WHY I WORK IN AN OUTPATIENT METHADONE TREATMENT FACILITY
BY RANDI KONIKOFF, NCC, LPC
PG. 20

INSIDE BOOKS
ONE FOOT IN FRONT OF THE OTHER
BY TIAN DAYTON, PhD
PG. 80

THE MAGAZINE FOR ADDICTION & BEHAVIORAL HEALTH PROFESSIONALS

COUNSELOR®

CONNECTION AND INTERFACE IN **ANIMAL-ASSISTED THERAPY**

WHEN **SEX & STIMULANTS** ARE FUSED

PSYCHOTHERAPY APPROACHES FOR WORKING WITH **AOD CLIENTS**

PHYSICAL HEALTH IN **LONG-TERM ADDICTION RECOVERY**

MOST HEALING VS. MOST SATISFYING TREATMENT SERVICES

REMEMBERING
DAVID J. POWELL, PhD
PG. 8

February 2014 Vol. 15 | No. 1, $6.95

www.counselormagazine.com

BEHAVIORAL HEALTH OF THE PALM BEACHES

HOPE STORIES

Personal accounts of recovery from drug & alcohol addiction

THERE IS HOPE.
WE CAN HELP.

McDonald Oden

Behavioral Health of the Palm Beaches

Community Outreach Specialist

McDonald Oden is a former professional football player who was exposed to cocaine during his rookie season. Before he knew it, he was in the grip of an addiction that cut his career tragically short, alienated him from his family and eventually left him homeless. He eventually entered BHOPB with nothing but a few articles of clothing in a brown paper bag. After getting clean, Oden started sharing his story with audiences, becoming a valuable member of the BHOPB team.

Behavioral Health of the Palm Beaches treats our clients with the dignity and respect they deserve. We are a licensed, accredited drug rehab and medical detox center for the treatment of drug dependency, alcohol problems, and mood disorders. Our residential and extended care treatment programs employ an innovative and clinically oriented, multi-phase, 12-step approach that is tailored to each individual's unique needs.

CALL (855) 647-HOPE

BEHAVIORAL HEALTH
OF THE PALM BEACHES, INC.

See Mac's story and more at:

HOPESTORIES.COM

THE APRIL ISSUE OF *COUNSELOR* MAGAZINE

SPECIAL ISSUE ON ADOLESCENTS & YOUNG ADULTS

FEATURING . . .

An Exclusive Interview!

Counselor editor Robert J. Ackerman, PhD, will interview Reid Wilson, PhD, and Lynn Lyons, LICSW (the authors of *Anxious Kids, Anxious Parents*) about dealing with children and anxiety disorders. Their book is hailed as a "revolutionary approach to break the cycle of childhood anxiety and expose the most common treatment mistakes."

A Special Edition of "Inside Books"!

The newest book by Teen Ink, *Bullying Under Attack*, invites readers to "meet the bully, the bullied, and the bystander." This "Inside Books" special will include an excerpt from *Bullying Under Attack* written by a former bullying victim. In addition, "Inside Books" will also feature praise and accolades for *Bullying Under Attack* from various reviewers.

An All-New Directory!

This special issue of *Counselor* will feature a brand new insert of treatment centers specifically geared towards helping adolescents and young adults recover from mental health, substance use, and eating disorders. Watch out for this informational directory which will feature treatment centers from all over the United States!

A New Article from the *Journal of Substance Abuse Treatment!*

Counselor's renewed collaboration with the *Journal of Substance Abuse Treatment* (*JSAT*) begins with an article on the effectiveness of outpatient treatment for adolescents by Emily E. Tanner-Smith, PhD. Adapted *JSAT* articles will be appearing in every issue of *Counselor* through the rest of 2014!

The Last Column of Dr. David J. Powell

The April issue of *Counselor* will feature Dr. David J. Powell's last column—the second part of his two-part series on mentorship—that he submitted to the magazine before his passing in November 2013. Part one can be seen on page 28.

This is a must-read issue for any and all counselors treating adolescents and young adults!

In addition, this issue will be just in time for the U.S. Journal Training Conference on Adolescents and Young Adults held in Las Vegas, Nevada from April 24-26.

Contact Larry Mendoza at Larry.Mendoza@usjt.com for marketing opportunities.

See page 27 for more information!

FEATURING THESE EXCEPTIONAL SPEAKERS:


Daniel Amen, MD


Jean Kilbourne, EdD


James Garbarino, PhD


Jane Middleton-Moz, MS


Patrick DeChello, PhD


Robert Ackerman, PhD

We support recovery.

RAPID, ACCURATE, AND COMPREHENSIVE DRUG TESTING

Trust your addiction and treatment testing to Alere Toxicology.

At Alere Toxicology we understand the unique challenges facing addiction treatment professionals. Objective monitoring of drug and alcohol use is integral to effective treatment strategies and essential for early detection and intervention.

Alere offers customized testing and documentation solutions, scientifically credible data interpretation, and world-class service to help addiction professionals individualize therapy and optimize patient outcomes.

Call 800.241.0467 or visit aleretoxicology.com/treatment

- Superior analytical methods using state-of-the-art technology, including Immunoassay and LC/MS/MS technology
- Panels for a broad array of drugs and metabolites, with a dynamic test menu continually expanding to include emerging synthetic drugs
- Access to highly qualified, expert toxicologists
- Comprehensive, accurate, easy-to-read reports within 1-2 days
- Dedicated client support team

Alere™ Toxicology

STRETCHING INTO THE NEW YEAR

THE MAGAZINE FOR ADDICTION & BEHAVIORAL HEALTH PROFESSIONALS
COUNSELOR

As we enter our 38th year of professional publishing, we have modernized our masthead and broadened our target audience to include "behavioral heath" counselors/therapists, in addition to addictions professionals.

In the late 1970s and early 1980s, the term dual-diagnosis was first applied to those who were addicted, the idea being that the addict often had an accompanying behavioral health or mental disorder. Clinicians soon realized that the phrase "dual-diagnosis" was too restricting, since addiction most often involved multiple disorders—thus, a new term, "co-occurring disorders," was introduced.

Today, as evidenced by the new DSM-5, the importance of understanding the complexity of addiction and the relationship with behavioral disorders is even more paramount. Equally, the necessity for cross-training between addiction professionals and behavioral mental health professions is a must.

Whether a behavioral health problem increases one's likelihood of substance abuse or whether substance abuse increases the likelihood of behavioral health disorders is a conundrum for clinicians.

It is with this increasing complexity and the demand for more sophisticated treatment that the decision has been made to expand the audience for *COUNSELOR* to include those professionals working with behavioral disorders.

Not only does this change relate to the addictions field, but also to the ever increasing awareness of "process addictions" which are highly correlated with such behavioral disorders as compulsive gambling, overeating, sex addiction, compulsive spending, internet and gaming . . . all behavioral problems which, if left untreated, can increase the risk for addiction relapse or increase the risk for developing substance abuse.

We at *COUNSELOR* are excited abut the expansion of the audience for the magazine and we look forward to bringing you cutting-edge articles reflecting the ever growing problems of addiction as well as behavioral disorders in 2014 and beyond . . .

THE MAGAZINE FOR ADDICTION & BEHAVIORAL HEALTH PROFESSIONALS
COUNSELOR®

A Health Communications, Inc. Publication

3201 S.W. 15th Street
Deerfield Beach, FL 33442-8190
(954) 360-0909 • (800) 851-9100
Fax: (954) 360-0034
E-mail: editor@counselormagazine.com
Website: www.counselormagazine.com

Counselor (ISSN 1047-7314) is published bimonthly (six times a year) and copyrighted by Health Communications, Inc., all rights reserved. Permission must be granted by the publisher for any use or reproduction of the magazine or any part thereof. Statements of fact or opinion are the responsibility of the authors alone and do not represent the opinions, policies or position of COUNSELOR or Health Communications, Inc.

Health Communications, Inc., is located at 3201 S.W. 15th St., Deerfield Beach, FL 33442-8190.

Subscription rates in the United States are one year $41.70, two years $83.40. Canadian orders add $15 U.S. per year, other international orders add $31 U.S. per year payable with order.

Florida residents, add 6% sales tax and applicable surtaxes. Periodical postage rate paid at Deerfield Beach, FL, and additional offices. Postmaster: Send address changes to Counselor, P.O. Box 15009, North Hollywood, CA 91615-5009

Printed in the U.S.A.

TRAUMA • ADDICTION • INTIMACY DISORDERS *Conference*


Bessel Van Der Kolk, MD


Rokelle Lerner


Joan Borysenko, PhD


Rob Weiss, LCSW

NASHVILLE *May* 6-9, 2014


Pat Love, EdD


Don Meichenbaum, PhD


Christine Courtois, PhD


Ralph Carson, PhD

PRESENTED BY

U.S. Journal TRAINING, INC.

COUNSELOR


Cardwell Nuckols, PhD


John Lee

CO-HOSTS

The Ranch • Promises

PROGRAM • REGISTRATION • SCHEDULE • HOTEL • EXHIBITS

WWW.USJT.COM

ALSO IN THIS ISSUE

60

Physical Health in Long-Term Addiction Recovery

Presents research findings about physical health in people who have and have not suffered from addiction and suggests ways to shift treatment into a culture of total-body wellness for addicted clients.

By William L. White, MA, and Arthur C. Evans Jr., PhD

64

Comparing Patient-Identified Healing and Satisfaction Factors: Differences Affecting Treatment Services

Discusses the research done on patients' own realization of healing treatments versus satisfying treatments, and presents conclusions as to what the results mean for treatment centers and their programs.

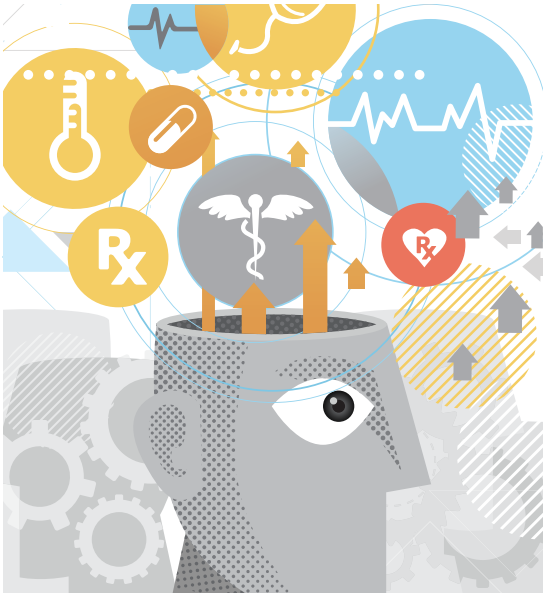
By David T. Smith, PhD, LICSW

70

Relating Clinical Assessment Considerations to EHR Meaningful Use, Part 1

Discusses the benefits of using electronic health records (EHR), provides reasons why the current health care system needs improvement, and presents the significance of EHR meaningful use (MU) implementation.

By LaVerne H. Stevens, PhD, NCC, LPC



U.S. Journal
TRAINING, INC.

The Institute for Integral Development

COUNSELOR

2014 Training Conferences


Florida • February • November • 2014


Seattle • May • 2014


Las Vegas • March • April • Sept. • 2014


Nashville • May • 2014


California • October • 2014

35th Annual Training Institute on
Behavioral Health & Addictive Disorders
Hilton Clearwater Beach Resort, Clearwater Beach, Florida
February 10-13, 2014

6th Annual
Counseling Advances Conference
The LVH, Las Vegas, Nevada
March 19-21, 2014

12th National Conference on
Adolescents/Young Adults
The LVH, Las Vegas, Nevada
April 24-26, 2014

Southeast Conference on
Trauma, Addictions & Intimacy Disorders
Doubletree Hotel, Nashville, Tennessee
May 6-9, 2014

27th Annual Northwest Conference on
Behavioral Health & Addictive Disorders
Hyatt Regency Bellevue, Seattle, Washington
May 28-30, 2014

4th Western Conference on
Behavioral Health & Addictive Disorders
Hotel Nikko, San Francisco, California
September 4-6, 2014

20th Annual
Counseling Skills Conference
Las Vegas, Nevada
September 17-19, 2014

National Conference on
Adolescents/Young Adults
Doubletree Hotel, Philadelphia, Pennsylvania
October 15-17, 2014

2nd International Conference on
Sex and Love Addiction
Ft. Lauderdale, Florida
November, 2014

Call 800-441-5569
for more information or
visit us online at www.usjt.com
For exhibitor information call 800-851-9100, ext 220

2014: An Exciting New Year!

Happy belated New Year!

As we move into the New Year there are many exciting events planned for *Counselor* magazine. First, however, I would like to thank the many contributors for their articles—especially our regular contributors over the past year. Their articles continue to bring solid information, cutting-edge ideas, and current trends in the addiction field to the magazine. In their own way, each of them has contributed to the depth of *Counselor* magazine. We thank them for their work.

Additionally, we would like to thank a major contributor to *Counselor*, the many authors from the *Journal of Substance Abuse Treatment* (*JSAT*). Over the past years they have contributed many feature articles based on research, theoretical discussions, treatment innovations, and ongoing studies in the field of addiction science. *Counselor* magazine is very pleased to announce that a new memorandum of agreement has been reached with *JSAT* to continue our mutually beneficial relationship. We look forward to their future articles and contributions.

One of the new features for 2014 includes a "Substance Abuse in Teens" column by Fred Dyer. He is well known for his excellent seminars on the topic of adolescents, as well as his publications. We look forward to working with him. Additionally, a special issue on adolescents and young adults will be published this year in April.

