much so that it was predicted that nearly forty-eight million adolescent and adult Americans aged twelve and over have used or are using prescription drugs for the unintended effects. The survey reported that this statistic characterizes almost 20 percent of the population. These numbers are staggering and speak to the increasing prevalence of substance related issues in the United States.

Onset of Use

Though alcohol and drug addiction may affect any individual at any age, "Addiction is a disease that in most cases begins in adolescence, so preventing or delaying teens from using alcohol, tobacco or other drugs for as long as possible is crucial to their health and safety" (US News, 2011). A study

conducted by the National Center on Addiction and Substance Abuse (CASA) at Columbia University found that "90 percent of Americans who meet the medical criteria for addiction started smoking, drinking or using other drugs before age eighteen" (2011). The researchers also revealed that "One in four Americans who began using any addictive substance before age eighteen are addicted, compared to one in twenty-five who started using at age twenty-one or older" (CASA Columbia, 2011).

In another report by Hingson, Heeren, and Winter, as cited by Hazelden, it was indicated that "adolescents who begin drinking before age fourteen are significantly more likely to experience alcohol dependence at some point in their lives compared to individuals who begin drinking after twenty-one years of age" (Hingson, Heeren, & Winter, 2006; Hazelden, 2010).

Based on the current literature and research available, adolescent experimentation with alcohol and other drugs may lead to more serious use and increased risk for dependency. Because of this heightened susceptibility, more concentrated prevention efforts are necessary to help detract from these detrimental figures and unfortunate statistics.

The Importance of Prevention

Prevention against alcohol and drug abuse is important because addiction is harmful not only to the chemically dependent individual, but also to those who are close to them, and society at large. For underage individuals, developmental stages are greatly impacted by substance use and may lead to serious psychological and health concerns in later years. According to the National Highway Traffic Safety Administration, early onset of substance use is linked to a higher likelihood of developing an addiction, and there have also been reports that drinking among minors is linked to violence and crime (2001). Research has shown that early alcohol and drug use is more likely to contribute to risky behavior and result in negative consequences such as: injury, assault, impaired memory, decreased academic performance, altercations with the legal system, and compromised sexual health, including contraction of sexually transmitted diseases and unplanned pregnancy (Hazelden, 2010). With these considerable factors in mind, it is crucial to realize that prevention programs and procedures are absolutely necessary to help delay the onset of alcohol and drug use, which undoubtedly contributes to addiction problems later in life.

The National Highway Traffic Safety Administration outlines two main theoretical frameworks to help guide prevention strategies and speaks to the importance of their implementation. One framework is the "risk and protective factor" approach, which encompasses a biopsychosocial model (National Highway Traffic Safety Administration, 2001). This model looks at various and overlapping influential forces that may help assess why some people may turn to alcohol and other drugs and have a higher probability of becoming addicted, and why some may not. Another framework is the public health "agent/host/environment" model (National Highway Traffic Safety Administration, 2001). This model views the "agent" as the actual substance being used, the "host" as the person ingesting or using the substance, and the "environment" as the surrounding settings in which the person uses the substance. Environment can also include attitudes and norms associated with use. Previously, most views of prevention concentrated on the agent and the host with little consideration for the environment. Now, "the focus has shifted to how the agent and the host interact with the third element in the model—the environment" (National Highway Traffic Safety Administration, 2001).

Because of these complex and interlinking factors associated with the onset of alcohol and drug use, it is imperative that adequate programs, services, and resources be allocated to the development and implementation of concentrated efforts for preventing alcohol and drug addiction.

How to Begin

Prevention should begin early so as to delay the onset of alcohol and drug use. Ideally, intervention should occur in underage youth, at the entrance of middle school or before, where many

individuals become increasingly exposed to alcohol and other drugs. With this focus on youth, prevention education should initially take place within schools. This strategy would help to establish a consistent and widespread campaign that is sure to reach a full demographic of students across the country. From here, prevention should develop throughout the community and contain comprehensive, wrap-around outreach programs. This may include stricter law enforcement efforts along with individually focused strategies encompassing family and peer group dynamics; each portion of this prevention strategy works together to examine the aforementioned risk and protective factors (National Highway Traffic Safety Administration, 2001). Beyond this, however, prevention efforts should also expand further to include public policies and national procedures. The National Highway Traffic Safety Administration suggests that this helps institute universal penalties and provides an overall reduction to access, guiding the community and home front efforts (2001).

To help explain the connection between adolescent substance use and the development of addiction, Manceaux, Maricq, Zdanowicz, and Reynaert (2013) conducted a study to highlight the role of the prefrontal cortex in the cognitive and behavioral aspects of addiction. Maturation of the prefrontal cortex occurs during adolescence—and is not fully developed until well into the mid-twenties—and significant peaks in the expression of dopamine levels also occur in this phase of development (Manceaux et al., 2013). Additionally, Manceaux et al.'s (2013) results concluded that there is a parallel between addiction and the feeling of love relations in terms of neuroscience and brain imaging. This demonstrates that a greater emotional sensitivity might be a considerable factor in the higher rates of substance abuse during adolescence.

For these reasons, it is important for prevention efforts to be implemented early on in the school system, in order to provide psychoeducation for some of the underlying biological factors influencing the effects of alcohol and drug use in these key developmental stages. Some underage youth may not be equipped with the appropriate family or social environment to provide this level of support and encouragement for the delayed onset of use. Therefore, it is paramount that the school systems become a primary place for early prevention. Beyond this, however, it is important that within this educational component there be an element of discussion and interaction to enhance this instructive piece. Moreover, it is difficult to ascertain an exact location for prevention interventions to take place. Though schools may be a great start, comprehensive community involvement is essential to wrap-around preventative care.

Current Prevention Models

There are currently many approaches to substance abuse prevention in the United States. Most preventative efforts begin as educational programs in schools and target individuals during adolescents. These models of substance abuse prevention have continuously evolved throughout the years. Initially, Botvin found that original models of prevention relied more on "intuition than theory" (2000, p. 887). These original models were developed with three intentions: provide accurate knowledge, encourage emotional expression, and offer appropriate choices to using substances. It was found that these initial models of prevention might have had an influence on the understanding and comprehension of substance use. However, it was also found that these models were continually unable to actually effect individuals' plan to use and abuse substances. Additionally, Botvin explains that over time research

has identified a change in viewpoint when it comes to approaching prevention in academic setting (2000). Rather than concentrating on general education related to the devastating effects of substance use, prevention models implemented in school settings have transitioned their focus to the various risk and protective factors related to adolescent individuals. All factors considered, Botvin concludes that "the science-based prevention approaches developed and tested over the last two decades can be grouped into two general categories: (1) social influence approaches and (2) competence enhancement approaches" (2000, p. 888).

The Social Influence Model

The social influence approach to prevention emphasizes "the importance of social and psychological factors in promoting the onset of drug use" (Botvin, 2000, p. 888). This prevention model primarily focuses on factors such as norms, commitment, and intention not to use (Cuijpers, 2002). The model strives to add community-based interventions to school-based interventions as an effort to provide wrap-around care. Additionally, the social influence model utilizes peer leaders for education facilitation and provides life skills training to participants (Cuijpers, 2002).

The Competence Enhancement Model

The competence enhancement approach to prevention emphasizes the "teaching of generic self-management skills and social skills" (Botvin, 2000, p. 892). Botvin explains that according to this prevention approach, the use of illicit drugs is viewed as a behavior that is socialized and learned through modeling. For adolescents, this process of modeling occurs on two levels: interpersonal and intrapersonal, and is impacted by "prodrug cognitions, attitudes, and beliefs" (Botvin, 2000, p. 892). Such modeling and replication is consistently reinforced throughout society at many levels. These dynamics, along with undeveloped life skills, are thought to raise the risk of adolescents' likelihood to concede to environmental influences related to drug use and abuse.

In summary, Botvin categorizes the recent evidence-based substance abuse prevention models into two categories, as was previously discussed. Substance abuse prevention models such as the social influence approach and competence enhancement approach are generally implemented throughout school-based settings. Thus far, based on the literature, it seems as though many school-based prevention approaches are turning out to be ineffective in the long term (Botvin, 2000).

According to Fisher and Harrison (2013), there are three distinct types of prevention strategies within the Institute of Medicine Classification System: universal, selective, and indicated. This specific classification system aims its prevention activities towards various targeted populations. First, the "universal prevention strategies are directed toward the entire population of a county, state, community, school or neighborhood" (Fisher & Harrison, 2013, p. 316). Next, Fisher and Harrison state that "selective prevention strategies are targeted at subsets of a population who are considered at risk for substance abuse" (2013, p. 317). Finally, the "indicated prevention strategies are directed toward individuals who have demonstrated the potential for substance abuse based on their behavior" (Fisher & Harrison, 2013, p. 317).

In addition to the populations that can be targeted for various substance abuse prevention efforts based on risk factors, there are also classifications specified by the Center for Substance Abuse Prevention (CSAP). CSAP is "the federal agency that coordinates prevention efforts throughout the country" and they currently use a prevention classification system based on six key strategies: information dissemination, education, alternatives, problem identification and referral, community-based processes, and environmental approaches (Fisher & Harrison, 2013).

For starters, Fisher and Harrison state that information dissemination "involves communication of the nature, extent, and effect of substance use, abuse, and addiction on individuals, families, and communities" (2013, p. 317). Next, education activities "are designed to build or change life and social skills—such as decision making, refusal skills, assertiveness, and making friends—that are usually thought to be associated with substance abuse prevention" and alternative strategies "involved the development of activities that are incompatible with substance use" (Fisher & Harrison, 2013, p. 317–8). Additionally, Fisher and Harrison write that problem identification and referral is a strategy that is "generally targeted to indicated populations who have been identified as using tobacco, alcohol or other drugs or who have engaged in other inappropriate behaviors" (2013, p. 318). Community-based processes "involve the mobilization of communities to more effectively provide prevention services" and environmental approaches are "written and unwritten standards, codes, laws, and attitudes that impact substance use and abuse in a community" (Fisher & Harrison, 2013, p. 318).

Fisher and Harrison (2013) also present various risk and protective factors that could be related to a higher or lower chance that individuals will or will not abuse alcohol and other drugs (AOD). Such risk and protection factors should be considered when it comes to discussing the concept of prevention. These risk and protective factors are separated into five categories including: community, family, school, individual, and protective (Fisher & Harrison, 2013). Fisher and Harrison state that community risk factors include the "availability of AOD, laws and norms, mobility, neighborhood attachment, [and] economic deprivation" and that family risk factors include "history of problem behavior, management problems, conflict, [and] involvement with AOD" (2013, p. 320). School risk factors include "antisocial behavior, academic failure, [and] lack of commitment" while individual risk factors include "alienation and rebelliousness, peers who use AOD, favorable attitudes toward AOD, [and] early problem behaviors" (Fisher & Harrison, 2013, p. 320). Finally, Fisher and Harrison write that overall protective factors include "bonding and healthy beliefs and clear standards" (2013, p. 320).

Efficacy

As was previously discussed, substance abuse prevention models that are generally implemented through school-based settings, such as the social influence approach and competence enhancement approach have been found to be somewhat ineffective over longer periods of time (Botvin, 2000). However, according to a study by Botvin et al., "drug abuse prevention efforts targeting adolescents during junior high school in general, and the prevention approach tested in this study in particular, can produce prevention effects that last beyond the end of high school" (2000, p. 773). Furthermore, the "data also provide[s] additional support for the long-term effectiveness of a broad-spectrum, cognitive-behavioral, universal prevention approach called Life Skills Training (LST)" (Botvin et al., 2000, p. 773).

Ultimately, because prevention efforts are designed in research settings, they are not always fit for actual use in the environment for which they were designed—most specifically schools (Cuijpers, 2002). In addition, Cuijpers explains that it seems as though school-based prevention efforts have been researched most extensively, and it has been discovered that they serve only as a short-term delay in the initial use of substances among adolescents (2002). Furthermore, Cuijpers shares that some preventative interventions have been found to be more effective than others (2002). For example, interactive methods are more effective than educational methods, meaning there needs to be a discussion as opposed to a lecture. Cuijpers also found that life-training skills are important when it comes to substance abuse prevention efforts with adolescents (2002).

According to Fisher and Harrison, prevention efforts are a "long-term process involving public policy (legislation) and public awareness" and "the effectiveness of prevention efforts would be enhanced if the contradictory messages [in the media] were less pervasive" (2013, p. 320–1). The aforementioned CSAP prevention classification system presented by Fisher and Harrison has been evaluated for effectiveness based on each of the separate categories.

First, when it comes to information dissemination, it was found that prevention efforts that solely offered information did "increase knowledge of participants but had no effect on attitudes and drug use" (Fisher & Harrison, 2013, p. 321). Second, when evaluating the effectiveness of education prevention strategies, it was found that some school-based programs were effective. When it came to alternatives, it was found that "entertainment, vocational, and social alternatives programs have been associated with more rather than less substance use, although academic, religious, and sports activities are associated with less use" (Fisher & Harrison, 2013, p. 324). When evaluating the effectiveness of problem identification and referral

"Ultimately, because prevention efforts are designed in research settings, they are not always fit for actual use in the environment for which they were designed."

prevention strategies, it was found that these programs must have "valid procedures and trained personnel to determine where the individual is on the use continuum" (Fisher & Harrison, 2013, p. 325). Similarly, Fisher and Harrison found that "appropriate organization, leadership, and evaluation have been shown to be important components in successful community partnerships" (2013, p. 326). Finally, environmental approaches were found to have "demonstrated a direct impact on the use of tobacco and alcohol and on the problems associated with the use of these substances. However, environmental strategies have not been as effective with regard to illicit drugs" (Fisher & Harrison, 2013, p. 326).

According to the National Registry of Evidence-Based Programs and Practices (NREPP), as of April 2014, there are 115 evidence-based substance abuse prevention models (2014). Fisher and Harrison mention that the NREPP website currently contains a list of "prevention, intervention, and treatment programs, [but] it was initially started as a process to determine which prevention programs could be called 'model programs'" (2013, p. 327). Moreover, because the NREPP website lists all evidence-based substance abuse prevention programs, it can be used as a tool so that "states can ensure that the prevention programs they fund have evidence to support their effectiveness" (Fisher & Harrison, 2013, p. 327).

Cultural Issues

According to Castro & Alarcón, "in the past, substance abuse prevention and treatment programs have given limited or no attention to cultural variables as potential determinants of substance use and/or as integral components of programs for substance abuse prevention and treatment" (2002, p. 783). However, over time, it has been seen that there are in fact cultural issues related to prevention efforts.

For example, drug and alcohol use is extremely normalized in American culture—so much so that use is almost expected with age. Research on drug and alcohol marketing indicated that marketing cues could act as environmental triggers for individuals who are in the "preaddiction phase" (Martin et al., 2012). The research described how marketing cues might facilitate dysfunctional consumption based on the consumption continuum from non-use to addiction. Newcomb and Bentler explained that, "even though child or teenage drug use is an individual behavior, it is embedded in a sociocultural context that strongly determines its character and manifestations" (1989, p. 242).

When it comes to other cultural issues related to prevention efforts, research conducted by Griffin, Botvin, Nichols, and Doyle indicated "that a universal drug abuse prevention program is effective for minority, economically disadvantaged, inner-city youth who are at higher than average risk of substance use initiation" (2003, p. 1). Griffin et al. also concluded that such universal drug abuse prevention programs could in fact be effective for a range of youth along a continuum of risk (2003).

As a whole, when it comes to cultural issues related to substance abuse prevention efforts, there are many factors that should be considered. According to Resnicow, Soler, Braithwaite, Ahluwalia, and Butler (2000), the procedure of creating chemical dependency services that are culturally appropriate should start with an in-depth assessment of chemical use patterns, while also examining risk and protective factors relevant for the specific population.

Best Practices

As noted by the 115 different prevention strategies that are currently considered evidence-based (NREPP, 2014), there are many ways in which prevention efforts can be designed, implemented, and measured, but still be effective. However, there are important factors that still warrant considerable attention when designing, implementing, and measuring substance abuse prevention strategies.

To begin, Foxcroft, Ireland, Lister-Sharp, Lowe, and Breen (2002) sought out to explore various long-term prevention interventions for younger individuals, meaning those aged twenty-five years and below. Foxcroft et al. (2002) discovered that there are five main factors that need to be considered for longevity and that four of these are potentially applicable to other prevention strategies. These factors are as follows:

1. Extensive research linked to specific desired outcomes
2. More accurate evaluation procedures
3. The advancement of interventions designed for diverse populations
4. More standardized and easily assessable means of obtaining information related to prevention strategies.

With regard to the last factor, Foxcroft et al. specifically suggests "an international

register of alcohol and drug misuse prevention interventions should be established and criteria agreed for rating prevention interventions in terms of safety, efficacy, and effectiveness" (2002, p. 397).

Next, Allamani identified that, "in any case, prevention intervention is based on the individual decision to change one's own behavior mediated by collective health messages" (2007, p. 430). Additionally, Allamani identified several significant abilities or skills the substance abuse prevention provider should possess; these skills include proficiency and capacity related to communication, and the ability to inspire motivation. Allamani also suggested that substance abuse prevention providers should also be able to demonstrate exceptional listening and attending skills, with the capability to absorb what was heard before attempting to reframe them within the confines of an appropriate prevention strategy. Other skills include the ability to facilitate healthy connections among a range of participants, ensure a relevant relationship between program objectives and prevention strategies, and function within a group that is team-oriented and supportive, as to foster collaboration. With these considerations in mind, it may be important to remember that effective prevention models should be individualized to the targeted population to some extent, so that they can be compatible and effective based on the specific population's risk and protective factors.

Conclusion

All things considered, prevention is a team effort between individuals, professionals, community partnerships, and family and social supports. An open dialogue that flows between the pieces of this delicately intricate puzzle is essential. One "best approach" to substance abuse prevention may not currently exist. Nevertheless, it is vital to realize that successful substance abuse prevention is not solely determined by each individual part, but is rather accomplished by all of the parts working together as a whole.

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WAITING FOR "BREAKING GOOD": THE MEDIA & ADDICTION RECOVERY

WILLIAM L. WHITE, MA

The major media outlets have long been chastised for the content and style of their coverage of alcohol- and drug-related problems. Such criticisms include the glamorization of drug use, the demonization of drug users, and charges that the media is complicit in ineffective drug policies. Few have raised parallel concerns that popular media coverage of addiction recovery is rare, often poorly selected, and told through a lens that does little to welcome the estranged person back into the heart of community life. If media representatives do not "get it"—"it" being recovery—then what precisely is it that they don't get? What are the untold stories and their personal and public consequences to which media leaders ought to be held accountable?

Having closely observed such coverage for nearly half a century, I would offer twelve points from the perspective of a long-tenured addiction professional and recovery advocate.

Stigma

Distorted media coverage of active addiction fuels social stigma and contributes to the discrimination that many people in recovery face as they enter the recovery process. Caricatured and sensationalized media images of addiction—from hijacked (diseased, deranged, dangerous) brains to the most lurid stories of crime, violence, neglectful and/or abusive parenting, insanity, and infectious disease—minimize problem recognition among those with alcohol and other drug (AOD) problems. Additionally, it cultivates fear and revulsion among the general population and removes the welcome mat to community reentry for those seeking recovery. When combined with the failure to provide alternative associations, images, and expectations of recovery, as well as images that would distinguish the status of addiction and the status of addiction recovery, these media-shaped social attitudes push those who would potentially seek recovery further and further into subterranean subcultures. As an example, consider the images of methamphetamine addiction in the popular media. Now imagine a person seeking recovery from methamphetamine dependence confronting such stereotypes as they seek to reconstruct their social world and lifestyle. Imagine how images affect the community's willingness to welcome home these lost sons and daughters and mothers and fathers. Also imagine how the emaciated images of the meth stick figures inhibit the help-seeking of the majority of people experiencing methamphetamine dependence who look nothing like those images.