In addition, a series of articles on process addictions—gambling, sex addiction, hoarding, bullying, compulsive spending, relationship sabotage—will be featured in 2014.

Another feature will be interviews with authors of new books for 2014. For example we look forward to talking with Reid Wilson and Lynn Lyons on their new book, *Anxious Kids, Anxious Parents*.

We are looking forward to featuring *Counselor* magazine at all of the U.S. Journal Training conferences for 2014. The conference schedule is very ambitious for next year with nine national conferences on their agenda. Many of the conference themes correlate well with upcoming editions of *Counselor*. This will be a great opportunity to meet thousands of addiction professionals as well as introduce them to the magazine.

For myself, I look forward to recruiting and working with many new authors, continuing to build relationships with our regular authors, working with U.S. Journal Training, and keeping you informed about cutting-edge advances in clinical and research findings in addiction treatment and recovery.

Finally, although editor for only half of 2013, I want to thank many of you for your letters to the editor. I appreciate hearing from you and I look forward to your comments, ideas, and contributions for 2014.

Remembering David J. Powell

Despite all the good news I have about *Counselor* in 2014, I would like to take a moment to address a most unfortunate occurrence in 2013. Since 2005, David J. Powell, PhD, has been a regular contributor to *Counselor* and a vital member of our advisory board. It is with deepest regret that I inform our readership of David's fatal fall while working at his home on November 1, 2013. Dr. Powell's work was worldwide; he in trained in eighty-seven countries and authored ten books. Perhaps his most important accomplishment involved teaching clinical supervision to counselors who worked in the alcohol and drug abuse field. With the permission of his wife, Barbara, David's last two "Clinical Supervision" columns will be featured in this issue and the April issue, respectively. We were privileged to have Dr. Powell's work featured in *Counselor* for the past eight years. We, along with thousands of others, will miss him.

Sincerely,

Robert J. Ackerman, PhD
Editor *Counselor*,
The Magazine for Addiction & Behavioral Health Professionals,
A Health Communications, Inc. Publication

Equine-Facilitated Psychotherapy

It has been said that horses are a mirror into our souls.

Let our team of licensed mental health professionals and certified instructors guide you through a journey of healing. Build, improve and start clients on a path towards an improved life using the power of the horse. Experience the power of Equine-Facilitated Psychotherapy at our facility in Florida.

Creating Unbridled Moments . . .

Horses Strengthen Mind, Body and Soul

Photo by Arron Haggarty

Equine-Assisted Therapies
of South Florida, Inc.

To learn more about our services call
954-974-2007 or visit **www.equineatsf.org**

How to Be An Effective Addictions Counselor in a SUD's World

Pete Nielsen, CADC-II, and Dee-Dee Stout, MA, CADC-II

"Do you think it's easy to change? Alas, it is very hard to change and be different. It means passing through the waters of oblivion."
—D. H. Lawrence, "Change" (1971)

Much has been made of the Affordable Care Act (ACA), also known as Obamacare, which has recently become active. Perhaps you're wondering how the ACA will affect you, an alcohol and other drug (AOD) counselor and our profession. As it turns out, it will affect us a lot! In fact, according to two experts, Dr. A. Thomas McLellan—the Director of the Treatment Research Institute and the former Deputy Director of the Office of National Drug Control Policy—and David Neilsen, from the California Department of Health Services, the ACA will likely affect California's AOD counselors more than any other. This is because the United States' health care budget is currently 25 percent of the overall US budget—more than any other single category—and California is still the largest state by population in the Union. Neilsen stated that the ACA will require some sixty thousand new AOD counselors in California alone to provide services (personal communication, September, 13, 2013). So, the better question might be: What kind of services will we need to provide under the ACA? We will get to that question a bit later; instead, let's begin with how the ACA will affect us counselors professionally.

We were so excited when we heard this news recently in a conference, we think you might be too. According to Dr. McLellan, *sixty thousand* new jobs are coming to our profession, one that already needs new workers daily as many of us begin to look at retirement or perhaps are weary of working in a profession that generally gets little respect, even less pay, and has high turnover rates (personal communication, September, 13, 2013). Incidentally, those statistics are the same as the fast food industry standard, according to a report done several years ago. In addition, perhaps some of us are unprepared—or even reluctant and/or resistant—to meet the challenges of a new culture of drug treatment rooted in science, like the ever-growing popularity of evidence-based treatments or practices. Another big change will be the necessary electronic health records (EHR), which will be the only way agencies, individuals, and other practitioners will be paid. "No EHR, no payment," said the State of California's Deputy Director of Health Services recently (personal communication, September, 13, 2013).

So, what kinds of skills do these experts say are needed to work in this new Mental Health (MH) and Substance Use Disorders (SUD) treatment system? How will the culture change? Are we, individually and as a profession, ready? That last question is an important one, and we believe the answer is, "no, we're not—but we can be!" How we get ready is the aim of both this article and the subsequent training we

will be offering in the coming months.

> "We are the servant of the patient not the master."
> —Hippocrates

These experts believe that one of the biggest areas of change for us will be in the new general health care teams we will be working alongside—think doctors, nurses, physician's assistants, nurse practitioners, not to mention social workers, nutritionists, and more. Along these same lines will be the need for more extensive education for us. How much education you will need and of what kind will likely be driven by decisions on how and with whom we may work. Many of us will likely need to make some important decisions about the area of our profession in which we desire to work, if at all, and come to see our work as a specialty area *within* health care come January 1, 2014, not as a stand-alone specialty anymore. For example, are we happy doing educational groups and providing peer support, or do we want to provide more direct consumer care? The latter will likely require more formal education.

Another major shift will be in how clients are viewed. According to Dr. McLellan especially, treatment providers will need to work within a model of helping consumer-clients to reduce the harmful effects of their drug use, not simply abstain from it, though certainly many of these consumer-clients will choose abstinence as their goal. Furthermore, Dr. McLellan states that treatment will no longer be seen as something one would do only once to be successful but rather, addiction would move into a chronic illness model. This means that we would treat addiction as a complex, chronic condition that cannot be cured, but which can be managed as other chronic diseases are, like diabetes, heart health, nutrition, and weight management. For some of us, this shift may also mean an extra dose of open-mindedness is in order.

One area of concern for us was Dr. McLellan's comment regarding how many of us are lacking training in the very areas that will bring new life to our profession. "How could that be?" we said. According to Dr. McLellan, we could potentially need to rethink most of our professional world: Are we *addiction* counselors, or MH/SUD counselors? Are we only going to treat the addicted, or are we going to need to expand our role to become MH/SUD counselors in the new era of treatment via the ACA? This is a fundamental shift in who we are and have been since the 1970s. It means we would need to expand treatment services to include those consumer-clients who simply need a bit of help in the form of treatment for a chronic illness, not only an addiction, as we are currently trained. It also means that the kind of treatment that will be effective may also be different. How can we even tell if what we're doing now is or isn't what the ACA will be asking of us? "Lions and tigers and bears, oh my!" you may be saying. Hold on, there's a simple way!

One brilliant way to view this shift was suggested by Dr. McLellan: "When you think of treatment for SUDs, take out the word 'addiction' and replace it with 'diabetes care.' If what you're about to do sounds silly for diabetes care, then stop; don't do it!" One of his examples was around the traditional celebrations held for clients and patients when they complete an addiction treatment episode. You know the ones: consumer-clients share the stories of what their lives were like before treatment; the family is in attendance and usually in tears; a coin or stuffed animal goes around the room and everyone rubs good "juju" on the item, which is finally given to the consumer-client as a token of their commitment to (usually) abstinence and life, etc. Now, go back and read that section again only with "diabetes care" in place of addiction. Doesn't sound the same, does it? One could say it even sounds a bit nonmedical. Yes, we're talking a whole new world here!

The ACA is also unintentionally forcing us as a profession to ask some difficult questions about who needs treatment and what that treatment should look like if it's not for addiction. As AOD counselors, we have

traditionally focused our treatment efforts on those whose drug use led to abuse and/or dependence, using DSM-IV-TR terminology. Well, what about those consumers whose use does not lead them to become dependent or "addicted?" Should we care? We now know that there is a large percentage of the general population that may be able to use substances without that use ever becoming a problem for them. The question is what kind of help do they need if not to quit? If they're not addicted, why would they seek help? Are we prepared to treat these consumers differently, as nonaddicted users, rather than like those who are addicted?

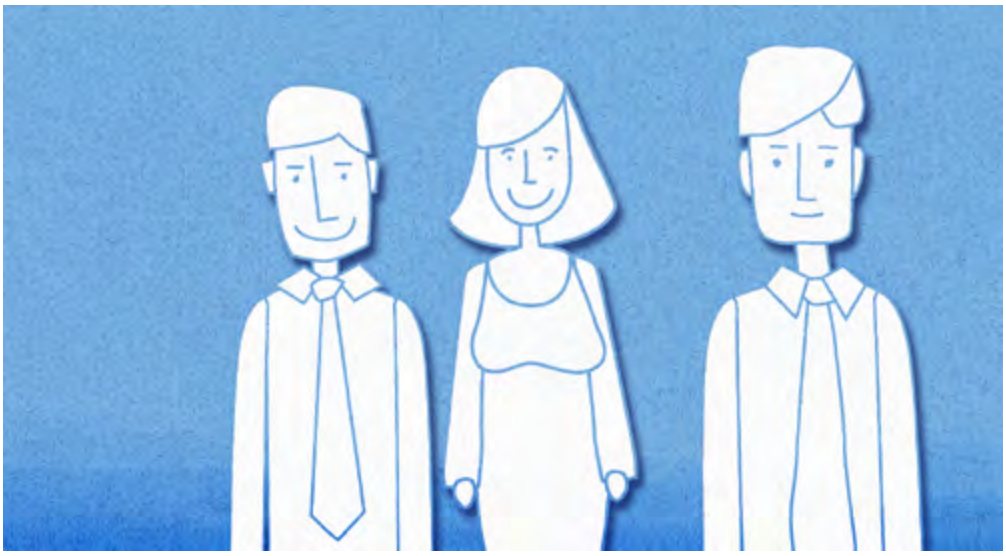
The good news is that there are treatment answers for both of these consumer groups though they are indeed different. One group would include individuals who cannot drink because of a recent health issue and who may require education or guidance in making this change or adjustment—think a patient with a recent hepatitis C diagnosis, or a woman who discovers she is pregnant. This group could also include someone who simply wants to reduce their drinking as part of an overall healthier living plan. The second group would include those who have reoccurring problems as a result of their alcohol or other drug use, such as consumers with multiple driving under the influence offenses or those who have yet to reach their stated goals after several treatment episodes. These consumers would be seen to have a chronic substance use disorder and would likely do well to receive some more traditional, yet still evidence-based, treatment.

In traditional addiction treatment the goal is usually abstinence. In this new world of SUDs, the counselor may not be working with someone with an addiction problem. Both of us have worked with cases in which our consumer-clients wanted to drink more responsibly but realized they did not know what that really meant. As a culture, we don't generally teach this information to young people in the same way we don't educate counselors in such. These were consumers who did not want abstinence, though many times we've both worked with consumers who simply decide to quit, and said that it's easier than counting drinks, and they do—they just quit! SUDs counselors may be asked to work with a consumer with substance abuse only or perhaps merely someone with a current problem using drugs, including alcohol. Since most addiction professionals are only trained to promote abstinence, it may be difficult for them to meet these consumer-clients where they are. Again, in our experiences, a moderation plan sometimes fits consumer-clients' needs and their diagnostic criteria better than abstinence. Sometimes it helps to remember that just 20 percent of all substance abusers become dependent and no one knows who the 20 percent will be. Also, ASAM Patient Placement Criteria states that, "you start with the least restrictive environment" then increase services and treatment, as needed. Maybe the consumer-client just needs a moderation plan or a bit of guidance to help them determine how a substance is impacting their quality of their life, both the positive and the less positive. This new SUDs world will have counselors helping individuals discover for themselves whether or not they have a problem, rather than spending precious time and energy demanding that client-consumers see that they have a problem or risk being viewed as being in denial.

> "All truth passes through three stages. First, it is ridiculed. Second, it is violently opposed. Third, it is accepted as being self-evident."
> —Arthur Schopenhauer

To conclude this conversation, let's return to the discussion on who our consumer-clients will be, now that the ACA is in full effect, since Dr. McLellan discussed this topic at length at the conference, and what kind of treatment they will expect. Remember, the ACA also provides for parity of all conditions. First of all, the DSM-5 has done away with the binary dependence and abuse terminology. Instead, drug and alcohol use is now seen as on a continuum, which we believe better reflects how real people move in and out of patterns of drug use. The movement is rarely in a linear fashion; for example, from no use or little use, to moderate use, to harmful use, to problem use, to chaotic use, but not necessarily always in that direction or order. Let's use the pyramid model that Dr. McLellan used to show use patterns in the United States for all potentially harmful drugs, except tobacco.