Coverage Frequency and Bias

Media coverage of addiction recovery is rare and tangential. If the media's coverage of alcohol and drug-related topics was plotted on a map, one would be hard-pressed to find the location of recovery. A survey conducted some years ago on behalf of Faces and Voices of Recovery revealed that the American public understood addiction "recovery" to mean that a person was trying to resolve an alcohol or drug problem rather than as a stable and sustained state of having resolved such problems. Such a view is understandable in light of just how infrequently the story of people in long-term recovery is conveyed through the major media channels, whether in the form of news, film, television dramas or print and electronic media. The rarity of recovery portrayals through those media outlets is even more pronounced for people of color, where its effects are even greater due to the saturation of images linking people of color and addiction. People of color and communities of color are wounded by the magnified coverage of their addiction stories and the marked absence of their recovery stories. When the media covers the addiction and recovery stories of people judged to be "one of us" or of one of their own, such as ABC's Elizabeth Vargas, a compassion-evoking story is told about the source of excessive AOD use—physical pain, emotional trauma or distress, death of a loved one, and so forth. No such explanations are offered for those judged to be "one of them": poor people of color, people living with HIV/AIDS, people in the criminal justice or child welfare systems. Medical models of understanding addiction/recovery are applied to the privileged; moral and criminal models are applied to the culturally disempowered.

Celebrity Addiction

The media mistakenly conflates recovery with active addiction and addiction treatment with recovery. Peripheral recovery references can be found in the sensational coverage of celebrities of the moment announcing their latest sagas of "crash, burn, and back to rehab" or in the press conferences of politicians, sports figures, actors, musicians, and notable others expressing—in words written by their publicists—a profound apology for their recently-exposed public indiscretions and their just discovered, but profound commitment to recovery. These are not the voices of recovery; these are the voices of addiction seeking a reprieve to chase the dragon another day. Ironically, when real recovery is actually achieved under such circumstances, media attention disappears. An unending number of experts are available to comment on a celebrity's out-of-control addictive behavior, but none are shown explaining how that out-of-control behavior later disappeared. For example, compare the wild media frenzies and the excruciating details of Robert Downey Jr.'s addiction-related misadventures with the sparse attention to and rare acknowledgement of his sustained recovery story.

When celebrities enter addiction treatment, it is often referred to as an entry into recovery or a "trip to recovery." Entering treatment is not synonymous with entry into recovery. Entering treatment is more like a benchmark in one's addiction career, the beginning of sustainable recovery and a respite from, rather than an end of addiction. The media's conflation of treatment and recovery leave people in long-term recovery lamenting, "They just don't get it!"

Expectations

Media outlets portray addiction recovery as an exception to the rule. Recovery is too often portrayed as the heroic efforts of a small, morally enlightened minority, yet scientific studies of alcohol and drug problems in the community consistently reveal that most addictions end in recovery, not with perpetual addiction, prolonged institutionalization or death. Recovery should be an expectation of every individual and family experiencing an alcohol or other drug problem and the American media fails to convey that hope and expectation. Recovery is the norm, and the normality of recovery is the most important missing story (see White, 2012).

Biased Portrayal

Media coverage of drug-related celebrity mayhem and deaths contributes to professional and public pessimism about the prospects of successful, long-term addiction recovery. Categorizing

"People in the early months and even years of recovery can detail the 'recovery from' story, but the 'recovery to' story takes years to create and understand."

repeated mayhem as "relapses" further conveys a failure of recovery when most often there has been no sustained period of recovery preceding such events. These events are manifestations of sustained addiction, not a loss of recovery. I am not suggesting a moratorium on reporting such events, only placing these details within a larger context—noting the value of professional treatment and peer recovery support for millions of individuals and helping readers or viewers understand what special circumstances may have made these valued aids less effective for this particular individual and what we as a community might do to change such circumstances. Media coverage portraying addiction treatment as a refuge through which spoiled stars escape the consequences of addiction, rather than as portals of entry into recovery, contribute to addiction treatment facilities being used for precisely such purposes and being perceived as such by the public and policymakers. The addiction treatment industry and recovery communities share the responsibility of not providing visible alternatives to these images.

Perspectives

When the story of recovery is told, it is most often told from the perspective of the initiate rather than the perspective of long-term recovery. This is analogous to interviewing an infant about the meaning of life. The person who is most frequently invited to step to the microphone to talk about recovery is often the least qualified by knowledge and experience to do so. Here is the question for any defensive media representatives reading this: After examining all the stories related to addiction recovery you have produced, written or performed in the past five years, what percentage involved telling the stories of individuals and families with more than ten years of continuous recovery? That is the missing story! People in the early months and even years of recovery can detail the "recovery from" story, but the "recovery to" story takes years to create and understand. Many people in long-term recovery would shudder at the thought of having shared their "wisdom" about recovery at such a fledgling stage of recovery. Media coverage of intervention and treatment processes is often exploitive and poses potential harm to those participating. Who could have conceived that placing people in active addiction—some of the most narcissistic people on earth—in front of television cameras would ever produce an authentic, let alone helpful, experience?

Glorified Roles

When personal recovery is conveyed by the media as a dramatic story of redemption, the media often inflates and elevates the recovering person to a pedestal position and then circles like piranhas in a feeding frenzy at the first sign of any failure to live up to that imposed image. Who could forget the cultural phenomenon of James Frey's *A Million Little Pieces* and the plummet from grace aftermath? People in recovery who readily volunteer or are enticed into this pedestal role should rightly fear the precarious footing of this position and the intentions of those who will profit equally from their rise and fall with little regard for the final outcome, as long as it draws attention

and sells products. Getting seduced into such transient ego-inflation creates a sense of recovery-endowed privilege and entitlement and a growing gap between this pedestal image and a person's real internal experience. Interviews with people in recovery should come with a warning label.

The Essence of Recovery

The media seeks to make the personal recovery story as dramatic as possible by emphasizing the details of the addiction story while glossing over the processes and fruits of long-term personal and family recovery. When recovery is portrayed, the focus is on the most lurid and dramatic elements of past addiction and early recovery initiation, not the processes of long-term recovery. Eliciting these dramatic details involves asking the most invasive of questions—questions never asked of those with other medical conditions—as if one's past addiction status eliminates any right to privacy. In media coverage of recovery, the language of recovery (e.g., hope, healing, gratitude, humility, humor, restitution, service, simplicity, spirituality), if present at all, is smothered by the more embellished language used to tell the prerecovery story (e.g., crisis, hopelessness, struggle, pain, suffering, failure, and harm to others). The lasting memory of exposure to such stories is not usually one of stable recovery and community contribution. While the sensational and dramatic are media staples, the essence of recovery is the displacement of such drama by living out these values of humility, simplicity, and unheralded service. When a life in recovery is not "newsworthy" by recent journalistic standards, this is a good thing.

The Real Story

The media fixation on celebrity addiction and recovery is a diversion from a much larger and more important story. The missing story is not that a celebrity, whose life few can relate to, achieves long-term recovery from addiction, but that millions of individuals and families have achieved such recoveries. Similarly, the real story of recovery advocacy is not the story of how one recovery advocate turned his or her pain into service, but that more than 125,000 culturally and politically mobilized Americans in recovery broke centuries of silence by participating in public recovery celebration and advocacy events this past year. The words and images of that larger story have yet to be revealed in any depth by mainstream media outlets.

Family Focus

The media tells the story of recovery only as a personal story rather than a larger story of the role of family and community in addiction recovery. The media is quick to tell the stories of families who have lost sons or daughters to addiction. Why don't we see the same attention devoted to families whose sons and daughters have recovered from addiction and how their families also experienced a recovery process? The media is quick to depict communities "plagued" by addiction, but rarely tells the stories of communities consciously creating the space in which resilience and recovery are flourishing.

Alternative Treatments

The rare media portrayals of recovery often depict only a single pathway of addiction recovery—specialized addiction treatment followed by lifelong affiliation with a Twelve Step recovery program. While many people successfully follow that pathway, this singular portrayal fails to convey the growing varieties of recovery experience—such as the secular, spiritual, and religious alternatives to Twelve Step programs—and the experience of persons who achieve recovery without the benefit of professional treatment and participation in a recovery mutual aid society. Additionally, stories of medication-assisted recovery are notably masked behind sensationalist and pejorative coverage of these medications and the patients who rely on them for recovery initiation and maintenance.

Recent Trends

The media is only just beginning to recognize newly emerging recovery support institutions and the existence of an ecumenical culture of recovery that is uniting people from diverse pathways and styles of long-term recovery. For more than 150 years, specialized support for addiction recovery has rested in two social institutions: recovery mutual aid fellowships—such as AA, NA, Women for Sobriety, Smart Recovery, and Celebrate Recovery—and professionally-directed addiction treatment. Today, new institutions like recovery community organizations, recovery community centers, recovery residences, recovery schools, recovery industries, recovery ministries, and recovery cafes are dotting the American landscape. This shift toward creating the physical, psychological, and social space in local communities within which recovery can thrive is of enormous historical significance, but still receiving only scant notice from mainstream media.

As the eternal optimist, I await with great anticipation a new quality of media coverage of addiction recovery. The "Breaking Bad" stories have been told ad nauseam. It's time for a new generation of journalists, scriptwriters, and filmmakers to convey the "Breaking Good" stories. C

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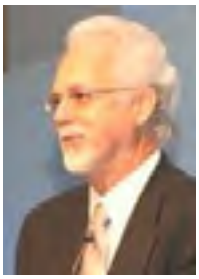

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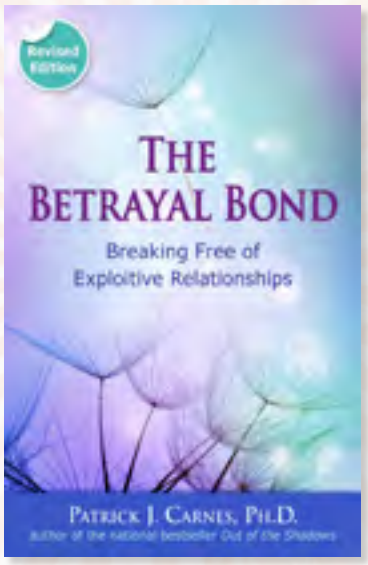
DR. PATRICK CARNES OFFERS NEW INSIGHT ON AN OLD CLASSIC.



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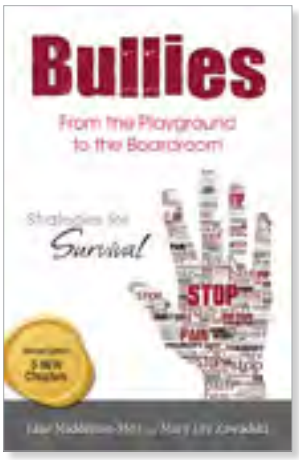

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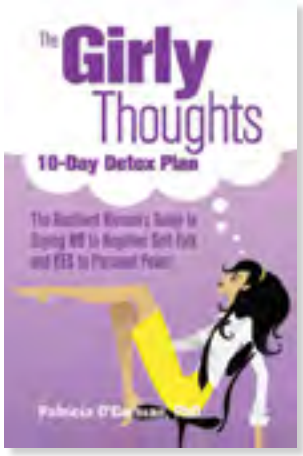

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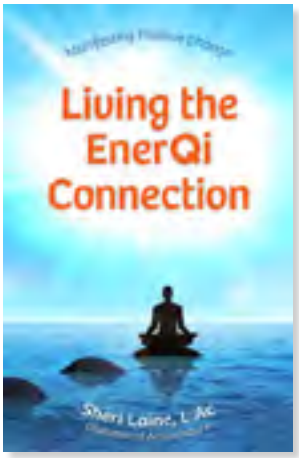

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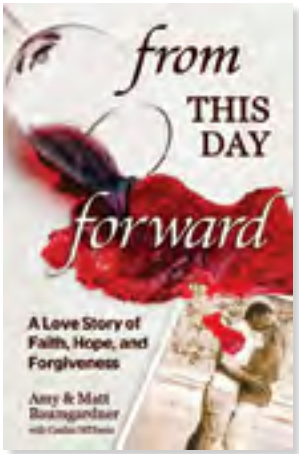

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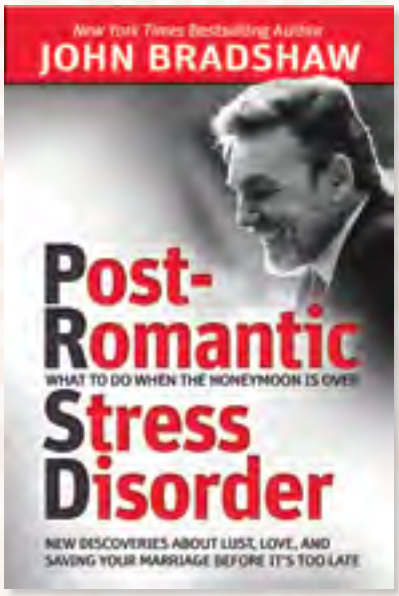

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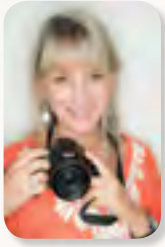

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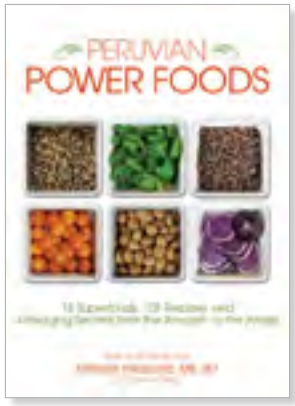

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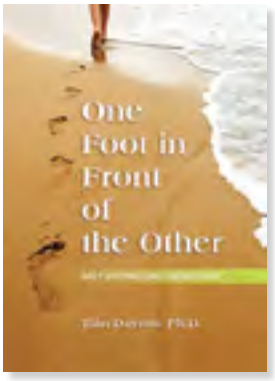

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From the *Journal of Substance Abuse Treatment*

Screening for MENTAL HEALTH CHALLENGES among People Seeking Help for SUBSTANCE USE DISORDERS

Brian Rush, PhD

It is widely recognized that only a small minority of people with addiction- and mental-health-related concerns seek help from either community professionals or less formal services. Reasons behind this are many and varied across communities, including limited access to services or just not knowing how/where to seek help; stigma and discrimination that challenge people to seek help or that impact the attitudes and behavior of the helping agents they encounter; feeling able to manage on their own; and personal challenges related to such responsibilities as work, school, and child care. Considerable research has also informed us for some time that, among those who seek help, the largest proportion will access a primary health care provider or other health and social service professional. Although many people with addiction- and mental-health-related problems, or those who are at risk for such problems, are in contact with

various service providers, these risks or problems are often not identified. These contacts are "teachable moments" and as such are missed opportunities for offering advice, more extended consultation or referral for additional support.

Best practices for the treatment and support of people with co-occurring disorders who are already engaged with specialized services call for more proactive screening of these co-occurring problem areas (SAMHSA, 2002; Health Canada, 2002). This includes screening for mental health problems among people seeking addiction treatment as well as screening for high risk/hazardous substance use and addiction-related problems among people seeking mental health treatment and support. The screening process must be followed up with more comprehensive assessment, appropriate interventions, and outcome monitoring. However, service providers differ in their attitudes and beliefs about how decisions and treatment plans are formulated. These beliefs reflect agency mandate, training, and personal experience. Some professionals may practice without using formal or validated screening and assessment tools, instead relying on their training and experience to guide problem identification and client-focused decisions. Some may have philosophical and ethical concerns about asking about mental health and addiction issues, considering it to be intrusive or possibly harmful due to potential stigmatization and labelling (e.g., in educational settings with young people). Some may doubt the increased efficacy and efficiency of these tools over their routine decision-making processes, and others may be reluctant to engage in consistent, structured screening if they don't believe they have the expertise or resources to address the concerns identified. These challenges, notwithstanding the research, suggest that critically important mental health and addiction concerns are missed when structured tools and processes to prompt thorough questioning are not used. Research also shows that screening is most effective when combined with other staged investigations and matched motivational, therapeutic, and motivation-based interventions.

Given the high level of heterogeneity in demographic, cultural, and clinical characteristics of people needing treatment and support for substance use problems, it is axiomatic that treatment must be highly tailored and client-centered. This calls for a thorough investigation of needs and strengths and a coconstructed matching of this profile to available service options within the agency and across a continuum of care in the community. The focus on screening and assessment is intended to increase the efficiency of client intake and engagement, facilitate placement matching, improve individual treatment outcomes, and minimize service delivery costs across the system as a whole (Hilton, 2011).

As a follow-up to the publication of the Canadian report on best practices for co-occurring mental and substance use disorders (see Health Canada, 2002), our group at the Centre for Addiction and Mental Health in Toronto, Canada, initiated a program of research and development in the areas of screening, assessment, and co-occurring disorders. Our initial consultation with substance use treatment service providers in the province suggested that a staged approach would greatly

facilitate their work to the extent that positive results on very brief, low cost screening tools would trigger the application of more in-depth, diagnosis-specific tools which, in turn, would set the stage for more comprehensive psychiatric assessment and mental-health-related intervention. The beginning of a conceptual framework evolved from these consultations and is presented below in its current form.

The Importance of a Staged Approach

An evidence-based approach encompasses several factors including clinician expertise, exploration of person characteristics, and contextual variables using psychometrically sound tools, critical-thinking skills, personal and collateral input, and knowledge of evidence-informed interventions. Importantly, screening and assessment must be seen as a process that continues over time as more information is shared and therapeutic relationships strengthen. A collaborative, longitudinal approach is particularly critical for the screening and assessment of complex, co-occurring disorders (Kranzler, Kadden, Babor, & Rounsaville, 1994) given the need to disentangle etiological sequencing (e.g., depressive symptoms induced by heavy alcohol use). Best practice for this longitudinal approach includes a staged, multigated strategy that links screening, assessment, and outcome monitoring with a family of tools and related decision-making processes. These tools and processes must be developmentally appropriate and delivered through a diversity-based approach to ensure equitable access and subsequent assessment and treatment. This approach to screening has been articulated in the *Conceptual Framework for Screening and Assessment* shown in Figure 1. This framework is consistent with the emphasis on staged assessment and interventions for addictions treatment, co-occurring disorders, and mental health assessment for primary care contexts.

As the project team's thinking evolved with respect to this conceptual framework, others in the field—in particular Mike Dennis and colleagues at Chestnut Health Systems—were continuing their work on the development and validation of screening and assessment tools that also aligned with a staged approach (Dennis, Chan, & Funk, 2006). Our Toronto group held an international research symposium on screening and assessment for co-occurring mental disorders in the substance use treatment population and gathered the advice of key international researchers as well as key stakeholders in our provincial treatment system. This was published in a collection of papers in a special issue of the *International Journal of*

Mental Health and Addictions (Rush, 2008). Our colleagues in the community services division of the organization adopted screening for co-occurring disorders as a high priority for province-wide implementation and system-change (Centre for Addiction and Mental Health, 2006, 2009). Additional research syntheses and pilot studies further shaped our research plans. While there were several options in the literature for brief screening tools, we noted that no studies were available that compared the tools in the same population and against the same validation criteria. This was reported to us as a major challenge for service providers and our community development consultants to decide which tool might perform optimally in a given context. We also noted a dearth of studies that distinguished between brief tools—what we referred to as "stage 1" tools—and longer, more complex "stage 2" tools and felt that it was important to compare performance across these groupings as length, administration time, and cost were reported as critical criteria in the decision-making processes of potential end-users. Finally, we noted a lack of studies that used a state-of-the-art independent psychiatric interview as the gold standard—many tools in fact being validated against other screening tools that may themselves be of somewhat questionable validity. It is against this backdrop that we launched our study to put a small number of mental health screening tools "head-to-head" in a comparison of their ability to detect Axis I psychiatric disorders in a substance use treatment population.