The tip of the pyramid represented those with very serious use patterns, whom previously we would have termed "dependent," which is about 2.3 million people. "These are the consumers that we, including me, traditionally work with and that we are experts at working with," Dr. McLellan said, "this is not the problem." The bottom of the pyramid represented people who use a little or not at all, which is a surprisingly large number of Americans—some 250 million people. The middle section, or the "problem-for-us-current-AOD-counselors area," signified the number of people whose use patterns would now be termed "medically harmful use." These are people who are not abusing, and certainly not dependent, yet still need some assistance; a category of forty million people. That's right, forty million! These are consumers that are willing to get some help but they will generally not be interested or willing to go somewhere that isn't convenient, with few or untrained staff, to buildings that are falling apart, who only treat addiction with a Twelve Step and abstinence-only model. Did we mention



that Dr. McLellan also states some of these consumers will need short-term residential treatment—two weeks at most—and again, they are not going to be willing to call themselves an alcoholic or addict, recite prayers, or be served less than nutritionally balanced foods (personal communication, September, 13, 2013)? They will want gyms and swimming pools, their electronic equipment, communication with the outside world when they need it, and regular, scheduled appointments with their medical team, including us, so that we can all work collaboratively with the goal of effective care for this, and every, consumer. They will not simply do what we say. Dr. McLellan's concern is that most SUDs counselors are not trained to work in this way since there is no requirement for training in moderation strategies. In fact, many of the MH/SUDs counselors we talk to state they still feel undertrained in co-occurring disorders and motivational strategies, both of which will be critical skills necessary to provide effective treatment and change strategies to these forty million consumers. Our profession needs to see these consumers as new clients who want a menu of options for treatment that they could see might work for them, which is perfect since Dr. William Miller—the author of *Motivational Interviewing; Controlling Your Drinking*—and other researchers have found that this menu of options is exactly what works in any effective treatment.

Finally, we would suggest that if some currently certified AOD counselors, without proper education, training and/or consultation, were to work with a consumer wanting moderation or temporary abstinence, that counselor *could* be working outside their scope of practice (some certifications have a boarder scope of practice than others) and/or competence—a serious ethical violation of our profession's Code of Conduct.* So the ACA is giving us a real opportunity to increase the consumer-clients we can connect with treatment, a chance to increase the service options we currently provide, and a reason to expand our knowledge of what works.

> "Treat people as if they are who they can be and you help them to become who they're capable of being."
> —Johann Wolfgang von Goethe

The bottom line is that the ACA is bringing us lots of opportunity for change, both individually and to our profession. We see this is an amazing opportunity even though change is always a bit scary. So, let's take advantage of this opportunity by taking that leap of faith together. Jump in—you're not alone!

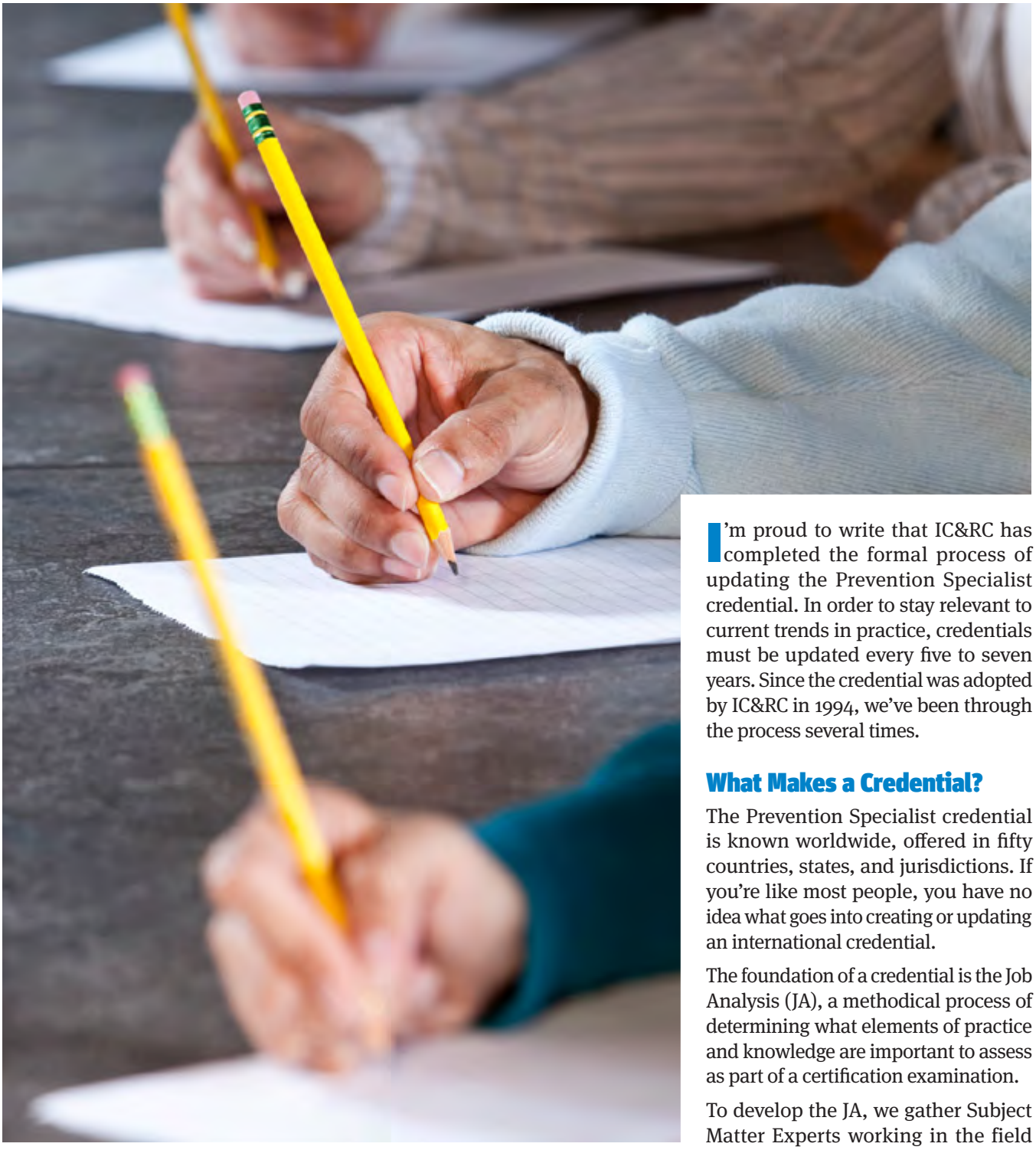
**We are not suggesting that all AOD counselors will now be working with moderation, nor that all those working in moderation are/will be working out of their scope of competence. As with any specialty area, one's scope of competence—unlike one's scope of practice—depends on specialized training/education. For more information, please contact either of us.*

Pete Nielsen, CADC-II, *is the Marketing Director for CAADAC. Mr. Nielsen holds an associate's degree in human services (counseling) and a bachelor's degree in business management. Mr. Nielsen has been on the Board of California Association of Alcoholism and Drug Abuse Counselors (CAADAC) since 2007. He founded Willingness To Change, a 501(c) 3 public nonprofit which, is committed to helping individuals and families improve their quality of life by addressing addiction and its related problems. His specialties includes substance abuse, DOT SAP assessments, and anger management.*

Dee-Dee Stout, MA, CADC-II, *has extensive specialized health training including: iRest, motivational interviewing, solution focus, relapse prevention, stages of change, CBT, seeking safety, CRAFT, harm reduction, client-directed/outcome-informed work, trauma-informed treatments, and more. Ms. Stout is an instructor with UC Berkeley Extension and a lecturer at CSU Monterey Bay. Dee-Dee maintains a private consultation practice, Dee-Dee Stout Consulting/Responsible Recovery, while regularly training around the country. She is the author of* Coming to Harm Reduction Kicking and Screaming: Looking for Harm Reduction in a Twelve Step World. *Dee-Dee has also been interviewed for press, radio, and film and has contributed to several publications. As someone with both a SUD history and a current mental health diagnosis plus other chronic illnesses, she knows what it's like to be in treatment. As she says, "I've been in treatment of some kind my whole life!"*

IC&RC Updates The Prevention Specialist Credential

Julie Stevens, MPS, LCDC-1, ACPS



I'm proud to write that IC&RC has completed the formal process of updating the Prevention Specialist credential. In order to stay relevant to current trends in practice, credentials must be updated every five to seven years. Since the credential was adopted by IC&RC in 1994, we've been through the process several times.

What Makes a Credential?

The Prevention Specialist credential is known worldwide, offered in fifty countries, states, and jurisdictions. If you're like most people, you have no idea what goes into creating or updating an international credential.

The foundation of a credential is the Job Analysis (JA), a methodical process of determining what elements of practice and knowledge are important to assess as part of a certification examination.

To develop the JA, we gather Subject Matter Experts working in the field

from all around country and world to contribute what tasks, knowledge, skills, and abilities they use in their jobs. IC&RC then creates a public survey for professionals to weigh-in on whether they do, in fact, complete the proposed tasks in their work—and how important they would rate them. The survey is announced on IC&RC's website, plus it is sent to IC&RC member boards and other relevant organizations for distribution.

Under the guidance of a psychometrician from our international testing company, a second group of Subject Matter Experts reviews the survey results, adjusting the original tasks, knowledge, skills, and abilities to reflect the input of thousands of professionals. This final document is called the Job Analysis, and it serves as the blueprint for the examination. The process used by IC&RC directly links an examination score to a specific job and ensures that each examination is valid, reliable, and legally defensible.

Updating the Examination

In May 2013, IC&RC released an updated Prevention Specialist Job Analysis. The domains have been revised to the following:

- Planning and Evaluation
- Prevention Education and Service Delivery
- Communication
- Community Organization
- Public Policy and Environmental Change
- Professional Growth and Responsibility

In addition to the new Communication domain, the former domain of Education and Skill Development has been changed to Prevention Education and Service Delivery. The new JA also broadens the scope of a Prevention Specialist from focusing strictly on Alcohol, Tobacco, and Other Drugs (ATOD) to encompassing aspects of mental, emotional, and behavioral health.

IC&RC used the updated JA to develop a new examination, which was administered for the first time on December 13, 2013 by IC&RC member boards. The new examination will continue to have 150 questions, of which twenty-five will be nonweighted, pretest questions. More on our pretesting policy, as well as the full exam content outline and updated reference list, can be found at InternationalCredentialing.org.

At the Forefront

IC&RC is the only organization offering standards and an examination for Prevention Specialist certification, and I am so proud to work with this organization that stays in the forefront of our ever evolving field.

Julie Stevens, MPS, LCDC-1, ACPS, *holds a Masters of Prevention Science degree and is a Licensed Chemical Dependency Counselor Intern and an Advanced Certified Prevention Specialist. With twenty-five years of experience in the prevention field, she currently serves as Executive Director of Williamson Council on Alcohol and Drugs near Austin. She has been a Certified Prevention Specialist since 1997. She is chair of IC&RC's Prevention Committee.*

Molly: Not Safe and Not Ecstasy!

Maxim W. Furek, MA, CADC, ICADC

Molly, the current drug *du jour*, is something old made new again. It is a substance that promotes feelings of euphoria, closeness, and sexuality. Although molly has the reputation of being natural and safe, it is believed to have contributed to the deaths of a number of individuals in the Northeast.

The drug is the pure power or crystal form of MDMA (3.4-methylenedioxy-methamphetamine), the designer stimulant-hallucinogen that is a favorite at clubs and outdoor festivals. In the 1980s, MDMA was a popular recreational drug and became the drug-of-choice at raves of the 1990s. During the last decade, the drug returned to clubs as "molly," a powder or crystalline form of MDMA that implied greater purity and safety—ecstasy rebranded as a gentler, more approachable drug. Thanks in part to that new, friendly moniker, MDMA has found another following in a generation of conscientious professionals who have never been to a rave and who are known for making careful choices in regard to their food, coffee, and clothing. Much as marijuana enthusiasts of an earlier generation sang the virtues of mary jane, they argue that molly—the name is thought to derive from "molecule"—feels natural and basically harmless (Aleksander, 2013).

However, the drug is not harmless. MDMA is a synthetic, psychoactive drug that has similarities to both the stimulant amphetamine and the hallucinogen mescaline. It produces feelings of increased energy, euphoria, emotional warmth, and empathy toward others, in addition to distortions in sensory and time perception. MDMA was initially popular among white adolescents and young adults in the nightclub scene or at raves, but the drug now affects a broader range of users and ethnicities (NIDA, 2013).

Hospitals reported that in 2011 they saw a 120 percent increase in MDMA-related trips to the ER over 2004. The use of MDMA has steadily risen in teens and young adults according to a Drug Abuse Warning Network (DAWN) study released by the Substance Abuse and Mental Health Services Administration (SAMHSA). As a direct result, visits to emergency rooms increased from 10,222

in 2004 to 17,865 in 2008, up 74.8 percent. Most of these emergency room visits (69.3 percent) involved patients between the ages of eighteen and twenty-nine, and 17.9 percent of those seeking help in ERs were between ages twelve and seventeen. SAMHSA says 77.8 percent of the emergency room visits involving ecstasy also involved the use of at least one other substance of abuse. Among ecstasy-related emergency department visits involving people twenty-one and older, 39.7 percent of the patients had used the drug with three or more substances of abuse, most often alcohol (Kraft, 2011).

Commonly known as ecstasy, E, XTC, clarity or the love drug, the substance was first created by the German pharmaceutical company Merck in 1912 for use as an appetite suppressant. During the 1980s, MDMA become popular as a recreational drug and its use has grown since then. Several side effects result from MDMA use, ranging from mild to potentially life-threatening (Busse, 2010). Because molly is not regulated, consumers have no idea what they are actually getting when they buy it. By adulterating MDMA with baking soda or stimulants such as PMA (para-methoxyamphetamine) or other white powders, drug dealers can increase the weight of their product and sell it for more money. One researcher has warned potential users to keep clear of this drug: "Consumers do not know what they are taking. To be clear, pure MDMA is extremely dangerous" (Greenagel, 2013). Syracuse University published a recent study in New York revealing that "20 percent of the participants responded that they had tried molly. One third of those students also stated that they did not know the ingredients of the drug they had ingested" (Ruth, 2013).

EcstasyData, an independent pill testing program whose mission is to collect, manage, review, and ultimately make their findings public for the safety of others, collected and tested molly tablets from Washington, DC in 2012. Some of the tablets contained nothing more than caffeine while others contained methylone, a substance found in bath salts. Bath salts created a media frenzy when a man in Florida who was high on bath salts at the time started to cannibalize a living, homeless man.

Another group, DanceSafe, has identified numerous substances found in pills sold as ecstasy: "Opiates are rarely seen while caffeine and amphetamines are common. Caffeine is easily the most common adulterant in drugs sold as MDMA. Piperazines like BZP and TFMPP were common through the 2000s but are declining nowadays. We've been seeing a lot of bk-MDMA (also called methylone) since about 2010, and sometimes MDPV. Once in a while we'll see some PMA/PMMA, which can cause runaway overheating and is really dangerous" (DanceSafe, 2013). Both methylone and MDPV are chemicals typically found in synthetic bath salts.

Sexualized Promotion

Because of endless, sexualized promotion, molly, the all-night party drug, has increased in popularity. A horde of hip-hop rappers including Danny Brown, 2 Chainz, Childish Gambino, Wiz Khalifa, Gucci Mane, and Kanye West shamelessly name-drop the drug in concert and over the airwaves.

The synthetic drug was at the epicenter of a recent controversy when rapper Rick Ross was dropped as a Reebok spokesman after he rapped about spiking a woman's champagne with molly. Ross collaborated with Atlanta rapper Rocko for the single, titled "U.O.E.N.O." The irresponsible lyrics in question boast about drugging a woman and taking her home. "Put molly all in her champagne/ She ain't even know it/ I took her home and I enjoyed that/ She ain't even know it," raps Ross (Soderberg, 2013).

Fortunately, the response from the hip-hop community was immediate. Journalist and hip-hop activist Rosa Clemente in a YouTube rebuke of the song said: "This lyric is obviously promoting rape. Not just date rape, but rape and rape culture and violence against women. We live in a society (where) by the time African American women and Latina women are eighteen, almost half of them—44 percent—have been sexually abused" (Huffington Post, 2013).

But molly lives and breathes far beyond the realm of hip-hop. The drug's resurgence slickly parallels the return of Electronic Dance Music (EDM), the pulsating Euro beat that has infiltrated a long list of pop radio acts like Rihanna, Kesha, and Katy Perry, many promoting the drug through their blatant lyrics. At the 2012 Ultra Music Festival in Miami, Madonna was criticized for asking her audience, "How many people in this crowd have seen Molly?" On Nicki Minaj's 2012 hit "Roman Reloaded," Lil Wayne raps "Pop a molly, smoke a blunt, that mean I'm a high roller." Miley Cyrus, on her single "We Can't Stop," sings "We like to party, dancing with Molly." That line was edited out during her performance at MTV's Video Music Awards.

The music that celebrates the molly culture is the current reworking of drug promotion through pop media. We have heard this before in hip-hop music endorsing the culture of Promethazine, a.k.a. "Purple Drank" and "Syrup," despite the overdose deaths of Big Moe, DJ Screw, and Pimp C (Furek, 2008). Additionally, we have heard it in grunge music that paid homage to the aesthetic and dissociative qualities of heroin.

Molly can cost twenty to fifty dollars for a 250 mg dose. According to a Drug Enforcement Administration (DEA) agent, the newest users of Molly are middle-aged professionals. David Dongilli of the DEA's Philadelphia Division said that this demographic group is experimenting with the drug; "They've sort of bought into this marketing plan, by the criminal

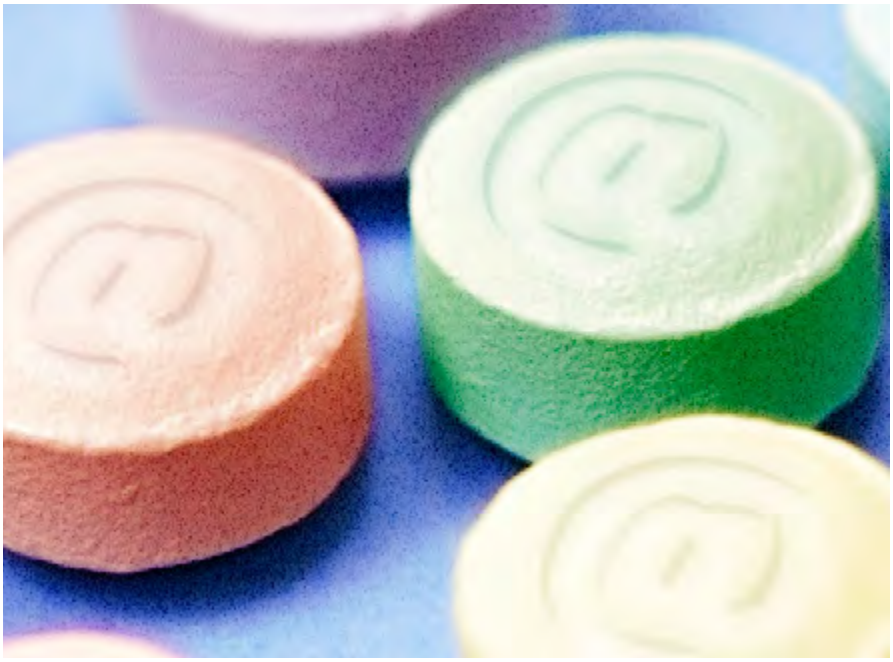
organizations, that this is pure MDMA. It's as if it has some sort of organic value and, unfortunately, it's anything but organic and pure (Join Together, 2013).

Drug dealers are mixing molly with other substances, Dongilli explained: "What you have are people ingesting rat poison, methamphetamine mixed with cocaine, acids, and any other chemical that they can get together in pill form or some sort of crystallized [form], and sadly people are ingesting this and dying from it."

In 2013, two attendees died at the Labor Day Electric Zoo music festival in New York City. The final day of the three-day festival was canceled after two concert-goers died and at least four others were hospitalized due to what was believed to have been MDMA in either capsule or power form. Founded in 2009, Electric Zoo features EDM, with more than 110,000 people attending the festival in 2012 (CNN, 2013). Investigators in Boston have said they believe a bad batch of the drug was being sold throughout the Northeast, leading to more than a dozen late-summer overdoses at clubs and music festivals in Boston, New York, and Washington, DC (Caulfield, 2013).

There may be cognitive impairment with those who experiment with this drug, according to Clinical Director Nike Hamilton of Aquila Recovery: "Yes, death is the ultimate tragedy but if (MDMA) affects your brain in such a way that you're not able to function on a daily basis because you can't concentrate, because you have memory loss, because you're depressed, all of those can ultimately lead to death" (Alfarone, 2013).

The DEA believes that the MDMA is originating from Asia, Canada, and the Netherlands and can vary from batch to batch. MDMA can induce euphoria, or a psychedelic high, but also can increase heart rate and blood pressure and can interfere with the body's ability to regulate temperature, according to the National Institute on Drug Abuse (NIDA, 2013). Research varies on MDMA's addictiveness, but some users do report symptoms of dependence and withdrawal effects.



Anthony Pettigrew, spokesman for the Drug Enforcement Agency's New England division, warned, "There's no 'good' batch of molly. Dealers want to make more money, so they'll mix and adulterate the stuff with meth and any number of other drugs to addict people to it" (Encarnaceo, 2013).

"It's not anything new," said Dr. Matt Mostofi, the assistant chief of emergency medicine at Tufts Medical Center, "the drug molly is a street name—what it is, no one is really sure" (Welker, 2013).

One organization is fighting to differentiate between clinical MDMA and the club powder called molly. The Multidisciplinary Association for Psychedelic Studies (MAPS) cautions, "MDMA is not the same as ecstasy. Substances sold on the street under the name ecstasy do often contain MDMA, but frequently also contain harmful adulterants. In laboratory studies, pure MDMA—but not ecstasy—has been proven sufficiently safe for human consumption when taken a limited number of times in moderate doses" (MAPS, 2013).

On their website the group states, "MAPS is undertaking a ten year, fifteen million dollar plan to make MDMA into an FDA-approved prescription medicine, and is currently the only organization in the world funding clinical trials of MDMA-assisted psychotherapy." MAPS is "studying whether MDMA-assisted psychotherapy has the potential to heal the psychological and emotional damage caused by sexual assault, war, violent crime, and other traumas. Our highest priority project is funding clinical trials of 3.4-methylenedioxymethamphetamine as a tool to assist psychotherapy for the treatment of posttraumatic stress disorder (PTSD). MDMA is known for increasing feelings of trust and compassion towards others, which could make an ideal adjunct to psychotherapy for PTSD" (MAPS, 2013).

In the early 1980s, MDMA was not illegal. It was a drug used in club settings and in therapy. Administrative Law Judge Francis L. Young, who was assigned the task of placing MDMA in one of the five controlled schedules, recommended that MDMA be placed in DEA Schedule III. That would allow for MDMA-assisted psychotherapy and continued research. But in July 1986, despite Young's recommendation and promising research data from numerous mental health professionals, the drug was placed in Schedule I, the most restrictive of the DEA schedules, and banned as a therapeutic/ research drug. Now, almost thirty years later, the drug is being revisited, not as a dangerous designer drug, but as an adjunct to treatment. Although trial groups have been relatively small, the evidence

suggests that progress is being made with MDMA-assisted psychotherapy—specifically with veterans returning from deployment with symptoms of PTSD. Hopefully we will soon be reading about these restored lives, rather than about the destruction brought about by the drug known as molly. 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.*

References

Aleksander, I. (2013). Molly: Pure, but not so simple. *New York Times*. Retrieved from http://www.nytimes.com/2013/06/23/fashion/molly-pure-but-not-so-simple.html?pagewanted=all&_r=0&pagewanted=print

Alfarone, D. (2013). Popularity of "molly" is growing; ER visits up 120 percent. *WUSA-9*. Retrieved from http://www.wusa9.com/news/local/story.aspx?storyid=273451

Busse, M. (2010). Side effects of MDMA. *LiveStrong*. Retrieved from http://www.livestrong.com/article/172668-side-effects-of-mdma/

Caulfield, P. (2013). Brilliant University of Virginia student dies from 'molly' overdose at DC club. *New York Daily News*. Retrieved from http://www.nydailynews.com/news/national/uva-scholar-dies-molly-overdose-article-1.1448597s

DanceSafe. (2013). *What adulterants are commonly found in pills sold as ecstasy?* Retrieved from http://dancesafe.org/faq/amphetamines/what-adulterants-are-commonly-found-pills-sold-ecstasy

Encarnaceo, J. (2013). DEA warning: There's no 'good' batch of molly. *Boston Herald*. Retrieved from http://www.lowellsun.com/news/ci_24011763/alarm-grows-louder-mollys-deadly-mystique

Furek, M. W. (2008). Lean abuse creates strange musical genre. *Counselor*, 9(6), 60–61.

Greenagel, F. (2013). Molly is not new, but remains highly dangerous. *Addiction Professional*. Retrieved from http://www.addictionpro.com/article/molly-not-new-remains-highly-dangerous?WA_MAILINGLEVEL_CODE=&spMailingID=42654707&spUserID=NTA3NTY1NDMxMTkS1&spJobID=204099652&spReportId=MjAoMDk5NjUySo

Huffington Post. (2013). Rick Ross date rape lyrics in "U.O.E.N.O." stirs controversy. *HuffPost Black Voices*. Retrieved from http://www.huffingtonpost.com/2013/03/26/rick-ross-date-rape-lyrics-uoeno_n_2954929.html

Kraft, S. (2011). Drug Report: MDMA, ecstasy still a teen choice; ER visits up 75 percent. *Medical News Today*. Retrieved from http://www.medicalnewstoday.com/articles/220267.php

Multidisciplinary Association for Psychedelic Studies (MAPS). (2013). *Research: MDMA-assisted psychotherapy*. Retrieved from http://maps.org/research/mdma/

National Institute for Drug Abuse. (2013). Drug Facts: MDMA (ecstasy or molly). *NIDA*. Retrieved from http://www.drugabuse.gov/publications/drugfacts/mdma-ecstasy-or-molly

The Partnership at DrugFree.org (2013). *Newest molly users: Middle-aged professionals, says DEA agent*. Retrieved from http://www.drugfree.org/join-together/drugs/newest-molly-users-middle-aged-professionals-says-dea-agent

Ruth, S. L. (2013). Driven by popular music lyrics, use of drug molly, or MDMA, surges. *The Washington Times Communities*. Retrieved from http://communities.washingtontimes.com/neighborhood/metro-news/2013/sep/2/driven-popular-music-lyrics-use-molly-or-mdma-surg/

Soderberg, B. (2013). The 'U.O.E.N.O.' rape rap controversy one month later. *Spin*. Retrieved from http://www.spin.com/articles/rick-ross-rocko-rape-rap-controversy-uoeno-childish-major/

Welker, G. (2013). Alarm grows louder on molly's deadly mystique. *Lowell Sun*. Retrieved from http://www.lowellsun.com/news/ci_24011763/alarm-grows-louder-mollys-deadly-mystique

Winsor, W. (2013). Electric Zoo musical festival canceled after two deaths blamed on drugs. *CNN.com*. Retrieved from http://www.cnn.com/2013/09/01/us/new-york-music-festival-canceled/index.html?hpt=hp_t2

Why I Work at An Outpatient Methadone Treatment Facility

Randi Konikoff, NCC, LPC, CCS, LCAS, BCPCC

I choose to work as an addictions counselor and clinical supervisor in an outpatient methadone treatment facility. I work for a company where people get well, where people are treated with dignity and respect, and where people learn that they can have hope for a better life.