Study Design

As the details of the research project are reported by Rush and colleagues (2013), only the highlights are provided here in order to prompt reflection on the key implications for clinical practices as well as future research.

Study Sites and Participants

Participants were recruited from three independent addiction treatment facilities in the province of Ontario, Canada. The sites were selected to include a heterogeneous mix of services, urbanicity, and clients. A total of 544 clients were recruited as a consecutive, nonrandom sample across the three sites between February 2007 and May 2008 (Site one: 152; Site two: 228; and Site three: 164). About two-thirds of the study sample were male and the average age was thirty-seven years.

Index Screening Tools

GAIN-Short Screener – Internalizing Disorder Screener (IDScr): The subscale of primary interest in the GAIN-Short Screener (GAIN-SS) was the five-item IDScr which screens for internalizing disorders (Dennis et al., 2006). Responses to each subscale are given in terms of the recency of each symptom (3 = past month; 2 = 2–12 months ago; 1 = 1+ years ago; 0 = never). The score is the count of symptoms endorsed in a chosen time period. In the present analysis, we use the symptom count in the last month (ranging from 1 to 5). This subscale was administered within the larger, twenty-item GAIN-SS. Completion time was one to three minutes.

K6: The K6 is a six-item, self-administered measure of nonspecific psychological distress and is a subset of the ten-item version (Kessler et al., 2002). Respondents rate each of six symptoms on a five-point Likert scale with the following stem: "During the past thirty days, how much of the times did you feel . . ." In the present analysis, scores range from 0 to 24 with "none" scored as "0" and "all of the time" as "4." Completion time was one to three minutes.

Psychiatric Sub-scale of the ASI: A prerelease version of the ASI-6 was employed and there were eleven self-administered items. In the main analysis, items were scored according to ASI-5 as it was still more commonly employed in the field. The response format in the Psychiatric Subscale varies across the items—some in yes/no format and others in Likert rating scales. Most items refer to the previous thirty days. Completion time was three to four minutes.

Psychiatric Diagnostic Screening Questionnaire (PDSQ): The PDSQ is a comprehensive 111-item screening tool for specific Axis I disorders designed for self-administration (Zimmerman & Mattia, 2001). It comprises thirteen subscales of yes/no questions, each set corresponding to a diagnostic category of DSM-IV-TR. The longest subscale has twenty-one items (the depressive module) and the shortest has five items (hypochondriasis). The time period for reporting is either two weeks or six months depending on the DSM-IV-TR requirements for each category. Completion time was fifteen to twenty minutes.

Reference Tool (Gold Standard)

Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID), Research version: The SCID represents the current state-of-the-art reference tool for psychiatric diagnosis in research. It renders a yes/no decision for each

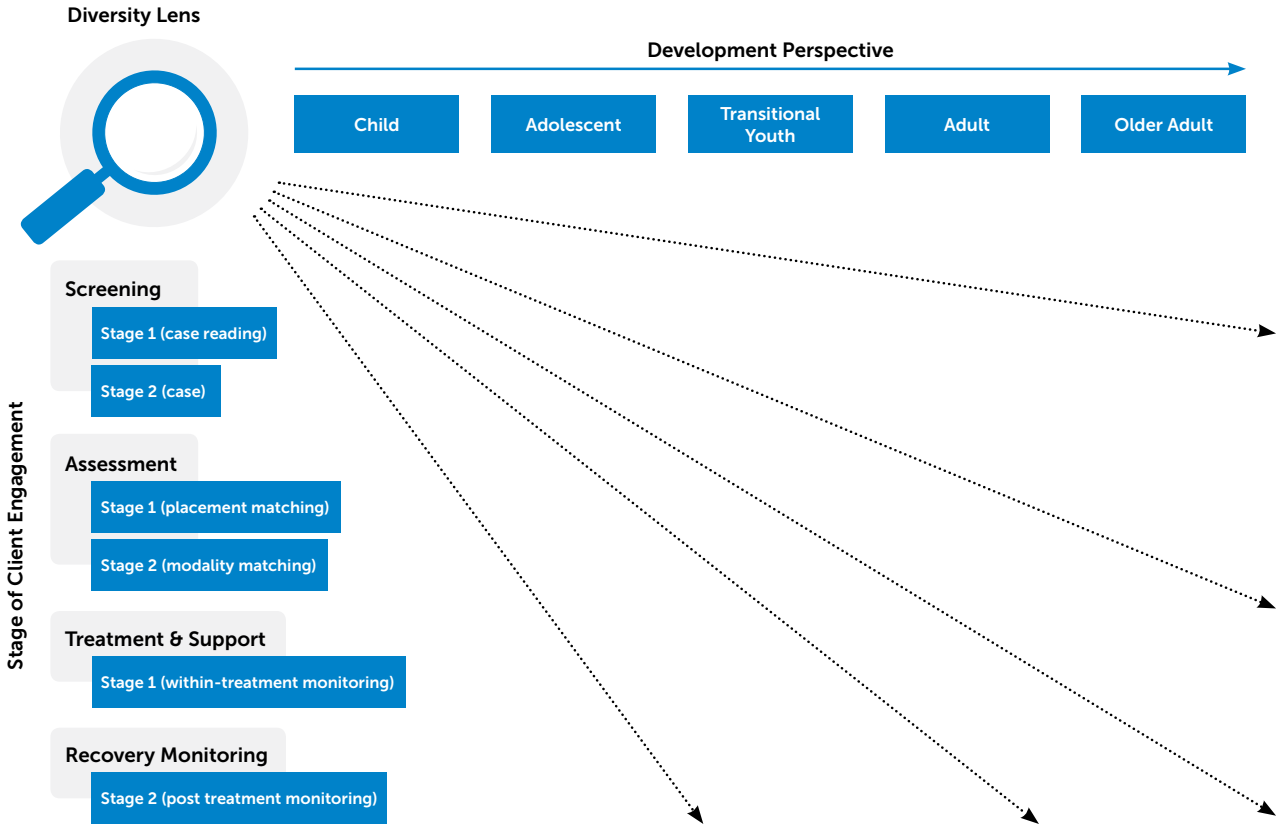

Figure 1. Conceptual framework for screening and assessment in context of collaborative care. Adapted from Rush and Castel (2011).

Table 1. Comparison of performance of alternative screening tools for major categories of Axis I mental disorders.

	GAIN-SS-IDScr		K6		ASI (5)		PDSQ	
	AUC	(95% CI)	AUC	(95% CI)	AUC	(95% CI)	AUC	(95% CI)
Any Disorder	.78	(.74 - .83)	.78	(.74 - .82)	.77	(.73 - .81)	.82(1)	(.78 .86)
Any Internalizing Disorder	.77	(.73 - .81)	.76	(.72 - .81)	.75	(.71 - .80)	.77(2)	(.72 - .81)
Any Depressive Disorder	.66	(.62 - .71)	.70	(.65 - .75)	.65	(.60 - .69)	.67(3)	(.62 - .71)
Any Anxiety Disorder	.72	(.68 - .76)	.70	(.65 - .74)	.67	(.63 - .72)	.74(4)	(.70 - .79)
Any Psychotic Disorder	.67	(.58 - .75)	.67	(.58 - .76)	.67	(.57 - .76)	.82	(.74 - .91)

(1) Total items endorsed of all PDSQ subscales.
(2) Total items endorsed of MDD, PTSD, OCD, panic disorder, agoraphobia, social phobia, and GAD.
(3) Major Depressive Disorder only
(4) Total items endorsed of all PTSD, OCD, panic disorder, agoraphobia, social phobia, and GAD subscales.

of the disorders covered by the interview, including substance use disorders. Completion time ranged from approximately forty-five minutes to four hours. The exclusion criteria for substance-induced disorders were ignored on the diagnostic algorithm because of the very nature of the population studied. A total of ten interviewers were SCID-trained according to an existing institutional (CAMH) certification protocol.

Data Collection Procedures

Following an informed consent process, a subsequent research appointment involved the administration of the screening tools in a predetermined order, starting with either the K6 or the GAIN-SS-IDScr in an alternating, balanced design, followed by the ASI Psychiatric Subscale, and lastly the PDSQ. This was then followed by the SCID interview with the interviewers blind to the results of the screening instruments and other assessment information. The study protocol was approved by the CAMH Research Ethics Board.

Analysis

Receiver operating characteristic (ROC) curve analysis was undertaken to assess performance of each screening measure using the SCID diagnosis as the dependent variable. The Area Under the Curve (AUC) and its 95 percent confidence interval were calculated. For any given disorder, or group of disorders, the AUCs of each screening tool were contrasted by examining the overlap in the 95 percent confidence interval. We calculated the optimal cut-off scores based on the optimal balance of sensitivity and specificity.

Key Findings

We estimated the prevalence of co-occurring psychiatric disorders using the SCID diagnostic interview, with 69.9 percent meeting criteria for any current/past month Axis I disorder, excluding substance use disorders, and 42.5 percent and 53.5 percent meeting criteria for any mood or any anxiety disorder, respectively.

Tool Performance

Table 1 compares the performance of the various screening measures on their ability to identify current/past month mental disorders at a fairly high level of grouping. In terms of "any disorder," the AUCs ranged from .75 to .80; the GAIN-SS-IDScr, the K6, and the ASI Psychiatric Subscale Version 5.0 all performing at an equivalent level based on the degree of overlap in the confidence intervals around the AUCs. Similar findings were obtained for "any internalizing disorder"

(depressive and anxiety disorders grouped together), with AUCs ranging from .75 to .78 across all the tools.