Contrary to a common misconception, methadone treatment is not merely substituting one drug for another. In the proper dispensation, methadone is neither mind- nor mood-altering. It is an opioid blocker, and is very effective in eliminating the debilitating symptoms experienced during voluntary and involuntary opioid withdrawal. In my three years with this company, I have also witnessed that methadone treatment can be a way to achieve restoration of relationships, assist with the ability to show up for work and perform as expected, significantly reduce drug-related expenses, and provide clients with a sense of getting life back to normal.

For most clients seeking methadone treatment, getting high from opioids is a thing of the past. The focus now is on being able to get out of bed and function normally, or even minimally. Opioid addiction is not a respecter of persons. It will take whomever it can devour. Whether you began shooting for recreation or you trusted that a prescription medication could never lead to life-altering dependence, both clients are sitting in the intake waiting room wondering how it ever got to this point and praying for something to help them off this ride.

As if a client's feelings of shame and failure from the effects of addiction aren't enough, they are often compounded by ignorance and prejudice about the treatment modality itself. Well-meaning relatives and friends, fearful of continued addictive behaviors and consequences, urge clients to "just quit using." Anyone who has experienced opioid withdrawal would have a strong reaction to that advice. While there are individuals who have successfully withdrawn from opioids cold turkey, there are a larger number of individuals who benefit from a harm-reduction approach while learning about addiction and building on their successes of seeing positive changes taking place in their lives.

Outpatient methadone treatment is not the best treatment for everyone. Methadone is not candy. It is a very powerful drug, requiring adherence to strict protocol and regulatory requirements. Not all those seeking this form of treatment are viable candidates. They must meet diagnostic criteria and be assessed by addictionologists and physicians familiar with methadone treatment. Some clients require a higher level of care and some come only as a temporary way to hold off withdrawal symptoms, with no intention of getting and staying clean. Pain is a great motivator. Remove the pain and some clients will become content; choosing to keep on their current dose amount of methadone and not deal with their fears about voluntary detox. These clients have stabilized their lives, but have stopped short of working on the issues preventing them from taking the next step of working on the emotional and behavioral modifications necessary to live drug free. That is not how the program is designed to work.

The program is designed to take the client out of the madness of constantly looking for something to keep the withdrawal symptoms at bay, to stabilize their lives, to provide for an end to the daily chase, and to educate and encourage clients that they are capable and worthy of having a more meaningful existence. This phased approach typically takes one to two years to achieve and at least one more year to slowly decrease the medication and successfully complete treatment.

Treatment begins with daily monitored dosing of a customized medication protocol, along with client participation in individual and group counseling sessions. After three months of treatment participation, if client has abstained from the use of all illicit substances and has participated in cognitive behavioral modification therapy, client may be eligible to earn take-home doses. This responsibility for self-dosing is earned and awarded based upon the client's demonstrated growth, insight, and behavior modification toward their goal of abstaining from illicit drugs.

Continued abstinence and treatment participation takes the client through a six-phased level advancement program, culminating in take-home privileges for up to two weeks at a time. Clients continue to participate in individual and group therapy. Voluntary detoxing is discussed at all points along the way, and clients are encouraged to learn about detox, process their resistance, and eventually participate in a slow and steady voluntary detox when they feel physically and emotionally ready.

There is a reason there are no drive-thru windows at the clinic! It is not just dose and go. The treatment consists of a trio of services, woven together to provide physical and emotional healing, education on the disease of addiction, and cognitive behavioral modification to help clients live a drug-free life after treatment completion. These three services are daily medication dispensing, on-demand individual therapy sessions, weekly group therapy sessions, and walk-in doctor visits. Competent and compassionate clinicians work with clients to address personal therapeutic needs and to empower clients to make wiser decisions.

Methadone outpatient therapy works when clients are committed to their goals and where treatment programs are committed to providing life-changing tools for a client's continued recovery.

Randi Konikoff, NCC, LPC, CCS, LCAS, BCPCC, *is the Clinical Supervisor and Lead Counselor at McLeod Center in Concord, North Carolina. She has her own private practice and volunteers with Celebrate Recovery; a faith-based Twelve Step recovery program. Randi graduated from Liberty University with a BS in psychology and an MA in professional counseling. She currently lives in Charlotte, North Carolina with her three children and her Sharpei, Wrinkles.*

Imagination: The True Ecstasy

Rev. Leo Booth

You are reading this article in 2014, but I'm writing it October of 2013. I know that recovery tells us not to project and to live in the moment, but for magazine contributors, we are often living and writing in two different time zones; two different worlds.

We achieve this challenge through our imagination.

Imagination is powerful. It's more than a gift from God; it's a demonstration of God. It enables us to create, to see beyond the present, and to make what starts as a seed of an idea, a physical reality. It takes us into worlds we have never known, that we have never experienced, and yet we mysteriously understand them. Imagination is a *mystical*, if not miraculous, time capsule that can take us back into history and into the future, into the real and into the fantastical.

What do I mean when I say that imagination is a demonstration of God? Well, it connects with that description of God as the Creator. Stories in every religion speak of God making the world, the stars in the heavens, the creatures that roam and swim on the planet, and humankind; both male and female. If we stand back and see what all these poetic writers are describing, it starts with an idea within God that is made manifest in creation. Creation surely speaks to the imagination of God. Again, poetically speaking, God sees a potential world in its myriad of forms and then makes it happen.

Within the heart of the Creator is imagination. The Creator sees how the world can be, with its necessary hiccups along the way, and then gently steps aside, never completely out of the picture, but giving us the freedom to create.

Yes, the Creator enables the creator to create. We share in God's imagination as we continue to make things happen. *This is the real ecstasy*. This is the divine experience, and it's happening all around us.

Counselor magazine records the results of imagination all the time in its presentation of treatments, research, new understandings of past remedies, and then in publishing philosophical data that bring fresh insights. Addiction therapy is but one small aspect of comprehensive healing that needs and involves the gift of imagination.

On a personal level, the gift of imagination has stimulated my life and my recovery for many years. I'm constantly thinking about aspects of spirituality that I've not yet explored; especially how imagination is rooted in the mind of God. Where have my ideas, that have eventually found themselves into my published books, come from? I think they came from God. However, I always need to be involved. As I've affirmed in my most recent book, *The Happy Heretic*, I imagine a partnership with God that brings possibilities into reality. God is constantly being demonstrated in our lives and our ideas.

Some of my ideas that have come to fruition over the years are:

- Spirituality and Religion are not the same.
- We need to become our own angels.
- It's okay to think differently and be a heretic.
- Spiritual awakenings are happening all the time; we need to recognize them.
- When we say we are doing nothing it's never true.

Never has this been truer than in my latest book, *A Guide to Spiritual Awakenings*, which will be published in January 2014. From blank paper a new book is created. Thoughts I never intended to be printed are now finding their way into this new book:

- Oscar Wilde becomes an angel to an agnostic gay man.
- My friend's child support becomes a template for a spiritual awakening.
- A stuffed teddy bear brings a message of hope to a young woman suffering from depression.

Imagination is powerful. It's more than a gift from God; it's a demonstration of God. It enables us to create, to see beyond the present, and to make what starts as a seed of an idea, a physical reality.

Where do these ideas come from? What feeds our imagination? God. Spirit. Higher Power. These spiritual awakenings exist within each of us.

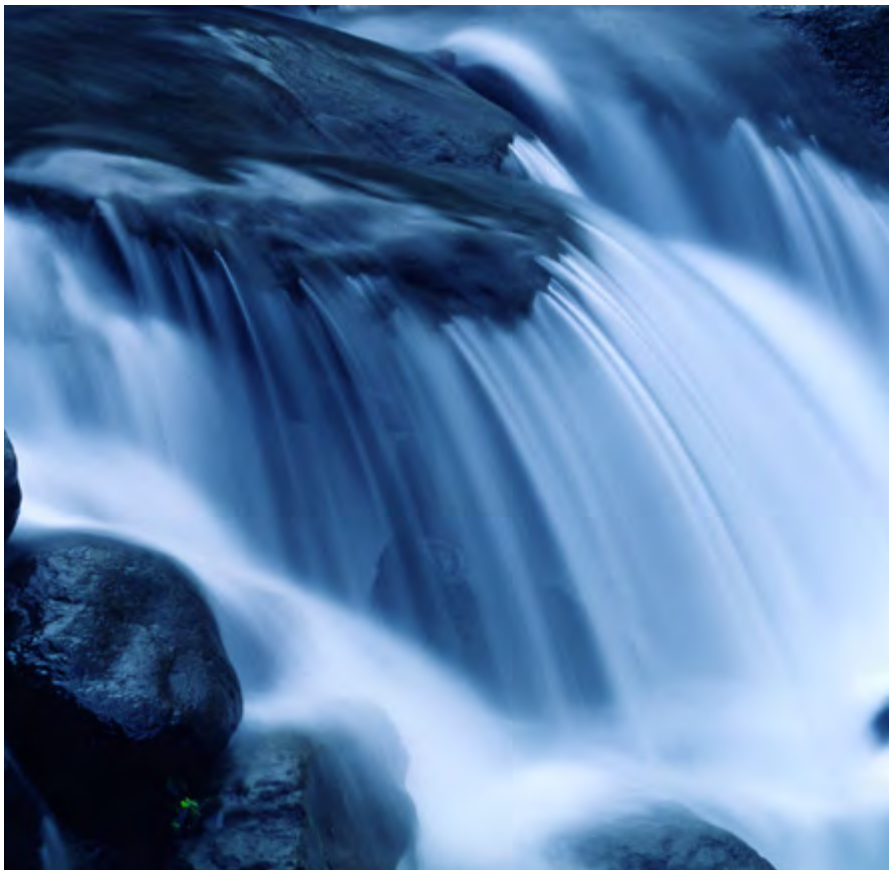
For those of us in recovery, the gifts derived from our creative imaginations appear limitless. Yes, we may sometimes think that we have exhausted a topic or subject but then a new thought percolates in our mind and we are off and running again. In this sense, the messages from God are inexhaustible.

This reminds me of a dialogue that occurs in George Bernard Shaw's play about St. Joan of Arc. *You say God speaks to you, but it's only your imagination*. Those are words spoken by the Inquisitor to Joan of Arc during her trial for heresy, to which she responds, *how else would God speak to me, if not through my imagination?*

Joan of Arc says what many of us are beginning to understand, that the power of our imagination demonstrates the presence of God in our lives.

It's a beautiful thing. C

***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.*



The Role of Faith in Recovery

John Newport, PhD

Faith in a beneficent higher power, a power greater than all of us, is a basic cornerstone of all Twelve Step recovery programs. Indeed, faith and its application is an explicit theme running throughout the Twelve Steps of AA, NA, and other programs.

Specifically, Step Two states that we "came to believe that a Power greater than ourselves could restore us to sanity." Step Three blends the qualities of faith and surrender by stating that we have "made a decision to turn our will and our lives over to the care of God as we understood him." Steps Five, Six, and Seven call for an active application of faith in our quest for recovery through stating that we admitted to God and ourselves the exact nature of our shortcomings, were ready to have our higher power remove our defects of character, and humbly prevailed upon that power to guide us in overcoming our shortcomings. Steps Eight and Nine deal with making amends to people we have wronged, an undertaking that would be impossible for most of us without the compassionate guidance of a beneficent higher power. Steps Eleven and Twelve powerfully emphasize the need to actively apply our faith, as in the process of following the Steps we seek to deepen our contact with God as we understand him through prayer and meditation. Finally, having experienced a spiritual awakening through the application of these steps, we commit to actively reaching out to carry this message to other suffering alcoholics and addicts (Alcoholics Anonymous World Services, 2002).

Defining Faith

In a spiritual context, faith often involves accepting claims about the nature of the universe or the meaning of life in the absence of objective supporting evidence. The Merriam-Webster Dictionary states that faith entails accepting something as true without proof or evidence that it is true, adding that active faith involves continuing to believe in, trust, or support someone or something when it is difficult to do so (Merriam-Webster Learner's Dictionary, 2013).

Indeed, when an alcoholic or addict finally admits that life has become unmanageable, he or she will hopefully choose the path of recovery out of sheer faith that following that path will enable him- or herself to gain freedom from the unrelenting grip of addiction that has come to dominate their life. Through actively seeking sustained sobriety through attending meetings, working with a sponsor, and otherwise working the program, the newly recovering alcoholic or addict is challenged to "keep the faith" despite the inevitable twists and turns that often make it exceedingly difficult to stay on track.

One of my own favorite definitions is from an unknown source that defines faith as a strong and steadfast belief in things as yet unseen. Consider the case of Nadine, a middle-aged woman in recovery who has a burning desire to help others as a psychotherapist. Despite the financial hardship, she enrolls in a graduate program in counseling with the goal of ultimately becoming a licensed therapist and applying the skills she has acquired in helping others improve their lives. Clearly when she embarks on this journey there are no guarantees that she will successfully complete her graduate studies and the subsequent steps leading to licensure. Yet her burning desire to achieve her goal translates into a strong faith that she will complete this process. That faith, in turn, buoys her along the way, even at those times when she encounters extremely trying circumstances that threaten to derail her from her chosen path.

Applying Our Faith

Recently I attended a church service with my wife in which the priest gave a talk on applying our faith in our daily

life. The point that really resonated with me was his statement that we often fail to use the faith that we have. In essence he proclaimed: "You wouldn't be in this room if you didn't have faith. Lack of faith is not the problem. The problem with many of us, however, is that we often fail to use our faith when we are confronted with what appears to be an irresolvable problem in our lives" (Kennedy, 2013).

Driving home, I reflected on how I often will pray to my higher power to strengthen my faith in order to deal with a particularly stressful situation, only to sabotage my good intentions by failing to roll up my sleeves and plunge into doing the legwork.

Let's employ a concrete example to illustrate the importance of focusing on our faith and applying it full force to tackle the challenges in our lives. Take the case of Bill, a forty-five-year-old recovering alcoholic who smokes a pack and a half a day and swears that he really wants to quit. Yet when his wife asks him why he isn't doing anything to kick the habit, he laments that he has tried to quit again and again, to no avail. "It's no use," he exclaims, "I just can't seem to ever get that monkey off my back."

Evidently our friend Bill has little or no faith in his ability to quit smoking for good—despite well-documented evidence that the average smoker attempts to quit between five and eight times before he or she finally kicks the habit. The first thing he needs to do is to instill in himself a grain of faith that he does indeed have the wherewithal to free himself from nicotine. He might, for example, begin to research the problem by attending some Nicotine Anonymous meetings and listening to testimony of former smokers who have successfully kicked the habit. Or he might call the free-of-charge stop smoking quit line sponsored by his state health department, and discuss his predicament with a trained counselor who has guided many former smokers in weaning themselves from tobacco. Readers can do a Google search to access the stop smoking quit line serving their state.

Armed with evidence that challenges his assumption that he is doomed to stay hooked on tobacco, Bill now has some semblance of faith in his ability to join the ranks of former smokers. Now he needs to bring muscle to that faith by rolling up his sleeves and tackling the problem head on. He can visit his doctor to become informed as to pharmaceutical agents that might help him through nicotine withdrawal, and obtain assistance in formulating a plan to quit. He then needs to use his faith and do the legwork, perhaps by enrolling in a group smoking cessation program sponsored by the American Cancer Society or the American Lung Association, becoming actively involved in Nicotine Anonymous, or linking up with a counselor with the stop smoking quit line. Throughout the process he can choose to actively keep his faith alive through turning to his higher power and by visualizing himself enjoying life as a successful non-smoker.

From time to time we all need a refresher course in strengthening and actively applying our faith. I hope this column has given you some helpful pointers along these lines. As always, feel free to share this article with clients who might benefit from the message. Until next time!

***John Newport, PhD**, is an addiction specialist, writer, and speaker living in Tucson, Arizona. He is the author of* The Wellness-Recovery Connection: Charting Your Pathway to Optimal Health While Recovering from Alcoholism and Drug Addiction. *His website, www.wellnessandrecovery.com, provides information on wellness and recovery training, personalized wellness counseling by telephone, and program consultation services.*

References

Alcoholics Anonymous World Services. (2002). *Twelve steps and twelve traditions*. New York, NY: Author.

Kennedy, P. (2013). *Using our Faith*. A homily delivered at St. Mark's Catholic Church, Oro Valley, AZ.

Merriam-Webster Learner's Dictionary. (2013). *Faith*. Retrieved from http://www.learnersdictionary.com/definition/faith

Stepping Stones

Sheri Laine, LAc, Dipl. Ac.

It seems the New Year comes so quickly now, in this flow of life. Days into months, months into seasons, seasons into change. People, places, emotions, movement, reflection—all are stepping stones to more awareness and opportunities.

Stepping stones can lead us onto a path, a walkway, through an opening, or toward a doorway. They create order and succession as they guide us towards or away from people, places, or things.

Stepping stones are like our intentions as we move toward our goals. In order to arrive at our destination, we must begin by taking the first step towards our vision . . . one foot in front of the other, one step at a time.

The New Year is the time to consider health goals, and to strategize how to achieve them. Each day offers a new opportunity to create a more fulfilling and healthier life, starting with diet, exercise, and a balanced emotional outlook. Creating a plan of action and putting that new action into use will lead your body to a positive reaction.

Starting with your thoughts, remember this Chinese saying: "Your mind leads your *qi*"—*qi* being our life force. This little saying can become a mantra of sorts. Devise a daily meditation plan and a commitment to positive thinking. When we look upon our life as more than half-full of gratitude, joy, wellness, and happiness, these positives become the first things we see and think about.

You might adopt a regular acupuncture, nutritional, and herbal approach to your lifestyle. Just as your car needs to go into the shop for regular tune-ups, your body needs regular maintenance to stay well-tuned and resilient.

A daily exercise practice is another vital stepping stone to ongoing wellness. Find ways to work out that you enjoy and integrate variety into your workouts—change your exercises, weight routine, and cardio routine on a regular basis. On sunny days, be sure to get outside and enjoy the warm sunshine. Take long, slow, deep, cleansing breaths. Stretch daily; flexibility creates less injuries.

Food is fuel. Fill your diet with an array of seasonal green vegetables and fresh fruits. Think of healthy choices first, with every meal. Consider drinking fresh green juices or green smoothies several times a week. Take time to chew slowly and savor the flavors of your food. This will enhance your digestion and limit food quantity. Make a point of getting enough water daily, and limit your caffeine consumption. You may not always eat perfectly, but healthier choices reflect a new respect for your goals as you walk toward wellness.

This is also a great time to clean up your personal space, such as your office and your home. Get rid of anything you are no longer using. Donate to those less fortunate. Replace old, worn-out clothing.

Surround yourself with like-minded people whenever possible. We all carry with us our own *EnerQi* vibration; be sure yours is surrounded with positive *EnerQi*.

Last but not least, make sure your life is filled with laughter and happiness. Why not enjoy yourself? If your life is not working, take the steps to bring about the necessary changes that will make you happy. You will find that your contentment, laughter, and happiness will be contagious to those around you, creating an enjoyable, light atmosphere for all in your space. Within six weeks of your new plan, I promise you will walk with more power and pleasure along the stepping stones of your life.

Now is the time to walk upon a new path. 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.*

U.S. Journal TRAINING, INC.

The Institute for Integral Development

COUNSELOR

PRESENT

12TH NATIONAL CONFERENCE ON

Adolescents AND Young Adults

APRIL 24-26, 2014

LVH Hotel | Las Vegas | NV

James Garbarino, PhD

Jean Kilbourne, EdD

Dan Amen, MD

Jane Middelton Moz, MS

Co-Sponsor

American Addiction Centers

For Exhibitor Information Call, 1-800-851-9100 | Ext 220

For More Information Call, 1-800-441-5589 www.usjt.com

Mentorship, Part I: Urgently Needed, Poorly Understood

David J. Powell, PhD

Mentorship of the next generation of addiction professionals is arguably one of the most urgent needs in the field, yet it is rarely provided and poorly understood. Too often, supervisors are seen not as mentors but tormentors. As our field is "graying out," taking the next generation under our wings to mentor them is critical. Therefore, we need to have a better understanding of who a mentor really is and what to look for in mentorship.

The SAMHSA Treatment Improvement Protocol on Clinical Supervision, TIP 52, defines one of the four roles of a clinical supervisor as that of a mentor. It states "The experienced supervisor mentors and teaches the supervisee through role modeling, facilitates the counselor's overall professional development and sense of professional identity, and trains the next generation of supervisors" (Center for Substance Abuse Treatment, 2009, pg. 4). As one of the lead authors of the TIP, I can perhaps say this—this statement does not provide us with sufficient clarity to understand the functions of mentorship in supervision.

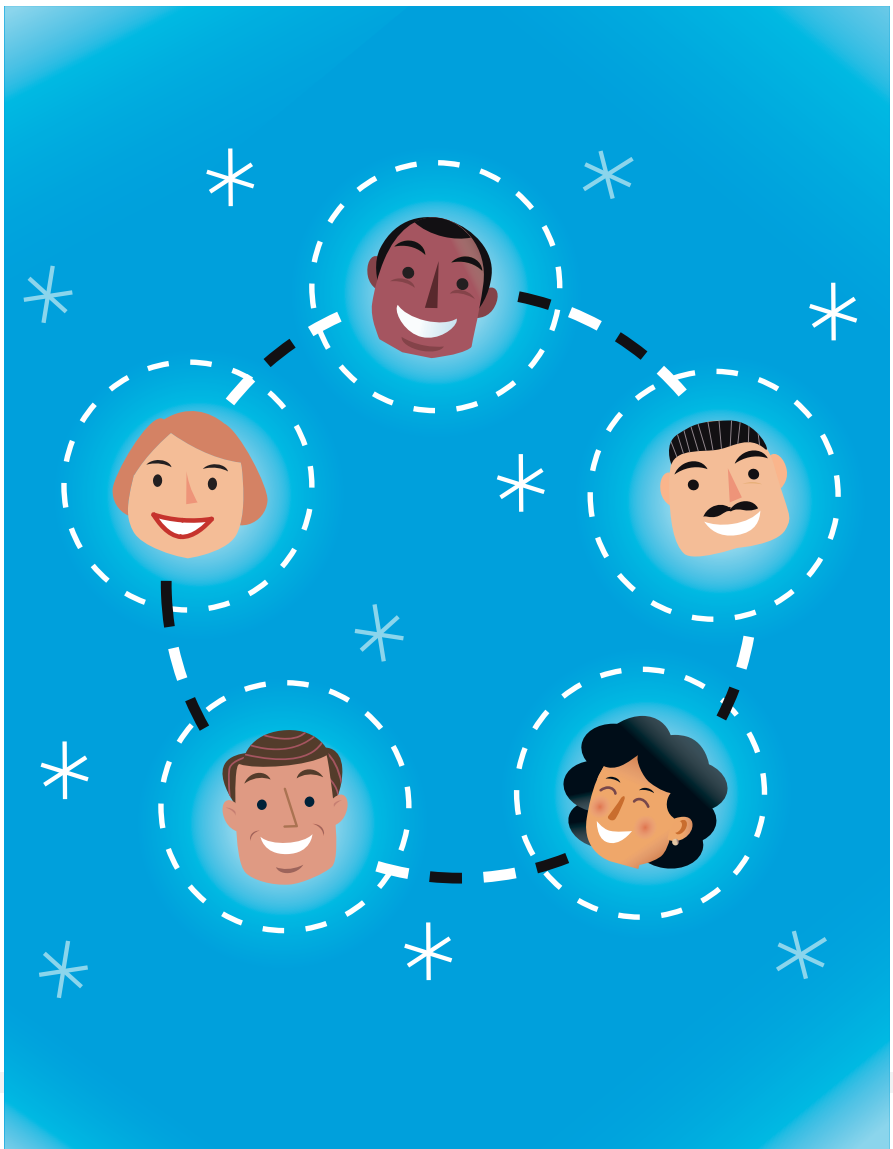
Mentorship is a developmental relationship in which a more experienced or more knowledgeable person helps to guide a less experienced or less knowledgeable person. It is about an ongoing relationship of learning, dialogue, and challenge. It is a relationship-based process that involves communication and the informal transmission of knowledge, social capital, and the psychosocial support perceived by the recipient as relevant to work, career, or professional development.

Here is some general information on mentorship and the role of a mentor.

A mentor should be grounded, spiritual, wise, experienced, and have a sense they have something to offer others. They should also be able to say "I don't know" and "I could be wrong" and serve as a catalytic agent in the lives of others.

The mentor role is different from the role of sponsor, supervisor, therapist, spiritual director, trainer, and friend. Mentorship is a voluntary relationship, with mutable roles, with diminished power differentials between mentor and mentee. It is less hierarchical and less formal. It generally does not carry the same degree of vicarious liability as might a supervisor-supervisee relationship. Issues related to confidentiality also differ and generally there is no "duty to warn" in a mentorship relationship. Mentors can remain more open, more self-disclosing, and provide a sense of presence in that relationship.

More than likely all of us have had teachers or mentors already, people who have helped shape us into who we



are today: sports coaches, educators, sponsors, and colleagues we admire. So, the first task in finding a mentor is to identify who have been mentors already in our life. What were their qualities? Second, it is important to ask "What are the questions I'd like answered? What issues would I like to discuss with a mentor?" Next, seek out individuals you admire, people about whom you can say, "someday, I want to be like her/him." Then, be bold and ask the person if they would be willing to mentor you. As Sheryl Sandberg says in her book, *Lean In*, if you seek a mentor, lean in to that relationship and ask the person for assistance.

Some of the issues a mentee might wish to address are whether it will be a formal or informal relationship. A formal mentorship agreement might entail a written, or at least verbal, agreement on the terms and conditions of the relationship. An informal mentorship relationship might be more open-ended. There needs to be a clear understanding how often and with what medium the mentorship will be provided, such as e-mail, face-to-face, Skype or telephone. Some mentorship relationships are based on the need to have a greater sense of direction at work, while others remain open-ended. The mentor and mentee need to agree on how important insight is in the relationship versus simply behavioral change.

Additionally, the age difference between a mentor and mentee might be important. Some might view an older professional to be wiser while others might seek a mentor closer to their age. Gender can also play an important role in the mentorship relationship.

Often, we are mentors to individuals without realizing so. People will come up to me and say, "I have admired and tried to follow in your footsteps for a long time." I didn't even realize I was having an impact on the person. Sorry, but in some cases, I didn't even know, or remember, the person. So, you might be a mentor to someone already and not even know it.

Mentorship offers a host of benefits. A good mentor is wise and willing to share his or her knowledge and experiences in order to help you succeed. It's like having a wonderful trusted ally to go to whenever you're feeling unsure or in need of support. They can help clarify and reach career goals, overcome professional challenges and roadblocks or simply offer another perspective on life decisions.