Drilling down past these broad groupings, performance of all the measures was more modest, with the AUCs for "any depressive" and "any anxiety" disorder ranging from .64 to .71 and .69 to .76, respectively. The AUC of .82 for the PDSQ for "any psychotic disorder" is higher than obtained for the other tools.

We also calculated the optimal cut-point for each tool with corresponding sensitivity and specificity. These data are provided in the original research paper and will be of interest to those wishing to apply these tools in a substance use treatment context.

The GAIN-SS is a screening tool in use in over 1,500 administrative treatment units in the US and Canada, including use in forty-nine states at the time of this writing (Dennis, Chan, & Funk, 2006). The use of the SCID diagnostic research interview as the reference criterion significantly improves upon previous validation of the GAIN-SS that used a criterion based on suggestions of mental health disorders derived from responses to the mental health items of the larger GAIN assessment tool in which the GAIN-SS is embedded. Thus, our validation results support continued widespread dissemination of the GAIN-SS, especially when one considers the low cost, ease of scoring and administration, and the fact that it allows for a common tool to be used across diverse settings, including mental health settings where one should be

"This was the first study of its kind to report on 'head-to-head' performance of various screening tools in the same clinical population of people with substance use disorders."

Discussion and Implications

We aimed to assess and compare the performance of a set of screening tools for Axis I mental disorders in a heterogeneous population seeking treatment for substance use disorders. Although the high level of co-occurring mental disorders found in this study has been well-documented in previous addiction treatment samples, few studies have employed structured clinical diagnostic interviews as a gold standard, and with a sample of this size and diversity. The prevalence of any Axis I disorder and any mood or anxiety disorder are similar to those recently published for a large heterogeneous addiction treatment population in the US (Chan, Dennis, & Funk, 2008). This concordance added to the external validity of the study. The high prevalence also supports the call for routine implementation of structured screening processes since often research shows co-occurring mental disorders are often undetected by routine intake and assessment processes.

This was the first study of its kind to report on "head-to-head" performance of various screening tools in the same clinical population of people with substance use disorders. The two briefest instruments—the five-item IDScr subscale of the GAIN-SS and six-item K6—detected individuals presenting with any one of a broad grouping of disorders at a comparable level of performance. Given that the IDScr subscale contains one less item than the K6, it is marginally more efficient.

screening for substance use disorders. Also in support of wide dissemination of the GAIN-SS is the fact that it contains three other subscales—externalizing disorders, crime and violence, and substance abuse—each with their own validation data which contribute unique information to client-centred treatment and support.

Although not developed as a screening tool *per se*, the ASI Psychiatric Subscale performed well in detecting broad groupings of mental disorders, with results in a similar range as the GAIN-SS-IDScr and the K6. This builds on previous retrospective validation work. Although substantially longer than the GAIN-SS-IDScr and the K6, those substance abuse treatment programs currently using the ASI as their routine assessment instrument should consider the embedded Psychiatric Subscale to perform an initial screening function for broad classes of Axis I disorders.

With respect to detecting broad clusters of mental disorders, the PDSQ did not perform better than the shorter screening tools, with the exception of psychotic disorders. Thus, the data suggest that the briefer tools be used when the aim is to cast a net for broad clusters of mental disorders. That said, unlike the other tools employed in this study, the PDSQ was developed as a screening tool for specific diagnosis. In the present sample the PDSQ performed well for most specific disorders (data not reported) and we return to this issue in the implications section below.

It is also important to note that overall performance of virtually all the screening tools evaluated in this study is not in the "excellent" range, as few AUCs surpassed the .8 level, but rather hovered around .7 to .8 for both broad categories and specific disorders. This suggests cautious interpretation of test results in the substance abuse treatment population. In addition to using routine screening processes, all available information with respect to mental health issues should be brought to bear in interpreting and acting on test results, including, for example, past and current utilization of mental health services, medication, family history, and information available from family members. Screening tools are meant to complement, not replace information that may be available from many sources and evaluated with good clinical judgement. An often neglected aspect of the clinical application of a screening tool is the relationship between the use of a screening tool and the process of engagement, motivation, and therapeutic alliance. An effective screening process depends on having a good tool to use, but also on the competence of the professional when using it with individuals in a nonthreatening and engaging manner.

Implications for Future Research

We are left with three major questions going forward that we consider critical for additional research and development in this important area.

Does screening for mental health improve outcomes of substance use treatment?

The usual approach to answering the question about the effectiveness of screening is to assess whether the screening tools and related processes are successful in identifying people with mental health and addiction problems that would not have been identified through routine care. Although this has rarely been put to the test in a systematic way (see Gilbody, House, & Sheldon, 2005, for a synthesis of the research in the area of depression), the well-documented level of undetected problems combined with the high predictive value of many validated screening tools point to the importance of systematic screening to improve case detection. There are, however, two additional aspects to the effectiveness question. The first is to ask whether the screening tools and processes, and subsequent review and actioning of the results, contribute to the management of the index problem. In other words, does screening and the screening results lead to meaningful action on the part of clinicians that would not have occurred otherwise? Secondly, one must ask if, at the end of the day, the screening and subsequent action have improved the status of the index problem or related challenges. The systematic review on screening for depression by Gilbody and colleagues (2005) suggests that screening can contribute to better care management and health outcomes if there is some selectivity in providing feedback to only moderate-to-high risk cases, rather than all people who may score positive according to test guidelines. This suggests that screening alone will make little difference without a detailed response plan and follow-up intervention. This remains an empirical question, however, in the substance use field.

How do we calibrate the tools in a staged model to be optimally efficient?

While we used our emergent conceptual model of a staged approach to screening and assessment (Figure 1 on p. 67) to help select the tools for our head-to-head comparison, the validation study did not itself test the veracity of the staged approach *per se*. For example, we did not present data on the percentage of cases that hit the cut off on the stage 1 screeners who did not hit the cut-off on the stage 2 screener (false positives). We have, however, continued this line of inquiry with two of the tools tested in our validation study the GAIN-SS-IDScr and the PDSQ. We found in a separate study that even at a cut-off of three to five positive items on the IDScr, over 75 percent of those screened positive did not meet criteria established on the stage 2 screener for moving forward for further psychiatric assessment. Thus there was a very high percentage of false positives highlighting the need to set the bar very high on the initial screeners and calibrate the cut-offs at each stage.

We have also come to appreciate that the tools organized in staged models need to be carefully selected according to the setting in which it will be implemented, taking into account time and resource availability, but also prevalence of the index condition. For example, while one might evaluate the combined efficiency of the GAIN-SS and the PDSQ for evaluating mental disorders in substance use treatment settings, one might choose different tools for busy, lower prevalence primary care settings, evaluating for example the combined efficiency of one- to three-item screeners for depression or anxiety (Means-Christensen, Sherbourne, Roy-Byrne, Craske, & Stein, 2006) and the GAIN-SS as the second stage screener.

How do we scale up screening for mental disorders in substance use services on a large scale?

Our study findings fit well with a larger body of research that points to the importance and the means to systematically screen for mental health challenges among people seeking assistance for substance use treatment. In subsequent work we have tested a staged model that uses some of the tools evaluated in the present project and found very high acceptance among our pilot sites (Rush et al., 2013). Based on the positive findings, one would think that embedding our staged tools into these agencies beyond the pilot and going from there to the wider regional and provincial system would be a relatively smooth process. The reality is, however, that successful implementation rarely begins and ends with the research evidence, but rather depends on a whole host of contextual factors and strategic activities (Sibley, 2008). For implementation, the role and purpose of screening should be well understood and articulated in the context of the mandate and objectives of the service provider. The tools must also fit with the trajectory of clients into and through the service delivery setting, and organizational policy must also support the implementation of screening and related protocols. Personnel who are administering the tools must be trained to introduce, administer, score, discuss, and take appropriate action based on the screening results. All of this needs to be clearly conveyed to individuals seeking assistance so that they understand how screening can be helpful. All of the above factors are the purview of the new world of "implementation science," an approach to the implementation of evidence-based practice that calls us to be much more proactive and strategic when it comes to moving evidence to the real world of clinical practice (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). This sets the tone for a new generation of research on the implementation of evidence-based screening tools such as those studied in our past work. C

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Special Interview with JOHN BRADSHAW on POST-ROMANTIC STRESS DISORDER

Gary Seidler & Leah Honarbakhsh

JOHN BRADSHAW is an educator, counselor, motivational speaker, and author. He has hosted a number of PBS television programs on such topics as addiction, recovery, codependency, and spirituality. Bradshaw is credited with popularizing such ideas as the wounded inner child and the dysfunctional family. With several *New York Times* best sellers, his books have sold over ten million copies and he is published in forty-two languages. At the age of eighty-one, Bradshaw is far from done. His latest book, *Post-Romantic Stress Disorder* will be published later this year by Health Communications, Inc.

In *Post-Romantic Stress Disorder*, Bradshaw helps couples figure out "what to do when the honeymoon is over." The book covers everything from the developmental stages of love and intimacy to skill-building exercises and the very latest research on love, lust, and attachment. As Bradshaw states himself, "My major goal in this book is to offer you a compelling argument that will stop you from throwing away what may well be your perfectly good marriage partner, or from ending a perfectly good relationship that seems stuck." *Post-Romantic Stress Disorder* features case stories about Bradshaw's patients and touches upon the work of several experts in the field, including Drs. Helen Fisher, Patrick Carnes, Pat Love, and Claudia Black.

Counselor's Consulting Executive Director, Gary Seidler, interviewed Bradshaw about his recovery, his work on the family, and his latest book.

Gary Seidler: I am delighted to speak with an icon in the addiction and behavioral health field. Welcome, John.