Mentors are helpful with clarifying who we wish to be professionally; whether we're fresh out of school or a few years from retirement, there are always others who have "been there" and "done that" from whom you can learn. If you have been in the addictions or mental health field for some time, this is a critical period for you to be mentoring the next generation of professionals. Lean in to that role, even if you humbly do not see yourself as qualified to be a mentor. Look at your qualifications and experience. Accept that you might have knowledge and experience to convey to the young, aspiring professional. It is important for the mentor to think about what is unique about them and what they have to offer others.

Over my long career I've been blessed with many wise mentors, such as Stan Obitts in college who introduced me to philosophy. Riley Regan from New Jersey was a mentor to me throughout my career. Bob Stuckey from Carrier Clinic often provided sound wisdom when I was pressed to make a professional choice. Gerald May was my spiritual director through challenging times. Today, I view Thich Nhat Hanh as my mentor. His followers call him Thay, which in Vietnamese means "teacher." All of the mentors in my life have gently guided me and were people I greatly admired and respected.

TIP 52 recommends these resources for mentorship:

- ATTC Leadership Institute (http://www.nattc.org)
- Michael E. Townsend Leadership Academy (http://www.mhmr.ky.gov/mhas)
- South and North Carolina Fellows Program (http://addictionrecoveryinstitute.com)

The Late David J. Powell, PhD, *was the president of the International Center for Health Concerns, Inc., in which he presented and consulted worldwide on addictions and supervision. He was also the assistant clinical professor of psychiatry at Yale University School of Medicine. Dr. Powell's books on clinical supervision are major texts in the field.*

References

Center for Substance Abuse Treatment. (2009). *Tip 52: Clinical supervision and professional development of the substance abuse counselor*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sleep and Addiction: Using the Current Information in Treatment

Michael J. Taleff, PhD, CSAC, MAC

Sleep and its link to addiction has been the subject of research for decades. Yet, the importance of sleep in today's treatment programs seems underappreciated. The general research indicates sleep is an important element in recovery, and needs to be woven into the actual treatment process. So, that's the heart of this month's column.

We first present a short review of some of the solid findings of sleep and addiction research. We then turn to sleep recommendations for use in day-to-day treatment.

What We Know

From the existing sleep and alcohol literature, we clearly know a number of things. A good source for this existing literature came out of Stein and Friedmann (2005). The authors sifted through the sleep publications, found over 400 relevant articles, and settled on 100 journal articles to produce an overall summary of the sleep and addiction research to date.

Some of the key findings included that substance abuse problems contribute to anywhere from 10 to 15 percent of chronic insomnia. This insomnia results in reduction in alertness and feeling tired. These effects can persist for several hours even after blood alcohol levels dropped to zero. The index of sleep insomnia included rates from 25 to over 70 percent in those diagnosed with alcohol dependence. Other research found that over half of this population experience sleep disturbance for several months even after their last use. The ill effects can linger for two years or longer (Brower, 2001).

Past research found that a large proportion of alcohol dependent persons, while still aware that alcohol disturbed their sleep, claimed they needed the alcohol to achieve sleep. While the data is strong that alcohol consumption interferes with sleep, the sleep interference has been shown to elicit greater alcohol use. These sleep disturbances can extend into early recovery and have been linked with relapse as well as ongoing cravings and the urge to drink (Vitiello, 2006). Moreover, sleep problems can aggravate primary psychiatric problems. Most professionals are aware that such psychiatric problems are often found with our clients.

Selected Recent Sleep Research

The present-day research has revealed that one night of sleep deprivation can result in profound cognitive impairments. Rob someone of two nights of sleep and the individual will begin to display signs of transitory psychosis (Bor, 2012). Consider the implications for treatment if clients are not getting sufficient sleep and the effect on the course of treatment—plus the implications for people still in an active addiction who do not get sufficient sleep due to the addiction lifestyle. The effects on their thought processing and already strained mental health are compounded.

Most sleep researchers believe the need for sleep and dream plays an important part in the ability to learn and solidify memory. During the day, neurons get overused and tired and need time to reset themselves. Sleep helps keep brains flexible and ready for another day of learning. Plus, we need a good night's sleep to keep our consciousness running smoothly (Bor, 2012). Consider the consequences for those in treatment or recovery who don't get the sleep they need.

In addition, we have known for years that sleep problems are associated

SERVING THE ADDICTIONS FIELD FOR MORE THAN THIRTY YEARS

COUNSELOR

GET COUNSELOR ONLINE!

FOR JUST $9.95 best deal
FULL-YEAR SUBSCRIPTION

INCLUDES A FREE THIRTY-DAY TRIAL!

COUNSELOR CONNECTION E-NEWSLETTER FREE WITH ANY SUBSCRIPTION

Sign up for a full-year subscription that includes all the editorial content from the print magazine. **PLUS,** gain access to additional information including the latest news and upcoming events.

Go to CounselorMagazine.com, click on register/subscribe at the top of the home page, and you're on your way!

Other subscription offers:

Sign up for the print magazine and all online content for $25.95.

Get the Zinio version for your tablet and mobile device for $14.95.

Bimonthly Bonus Newsletter

Recharge, relax, and stay abreast of upcoming events with *Counselor Connection* featuring:

- In the Spotlight: Addiction news you can use.
- Book Reviews: The latest books for professional and personal growth.
- Meditative Moment: Inspirational and/or meditative reading.
- Recovery Road: Messages of experience, strength, and hope.
- Continuing Education: Important training conferences and events.

with many psychiatric problems. The conventional thought was that sleep problems were symptoms of mental health problems, not the cause. The assumption these days is that sleep problems may contribute to psychiatric problems. For example, folks on the verge of depression may feel a spike in stress. That stress may then keep the person up all night, and the lack of sleep will make the person even more stressed, anxious, and upset. All of these negative moods will then add to the overall depressed mood (Bor, 2012).

REM Sleep

Alcohol consumption in particular interferes with rapid eye movement (REM) sleep. This type of sleep has been associated with revitalizing one's mind, and even helping to clear out extraneous information. Some studies have linked REM sleep with facilitating learning and memory components needed in a therapeutic process (Epstein, 2013). Plus, some older studies have linked REM abnormalities with alcoholics who have relapsed (Brower & Hall, 1998, Roehrs & Roth, 2001).

As most folks know, REM is linked to dreaming. Yet, modern research takes a rather skeptical view of the past analytic interpretations of dreams, which were perceived as the source of hidden conflicts and fears. The more recent studies see dreams as aimless chaotic images. To modern dream research, the dream is just your mind trying to make sense out of random signals. Today dreams are viewed as consolidating the day's memories and helping to retain important events in your life (Epstein, 2013).

The Need for Sleep Interventions

The problem with some treatment programs is that clients are told to focus on abstinence and the sleep improvement will follow. Yet, the research has noted that sleep disturbances can persist for some time despite long periods of abstinence. Thus, sleep problems need to be monitored closely, especially in early recovery.

Sleep Inducing Recommendations

To aid that process, consider discussing sleep issues with your clients, and if complaints are noted consider the following ideas. These are adapted recommendations from *Harvard Medical School Special Health Report* (Epstein, 2013).

- Go to bed and wake up at the same time every day, including weekends.
- Use your bed only for sleeping, not as a place to lounge around, play video games, or watch movies.
- Make concerted efforts not to nap during the day, especially close to bedtime.
- Only go to bed when you feel sleepy.
- If you can't fall asleep within fifteen minutes, or wake up and can't fall asleep again, get out of bed and try to do something relaxing until you feel sleepy again, like reading or progressive tensing.
- Avoid caffeine beverages like coffee, some teas, chocolate and cola drinks. Avoid such beverages after 2 PM, so your body can get rid of the caffeine before you hit the sack.
- Try to stay away from foods that contribute to heartburn such as acidic, fatty, or spicy foods.
- Definitely stay away from alcohol and stimulating drugs.
- Try to limit fluids before bedtime. This will cut down on trips to the bathroom in the middle of the night.
- Exercise will help with sleep, but not close to bedtime.
- The sleep setting is important. So, keep the bedroom cool, dark, and as quiet as possible.
- If you mattress is old, uncomfortable, or worn out replace it if you can.
- If need be, consider taking a warm shower or soaking in a hot tub before bedtime to bring on sleep a little better.
- Finally, try some relaxation techniques before bedtime such as a deep breathing, light yoga, or progressive relaxation imaging a warm feeling slowly relaxing you from toe to head.

Additional information can be found at the websites of The Sleep Research Society and The National Sleep Foundation.

Summary

Research has studied the relationship between sleep and addiction for a long time. There is no question that addiction does interfere with a good night's sleep.

More importantly, it has been discovered that the recovery time between the cessation of drug and alcohol use and finally getting good sleep ranges from a few months to a few years. That is potentially a long time to interfere with recovery.

Poor sleep habits have been linked with relapse.

Recently, the lack of sleep has been seen to not be so much as the result of addictive or mental health problems, but a contributor to those problems.

Awareness of problematic sleep issues needs an attention boost within treatment centers. C

Mike Taleff *has written numerous articles, books and book chapters, and he teaches at the college level. He also conducts trainings and workshops (e.g., Critical Thinking, Advanced Ethics, and Become an Exceptional Addiction Counselor) and can be contacted at michaeltaleff@mac.com or taleff@hawaii.edu.*

References

Bor, D. (2012). *The ravenous brain.* New York, NY: Basic Books.

Brower, K. J., & Aldrich, M. S. (1998). Polysomnographic and subjective sleep predictor of alcoholic relapse. *Alcoholism: Clinical and Experimental Research, 22*, 1864–1871.

Brower, K. J. (2001). Alcohol's effects on sleep. *Alcohol Research & Health, 25*(2), 110–125.

Epstein, L. (Ed.) (2013). *Harvard Medical School Special Health Report*. Boston, MA: Harvard Health Publications.

Roehrs, T., & Roth, T. (2001). Sleep, sleepiness, sleep disorders and alcohol use and abuse. *Sleep Medicine Previews, 5*(4), 287–297.

Stein, M. D., & Friedmann, P., D. (2005). Disturbed sleep and its relationship to alcohol use. *Substance Abuse, 26*(1), 1–13.

Vitiello, M. (2006). Sleep, alcohol, and alcohol abuse. *Addiction Biology, 2*(2), 151–158.

ONLINE

Continuing Education Programs Are Here!

Need to Earn CE Credits?

NEW FEATURES TO INCLUDE:

- WEBCASTS
- PODCASTS
- ACCESS TO SUPPLEMENTAL MATERIALS FROM PRESENTERS
- EASY TO SEARCH FOR ALL YOUR SPECIFIC LEARNING NEEDS
- AND MUCH MORE!

USJT.com offers individual Continuing Education units (CEs) to help you achieve your professional goals. Presented by credentialed leaders in the field, these lectures provide valuable information to enhance your career development. USJT.com's Distance Learning Center makes earning CEs easy!

- Search from over 200 available lectures
- Listen to lectures
- Take exams online and know instantly if you pass or fail
- Access and download your completed certificates from your personal www.usjt.com account

DISTANCE LEARNING TOPICS

- Treatment of Complex Trauma
- Brain Science
- Addiction
- Adolescence/Young Adults
- Mindfulness & Body-Mind Connection
- Process Addictions
- Co-Occurring Disorders
- Neuroscience & Therapy
- Nutrition & Recovery
- Anxiety & Panic Disorders

And Many More!

U.S. Journal TRAINING, INC.

Over thirty-five years of providing excellence in professional conferences

www.usjt.com

Ask the LifeQuake Doctor

Dr. Toni Galardi

It is a new year full of so many possibilities. What is it about resolutions that make us not want to keep them? What if we focused on what state of consciousness we would like to be in rather than resolving to give up anything? So much of addiction is driven by a feeling of deprivation—filling the soul hole. In late January, I will be giving a teleclass on moving through change into abundance, Italian style. I call it The Abbondanza Method: Seven Secrets to An Abundant Life I Learned From My Italian Grandmother.

Dear Dr. Galardi:

I don't quite know where to turn. I have been married for fifteen years to a man who supports our family really well. He came from a wealthy family and I came from a middle class family. We don't agree on how to raise our children. He believes in maids and nannies taking care of everything. I was raised to do chores in the home and I think our children need to learn to be more responsible.

Not only do my husband and I not share the same values, but we also do not enjoy doing the same things together. Six months ago, I was on the board of one of my children's soccer league and I met the father of one of the other children on one of the teams. At first we were just friendly with one another. It has now progressed to a full blown affair. I don't know what to do. I don't want to hurt my children or my husband, and I also don't want to hurt the family of this new man. There are so many people to consider here. A friend of mine is a therapist and I saw this magazine that carries your column in her office. I thought that perhaps you could give me another perspective. My girlfriend is thinks I should end the affair, and that I am sexually addicted to this man. She has seen so many bad divorces in her practices that came from extra-marital affairs. We've tried to end it but we always come back to each other. I

genuinely think he is my soulmate. I have never cheated before.

What should I do, Dr. Toni?

–Lost Soccer Mom

Dear Reader:

If this is your first affair in fifteen years of marriage, I doubt you are a sex addict. The greatest pain in life comes from indecision. Not all relationships that began as affairs are destined for failure. I can attest to that from my own practice. Ultimately, living in ambivalence about your husband and the fear of leaving is more damaging to you and your children. Although you may think you are concealing the affair, the deception is often read by children in other ways. I have often seen the children in these situations act out in their own ways through risky sexual behavior if they are of age or drug experimentation.