John Bradshaw: Hello, Gary.

Gary Seidler: You first burst onto the scene with your PBS series *Bradshaw on the Family*. When and how did you come to understand that looking into families of origin was something important for the self?

John Bradshaw: Well, I came from a severely dysfunctional alcoholic family. As a child, I didn't understand any of the dynamics that were going on. All of a sudden I got into the work of Murray Bowen and began to understand that the family is a social system. I later heard a lecture in Shreveport, Louisiana one day on the alcoholic family and the roles—"star," "hero," "scapegoat" and so forth—which suddenly put my family together in a way that I had never seen before. I probed it more and it became utterly fascinating for me to see what happens in dysfunctional families.

There are things like a child becoming a surrogate spouse, which is a role that I took on for my mother because my dad was in and out of house for varying lengths of time. Emotionally, to take that on, you're carrying all their problems—things that you shouldn't even have to deal with. So that was it, really. It was deeply personal for me and very exciting to be able to put that all together. Families of origin can tell you a lot, even about sexual preferences.

Gary Seidler: I'll never forget the first time I saw you speak, in the early 1980s in a very crowded church lecture hall in Fort Lauderdale, Florida. You were talking about shame. I wonder what your "aha" moment was in regards to shame and families.

John Bradshaw: I read Gershen Kaufman's book on shame, which really became the missing piece of the puzzle to my personality and my life. Although I'd been the class president and a star on the football field, I still felt like an impostor. It just put my whole life together and it reduced my shame. I'll never forget that night at the Fort Lauderdale lecture, and how enthusiastic you were and how you and Peter Vegso started talking to me about publishing my books. Interestingly, my books on shame still sell more than any of the other books I have published—it's still an incredibly relevant issue today.

The new book, *Post-Romantic Stress Disorder,* is about an issue that is very complicated by shame.

Gary Seidler: I also remember very well the workshops you were conducting all over the country around that time on healing the inner child. Could you talk a little bit about the value of inner child work and perhaps bring us up to date on why we aren't doing more inner child work in this current era?

John Bradshaw: Gary, I really don't know. To me, it is the most profound therapy that I have ever seen and I've seen a lot of them in fifty years. I started doing it independently, out of the work of transactional analysis, and I developed my own developmental model of it. That was the difference. It was the notion that I could embrace this kid, the one that I knew was still there, even after selling all these books, the one that was saying "You're an impostor and they're going to find out" and "You don't really know anything." It's just amazing. What's even more incredible is that I still get letters, even over ten years later, from someone who came to a workshop and is now a therapist, or someone who had been on their last leg, and how the inner child idea really changed them.

Now what's happened is that Allan Schore and Dan Siegel, these brain guys, have come along and they are saying that the "talking cure" and therapy is minimally effective. What's important is the deep feeling work and now there's the science and the brain chemistry that says it's all the right brain. A lot of my workshops involve music, poetry, non-dominant-hand writing, all of which are elements of right brain healing. I now have a tremendously valuable, clinical way to say that this is one of the fastest healing tools I know. It's faster than EMDR. In three days, peoples' lives can change and I didn't understand that for a long time.

Gary Seidler: That's impressive. Okay John, let's get personal. You've always

worn your own recovery on your sleeve. Where are you in your own recovery journey and have you beaten all your demons? Do you think we're ever *recovered*, or are we always in a state of recovery?

John Bradshaw: I'll jump right on that last question; I think we're always in a state of *recovery*. Right now, at eighty-one years old, my demons are ice cream and candy, which I stash and hoard and try to hide from my little girl and from my wife so they don't know I'm eating all this stuff! So my addiction is still hanging around, as it were, but the others—the alcohol, the love, the sex—they are gone. I'm thirty-six years sober from love and sex addiction and forty-nine years sober from alcoholism. So I feel really good about that.

I don't kid myself, though. About two years ago I was diagnosed with spinal stenosis and my doctor started giving me Vicodin. I was taking enough of that to sink a ship and because it doesn't have the amphetamine-like kick of alcohol and other drugs, I didn't think there was anything wrong with it. But when I was hospitalized, my wife told me that I was "getting gone" on that medication, so I'm never out of it in that sense. Anytime a doctor gave me something that was mood-altering, I'd feel that it was all legitimate because a doctor did it. I don't

feel that way anymore. I have to really be careful.

I think my demons are benign, but they're not gone. So yes, I'm still recovering.

Gary Seidler: Over the years we've had many conversations about these kinds of personal issues. I want to share a similar story to the one you just shared.

I stopped smoking thirty years ago. A couple of years ago I was at a social function and they were distributing these e-cigarettes, so I just thought "Okay, I'll try one of those and see what it's all about. There's no smoke involved, it can't hurt." Within two seconds, it triggered my whole smoking addiction. Thankfully, my partner was with me to say "You know what, I don't think this is a good idea." I could see myself smoking that e-cigarette and spiraling off into who knows what. So I'm completely with you in that we are always in recovery and that no matter how benign the behavior is, it's always just around that corner.

John Bradshaw: Well I'm glad you realized it! I want people to know that they can get out of this stuff, but that if they have an addictive personality and they've been addicted, they need to be careful.

Gary Seidler: Definitely. So, your last book was about virtues, titled *Reclaiming Virtue*. What led you to write that particular book?

John Bradshaw: Well, my own struggle with morality was part of it. I was raised Catholic, I had very pious grandparents, and we were expected to believe the church in everything without question. I wanted to find a way to have morality without God as it were. I don't mean *against* God, or to spurn God for people who have that—I certainly believe that some of the dogma is valuable—but morality is always contingent. You can't have a science of moral acts.

I studied Aristotle in seminary, and Aristotle's prudence virtue is about knowing how to make right decisions at the right time for the right reason. That's really what I wrote the book about. Then there's Aquinas's ethics, the notion that anybody can learn and have their morality internalized.

I remember one time when I was at a park here in Houston with my uncle, an all-American baseball player, and I watched him help this woman on a bucking horse. He didn't know anything about horses, but his own personal ethics told him to go and help her in a split second. The rest of us were standing around with our thumbs in our mouths. That's virtue; that ability to act spontaneously on an internalized morality.

Reclaiming Virtue is not my most popular book and I definitely wrote it for me and not for anybody else. It has a lot of autobiographical stuff in it about a lot of personal things that I've struggled with for a long time. Thank you for asking about that.

Gary Seidler: That actually leads very nicely into my next question. Many observers feel as though society is going to hell in a hand basket. There seems to be more hate, unwillingness to compromise, anger, and violence than ever before. Can you share your thoughts about that?

John Bradshaw: I believe that too. When I talk to elementary teachers, high school teachers, and college professors, it really is a nightmare—that's how they talk about it now. Kids just don't obey you like they once did. Maybe it's that in trying to get out of mere obedience, or obedience without content, we've gone too far to the other side and there isn't enough obedience. I don't think we should throw out all of the old values, but we have to understand that they need to be applied to this unique situation in this specific time. A choice I would make in this situation may not be the same choice you would make, but if both of us have virtue, we should be acting virtuously. Children don't seem to have any sense of discipline and I think we need more of that in the family.

As for married couples, they are the reason I wrote this new book, *Post-Romantic Stress Disorder*. About 50 percent of the couples that I have counseled who have divorced, did so needlessly. As the marriage goes, so does the family. When a marriage is dysfunctional, a kid will pick up on that and get caught up in all the dynamics of the family. Then the child is unable to develop his or her own internalized sense of morality and virtue.

Gary Seidler: Do you think children today are suffering more than ever from abuse, bullying, egotism, and even the rape culture we're seeing on college campuses? Is that all part of the same out of balance position?

John Bradshaw: Yes, I think we've overreacted to Victorian morality. Today you watch a show and there's something wrong with them if they don't sleep together on the first date. In my day, some of this stuff was just unheard of, but now we have teenagers having sex as fast as they can. A lot of parents don't know where they are with their own morality and their own sexuality, so I think a lot of that behavior is coming from children rebelling because they don't have a strong enough authority in their lives. A child will be angry when he or she doesn't have an authority figure, something to live by or someone to look up to. A lot of that has gone away because mom and dad are so engrossed with the child and not worrying about their own marriage.

In addition, a lot of parents are still resorting to physical punishment, even though that has lessened a great deal since my time. There's a lot of rebelling among the youth because of the passing values that are not being carried on. I think in the future we will see more couples and parents paying attention to their marriages, which is oftentimes where the dysfunction will come from.

Gary Seidler: Along those lines, do you think loving blended families, gay or straight, are good for our kids?

John Bradshaw: It really all depends on the parents. I know gay couples who have marvelous children. I know of blended families where the children are tremendously happy and healthy. However, these blended families can be just as dysfunctional as anybody else. The same laws that apply to relationships certainly apply to gays and lesbians. Blended families are harder because there are a lot of new roles, but there are a lot of families that work it out. I don't think there's any data that

suggests that blended families divorce more than other families.

Carl Jung once said that the most damaging thing to any child is the unlived lives of their parents. So when parents leave their wounded inner child untreated, they will pass that on to their kids. To answer your question, I think it really depends on the happiness and functionality of the parents.

Gary Seidler: So let's take a minute to talk about the present. Tell us a bit about your new book, *Post-Romantic Stress Disorder*? What is that, exactly?

John Bradshaw: Well, I grabbed the title because it was catchy! *Post-Romantic Stress Disorder* is based on three new discoveries about the brain. In fact, I keep putting off the book and typing day and night because I kept *finding* stuff to add. The new data on the brain tells us that lust is complete brain circuitry. Without lust, the human race would die out in one hundred years. But lust and love are not the same—when you fall in love there is a whole other brain program.

Everybody knows what it is when they're in it, when they have that infatuation. When you're in love, it's like you're drunk. You can't do therapy with people who are in love—I've tried! I've tried over and over again to help couples sort it out and help them break it off when it got dangerous, but once they are in love, they're impossible. However, that love lasts only eighteen months. After eighteen months, all the testosterone, all the "amazing" sex that was happening, all of it goes back to normal. At that point, the one with the lowest testosterone is usually the one who will say "Let's just end this." Now, if the other person is a shame-faced person, that one remark can start post-romantic stress disorder; they feel betrayed and ashamed. I start the book with an example of this kind of situation.

Then there's another program—after a couple has been together for the eighteen months and they're starting to talk about marriage or a family—that begins to form attachment. Nature forms that kind of bond because the woman is getting ready to have a baby. What Helen Fisher says is that the whole point of being in love is to meet, mate, and procreate. When you have chemistry with someone, it's because a certain thing in your brain that governs DNA is totally different from that of this other person. It's evolutionary and it's all nature. I think all this material is absolutely crucial to having couples realize that their sex lives are going to diminish as they prepare to recreate and keep their DNA going.

So those are the main discoveries that I touch upon in *Post-Romantic Stress Disorder*. This book is about stopping people from throwing away perfectly good marriages because they don't understand the natural dynamics at play in relationships. The book is trying to say "You can do this." I think this book is just as important as my B*radshaw on the Family* books, and it's relevant because it's full of brand new material and data.

There's a whole other side to the book about something that I learned in my recovery programs, the saying "Act yourself into a right way of feeling and thinking." It's about taking action and watching as your brain changes. Couples can learn that if they're willing to actually *do* something, they can have an entirely different outlook on spouses, relationships, and anything else.

Gary Seidler: Well, I know you have been working on this topic and this book for a long time. You're a terrific teacher and we still have a lot to learn from you. Thank you so much for taking the time to provide this interview for the readers of *Counselor*.

John Bradshaw: Thank you, Gary.

***John Bradshaw** has been called "America's leading personal growth expert." This* New York Times *bestselling author has created and hosted four nationally broadcast PBS television series based on his bestselling books. John pioneered the concept of the "Inner Child" and brought the term "dysfunctional family" into the mainstream. He has touched and changed millions of lives through his books, television series, and his lectures and workshops around the country.During the past twenty-five years he has worked as a counselor, theologian, management consultant, and public speaker, becoming one of the primary figures in the contemporary self-help movement.*

AD INDEX

Complex Trauma and Intimacy Avoidance

1. All of the following are childhood experiences that can contribute to intimacy avoidance, except?

Ⓐ Being raised by a smothering or narcissistic parent
Ⓑ Growing up in a home without mental illness or addiction
Ⓒ Witnessing emotional, physical or sexual abuse of a primary caretaker or sibling
Ⓓ Both A and C

2. True or False. The DSM-5 summarizes avoidant personality disorder as "a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation."

Ⓐ True Ⓑ False

3. Which of the following is not an example of an intimacy avoidant case?

Ⓐ The bachelor with many friends who avoids dating and being sexual with others
Ⓑ The mother who pours herself into childcare, neglecting the needs of her husband
Ⓒ The modern couple who allow themselves to be more engaged with technology than each other
Ⓓ None, these are all valid examples

4. True or False. Long-term healing that has been shown as effective for intimacy avoidance includes social learning, medication, cognitive therapies, and group therapy.

Ⓐ True Ⓑ False

5. Which of the following was not listed by the author as a basic type of trauma?

Ⓐ Impersonal trauma
Ⓑ Sexual trauma
Ⓒ Identity trauma
Ⓓ Community trauma

Discovering the Famine Within: An Intimate Look at Compulsive Shopping and Spending

1. True or False. Joyce McDougall's "The Psychic Economy of Addiction" states that a mother is not capable of instilling in her baby an addictive relationship to her presence.

Ⓐ True Ⓑ False

2. What does Bromberg propose about eating disorders that the author agrees applies to shopping/spending addiction in her client?

Ⓐ The description of dysregulation
Ⓑ The theory of mother-baby pattern
Ⓒ The idea about the nature of consumption
Ⓓ Both B and C

3. All of the following are things that the author's client truly needed when she turned to overspending and compulsive shopping, except:

Ⓐ Warmth
Ⓑ Recognition
Ⓒ Attention
Ⓓ None, all of the above are correct

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4. True or False. It is the mother who is in a state of dependency with regard to her baby, according to Winnicott.

Ⓐ True Ⓑ False

5. Which of the following were not things that assisted the treatment of compulsive shopping and spending for the author's patient?

Ⓐ Journaling
Ⓑ Mindfulness
Ⓒ Meditation
Ⓓ None of the above, these were all helpful

Best Approaches to Substance Abuse Prevention

1. True or False. The National Institute on Alcohol Abuse and Alcoholism states that 8.5 percent of American adults meet the criteria for an alcohol use disorder and 2 percent meet the criteria for a drug use disorder.

Ⓐ True Ⓑ False

2. According to Columbia University, 90 percent of Americans who meet the medical criteria for addiction began smoking, drinking or using drugs before what age?

Ⓐ 21
Ⓑ 15
Ⓒ 18
Ⓓ None of the above

3. All of the following are frameworks for prevention from the National Highway Traffic Safety Administration, except:

Ⓐ Risk and protective factor
Ⓑ Agent/host/environment
Ⓒ Attitude and norm factor
Ⓓ Both A and B

4. True or False. Fisher and Harrison's distinct types of prevention strategies are universal, selective, and indicated.

Ⓐ True Ⓑ False

5. All of the following are current prevention models, except:

Ⓐ The social influence model
Ⓑ The community-based intervention model
Ⓒ The competence enhancement model
Ⓓ None of the above

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:

Complex Trauma and Intimacy Avoidance

1. Explain what intimacy avoidance is and cite common examples.
2. Understand the difference between intimacy avoidance and avoidant personality disorder.
3. Name and describe the basic types of trauma.
4. Assess the relationship between early childhood trauma and intimacy avoidance.

Discovering the Famine Within: An Intimate Look at Compulsive Shopping and Spending

1. Observe how the patient's difficulty in her relationship with her mother resulted in the uncovering of emotion regulation issues that contributed to her compulsive shopping and spending.
2. Explain how compulsive shopping and spending in the author's patient was caused by a hole, something the client felt she was missing.
3. Recognize that the client's shopping became a symptom and a solution, as she would feel momentary relief after binge shopping, but then experience an increased "hunger" for the missing aspect in her life.
4. Assess how the author did not need to put her patient on a strict spending schedule, because upon discovery of the issues at work behind her compulsive actions, the patient was able to take responsibility for her expenses, create a shopping schedule, and use mindfulness as a way of working towards boundaries in her relationships.

Best Approaches to Substance Abuse Prevention

1. Explain the importance of substance abuse prevention and the impact it has at the individual, family, and community levels.
2. Analyze the research presented to form a better understanding of why prevention is essential.
3. Summarize the current prevention models and highlight their differences and uses.
4. Assess the efficacy of prevention efforts and learn how to implement them into daily practice.

Earn 1.5 continuing education credits by completing the following quiz. Pass with a grade of 75 percent or above and you will be awarded a certificate of completion for 1.5 nationally certified continuing education hours. This is an open-book exam. After reading the indicated feature articles, complete the quiz by circling one of the fourmultiple choice answers. Be sure to answer all questions and to give only one response per question. Incomplete questions will be marked as incorrect. Send a photocopy of the page along with your payment of twenty dollars. Be sure to print clearly and fully complete the information section.

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Purr Therapy

Kathleen McCoy, PhD

Reviewed by Leah Honarbakhsh

Animal-assisted therapy has been known to be effective for healing those suffering from substance abuse, alcoholism, posttraumatic stress disorder, and depression. Treatment centers utilize horses and dogs to bring about positive change, allow people to discover the roots of their emotional turmoil, and build a therapeutic alliance with their treatment staff. Cats, however, are not often seen as therapy animals—this might be because of their aloof nature, their seemingly casual friendship, and their proclivity for doing what suits them, when it suits them. *Purr Therapy*, however, introduces readers to two extraordinary cats who have been the source of happiness, healing, and love for so many people.

When author and psychotherapist Kathleen McCoy walked into her veterinarian's office to procure saline solution for her dying cat, she didn't expect to come home with two kittens. Timmy, a cream-colored Burmese and red tabby mix, and his brother Gus, a deep red tabby, provided much solace to McCoy and her husband Bob when their elderly cat Freddie passed away. Additionally, both cats were extremely attentive to Bob, who suffered from epilepsy-related depression, mood swings, night terrors, and grand mal seizures; Bob would often call them his "little therapists."

After an unusual circumstance that brought a client to her home for therapy, McCoy noticed that Timmy's presence immediately calmed her weeping client and allowed the client to speak and express herself more clearly. When the client asked if Timmy could be present at all of her sessions, McCoy realized that Timmy had a gift.

Purr Therapy examines Timmy's relationship with a range of clients, including caregivers, adolescents, older adults, individuals with anxiety or depression, people with eating disorders, and people in the throes of grief. With each client, the comfort, peace, and calm that Timmy provided helped in different ways, to different degrees. Sometimes it was as simple as having someone sit calmly with Timmy on his or her lap, and at other times it was about running around the room so Timmy could chase a ribbon. Through McCoy's detailed accounts of these sessions, readers will come to realize all the various ways that animals can assist with therapy.

After McCoy brought Marina, a flame-point Siamese just under two years old, into the house with two other cats, she didn't expect to see that Marina proved to be just as much of a therapy cat as Timmy. Marina assisted McCoy with at-home clients during her retirement, including a mother and daughter with communication problems, a father and son with differing opinions about life, and an entire family who had almost every issue in book—drug and alcohol use, academic indifference, lack of motivation, and a host of other conflicts.

Through love and courage, loss and pain, McCoy details the lives of her two beautiful therapy cats, Timmy and Marina, and their brother and sister. *Purr Therapy* is as much a book about self-help and healing as it is a memoir about the lives that touched so many others in such a short amount of time.

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