If you and your lover have tried to end it and have been unsuccessful, I would urge you to be courageous and tell your husband you want to go into counseling and deal with this. Once you are there, be transparent. Let the therapist guide the both of you toward a resolution that you both can live with. The truth shall set you free. There is an expression in Alcoholics Anonymous that says "You are only as sick as your secrets." Healing can only begin with honesty.

Dear Dr. Toni:

I am a college student seeing a therapist my parents picked out for me. They pay the bills so they feel they get to control who I get counseling from. When I was sixteen, she (the therapist) was perfect for me. Now that I am in my last year of school, I feel that I need someone who can help me transition to life after college. How do I convince my parents that I need to see someone else? She is kind of a friend of theirs.

–Frustrated Reader

Dear Reader:

It sounds to me like this is more than just an issue of career counseling. You are seeking psychological individuation from them by asserting your independence on who is meant to be the transitional authority figure in your life. Your current therapist may have been perfect for working with teens rebelling. However, you are in need of a transitional guide to adulthood signified by leaving college and getting a job. As a transition specialist, I can tell you that you are not alone. Many young people come to me as college is ending or has ended and they are floundering without a strategy for moving on.

You don't mention as to whether you have found this person you want to see next. If you have not found someone, you should do some research first. Ask for a free thirty-minute consult, talk to a few licensed therapists, and find one you like. Then, sit down with both of your parents and explain your reasons for wanting the change. Additionally, tell them you will do a session with your current therapist and put closure on the work you have done together and follow through with that. Do not just stop.

Good luck on your new adventure!

I have a new website—DrToniGalardi.com. Write to me through DrToni@DrToniGalardi.com. I am giving a seven-week teleclass beginning in late January; call 310-890-6832 for more information. I am still doing most of my individual work through phone coaching. If you are in the midst of a major transition, call the LifeQuake Doctor.

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

AT THE CROSSROADS:

CONNECTION & INTERFACE IN ANIMAL-ASSISTED INTERVENTIONS

Maryjo Brown, MA, LPC, &
Cheryl Knepper, MA, LPC, ATR-BC, ICCDPD, CSAT-S

"One of the most fundamental advantages of animal-assisted therapy over other therapeutic modalities is that it provides the patient a much-needed opportunity to give affection as well as receive it. It is this reciprocity—rare among medical therapies—that makes AAT a unique and valuable route to healing." –Dr. Andrew Weil

At the crossroads of effective interventions lies the therapeutic relationship—a critical component that defines the direction and outcome of the therapeutic process of relationship and change. One modality gaining prominence in both outpatient and inpatient clinical settings is animal-assisted intervention (Bardill & Hutchinson, 1997; Fine, 2010).

Our connection to animals runs deep throughout humankind's history. For hundreds of centuries, the human-animal connection has enhanced humankind's evolutionary success through increasingly intimate and reciprocal combinations of social interactions with domesticated animals (Serpell, 1986; Shipman, 2010). We are drawn to animals because we are like them and at the same time not like them. We are like them because we both are living beings sharing a related history spanning hundreds of centuries.

We attribute to animals human feelings, thoughts, beliefs, and values in a process known as anthropomorphism, which is a social interface between the boundary of self and animals (Serpell, 2003). When it presents itself during a treatment session, the client projects their thoughts and feelings onto the animal. This becomes a safe environment for symbolic exchange, expression, and exploration of emotionally laden topics. The insights gained from this therapeutic encounter help build the therapeutic alliance and guide the client toward healing (Fine, 2010; Kruger, Trachtenberg, & Serpell, 2004).

The inherent parallel process that occurs when animals are utilized during counseling or therapeutic visits is the individual's ability to project their thoughts, feelings, and values onto the animal. This process assists the building of a therapeutic relationship and can often strengthen the client's investment in their treatment. Therefore, this process

THOMAS DEITZLER AND SEVEN-YEAR-OLD GOLDEN RETRIEVER, FENWAY.

MARTY FERRERO AND SIX-YEAR-OLD PART AMERICAN-ESKIMO MIX, GRACIE.

can result in healthier relationships and real behavioral change.

Animal-assisted interventions are most notably a dynamic relationship of three; the experienced counselor who must be skilled in interpreting the patient's therapeutic process, the patient, and the certified therapy animal which will become the catalyst for healing. It is important to note that a certified therapy animal should always be selected keeping in mind the particular individual's needs in order to obtain the treatment goal. Animal therapy works with a patient or client who acknowledges the human-animal relationship as meaningful to their lives (Delta Society, 2001; Fine, 2010). In these therapeutic moments come opportunities for corrective emotional catharsis, teachable moments about one's struggles with illness, making amends, and learning opportunities about self, others, and the world at large.

> Mickey finally stopped at Kyle, looked at him, and placed his head on the patient's lap. Kyle began to sob.

Case Study Utilizing Animal-Assisted Therapy in Treatment

Kyle is a nineteen-year-old Caucasian male who is currently a senior at an alternative education program. His placement in the alternative program was a result of his acting out behaviors and consequences of his substance use disorder. Kyle has had two inpatient residential treatment stays for substance dependence and numerous outpatient mental health treatment attempts. He is currently attending an Intensive Outpatient Program (IOP) for treatment of his co-occurring disorder. His drugs of choice are alcohol, marijuana, and heroin. He also has a history of posttraumatic stress disorder, stemming from a childhood of physical and emotional abuse by his biological father who also had a significant substance use history. Kyle's father is sober and has been in recovery for twelve years. He has made amends to his son. Kyle, however, has yet to forgiven him. Kyle has a dysfunctional relationship with his biological mother who enables him by not holding him accountable as a

result of her own guilt. His parents are divorced.

Treatment Highlights

During his eight-week stay in IOP, Kyle had difficulty connecting with his peers, expressing an understanding of unmanageability in his life, and connecting the consequences of his addiction to his current need for treatment and an alternative education program. In addition, he had many unresolved issues regarding his family of origin. He attended individual and group counseling sessions up to six hours per week.

Kyle attended groups designed to educate him about the disease of addiction, how to gain greater self-awareness, increase coping skills, develop emotional regulation, and work a daily recovery program. Once a week he also attended an art therapy group designed to offer him an alternative way of coping and expressing painful content. There was significant shame and distorted beliefs covered over by a façade of toughness and keeping others at a distance with his anger.

CARON ANIMAL ASSIST TEAM

On one occasion during an art therapy group, the animal-assisted counselor joined to colead the session. She attended with her side companion, certified therapy dog Mickey. Mickey, an eight-year-old male golden retriever, was known for his gentle spirit, playfulness, ability to recognize emotional distress and be a stabilizing factor during emotional events. The focus of this particular art therapy session was to design animal totems representing the spiritual connection with animals and parallel it to one's own behavior. Kyle attended this group with six other teens all struggling with addiction and mental health issues. Early on during the session Mickey became very restless, a trait pretty uncharacteristic of him. He paced several times around the teens seated at the table, who were designing their animal images. Mickey finally stopped at Kyle, looked at him and placed his head on the patient's lap. Kyle began to sob.

This was the first time Kyle displayed any other emotion besides anger. A peer in the group asked Kyle what he was crying about. He revealed the following account of his grief. One night while in a drug blackout, Kyle severely kicked his beloved dog, Sam, effectively destroying by what then was the only meaningful relationship he trusted in his life. At this moment, Mickey triggered the event for Kyle and became the catalyst for him to explore his losses due to addiction. Kyle presented with guilt, shame, and remorse, finally realizing that his life was unmanageable. Mickey became his higher power and provoked a spiritual awakening. Kyle now found himself at a crossroad. This breakthrough may not have happened without Mickey's presence and his ability to key into the most emotionally closed and wounded individual in the group. Today Kyle is seven years sober, working a program, and being a productive young adult.

Selection of Animal Assist

Selection of an animal assist should be a decision made under careful consideration. The family pet may not

have the right stuff or be appropriate for work as an animal assist. The most common animals serving as animal assists are dogs, but other domesticated species such as cats, birds, horses, guinea pigs, and llamas have been certified as animal assists by Pet Partners. When selecting an animal one should take into consideration:

- The animal's specific species/ breed characteristics, personality, and temperament
- Tolerance for training and preparation towards certification as an animal assist
- The commitment to advocate for your animal partners needs and welfare at all times

The Handbook of Animal Assisted Therapy: Theoretical Foundations and Guidelines for Practice (Fine, 2010) provides guidelines for incorporating animal-assisted therapy into the practice of counseling. Fine stresses the importance of clinician education as well as the training of the animal (2010). He identifies the primary requirements that are essential in an animal assist:

- The animal should be motivated by an over-the-top desire to be with people from all ethnic and cultural backgrounds in settings with varied levels of stimulation and activity.
- Animal assists should be attentive to their handler, possessing a gentle, calm, and comfortable demeanor with an ability to regain self-control after play, and regulate levels of excitement with guidance from the handler.

Secondary requirements are those skills that enhance the animal assist qualities:

- Socialization via training in classes, such as puppy kindergarten, offering basic obedient skills, exposure to people in a variety of societal settings (e.g., retail stores, parks, schools, nursing homes, etc.)
- Completing training with the AKC Canine Good Citizen test puppy training and continued exposure to socialization and varying environments

The final phase of preparing an animal for work requires:

- An evaluation of temperament and obedience in service settings.
- Upon recommendation and passing of evaluation the final outcome is certification as a therapy animal.

Certification can be obtained through:

- Pet Partners – www.petpartners.org
- Therapy Dogs International – www.tdi-dog.org
- Therapy Dogs, Inc. – www.therapydogs.com

Advocating for the animal and providing a healthy work environment requires handlers to know the behavioral signs of fatigue and stress in their therapy animal. Handlers must be prepared to end any stressful situation utilizing a therapeutic approach. It is also important to provide the animal with frequent breaks from the working environment and people. Lastly, handlers must always remember to take care of the animal's basic needs—fresh water, play time, a relaxing massage, or a walk on a loose leash.

Therapeutic Visits

Caron Treatment Centers, a nonprofit leader in substance abuse treatment, integrated animal-assisted therapy visits on their Pennsylvania campus in 2012. The visits are part of the adolescent, young adult, and adult residential programs. Before introducing animals on campus, clinical leadership and the quality team explored benefits versus

BENEFITS OF **UTILIZING AAT DURING COUNSELING SESSIONS AND THERAPEUTIC VISITS**

ANIMALS . . .

- Serve as social facilitators
- Reflect self-worth
- Nurture forgiveness and compassion
- Encourage the safe exploration of loss and fears
- Facilitate higher power experiences and promote mindfulness
- Diminish addictive cravings by offering healthy expressions of physical touch
- Focus attention and assist with grounding and sensory integration
- Support emotional regulation
- Increase self-control and decrease aggressive or self-harming behavioral acting out and reporting of incidence
- Provide comfort through animal contact and therapeutic touch
- Establish empathy
- Provide a connection to happier times (reminiscence)
- Become trusted objects of attachment when humans cannot be trusted

risks. The team developed policies and practice guidelines around the use of certified therapy dogs. It was determined that two certified therapy dogs and their handlers would provide these visits. Senior Clinical Directors Thomas Deitzler (adolescent and young adult programs), and Marty Ferrero (adult programs), along with their two dogs, Fenway and Gracie, received certification and training by Therapy Dogs, Inc. located in Cheyenne, WY.

Fenway and Gracie have become part of the clinical landscape at Caron. Their visits consist of weekly rounds on the treatment units. "When is Fenway or Gracie coming to campus?" is an often posed question to Deitzler and Ferrero. Words commonly expressed by patients to describe their moods after a visit are: "excited," "energized," "at peace," and "happy." Without a doubt, Fenway and Gracie improve the mood within the communities. They allow the patients an opportunity to take their minds off of the stressful event of being in a treatment setting. Patients engage in play and walks with the clinical directors and their animal assists. "It is kind of a debriefing process and we have noted within the adolescent/young adult programs a decrease of incidents of behavioral acting out after Fenway has visited," states Deitzler.

"Patients have embraced Gracie as part of their treatment experience. Whenever she spends time on the units we tend to do general visits, but there are many instances where clinical staff request a visit by us for a particular patient due to a variety of therapeutic reasons" states her owner, Marty Ferrero. At Caron, we have integrated the visits into clinical practice. During case consults a visit may be recommended as an intervention and added to the patient's treatment plan. Most interventions assist with patients' anxiety, depression, grief process, and home sickness.

Gracie was rescued on a two-lane highway just North of Taos, New Mexico, in January of 2009. According to Ferrero, she has always appeared to have a sense of gratitude for having been rescued. Patients seem to connect with her on an intrinsic level, recognizing her as a survivor and paralleling it to their own experience.

Animal- assisted visits make a difference. Fenway and Gracie's ability to sit and listen in a nonjudgmental capacity enhances the patients' motivation for change. They experience unconditional love often echoed and talked about in the Twelve Step rooms, which is a valuable part of the patient's spiritual growth and reconnection with the lost self.

Conclusion

The power that fuels animal-assisted intervention is the connection between animal and human. Animal-assisted therapy as an adjunct to psychotherapy and counseling has far reaching possibilities when skillfully applied in the context of a therapeutic alliance. Considering AAT for inclusion into a counseling practice or treatment center requires careful investigation regarding benefit versus risk. Simply introducing an uncertified animal into a treatment setting is not best practice. Although the benefits of AAT are endless—providing anxiety reduction, acting as a catalyst for emotional expression, establishing rapport and relationship building—it takes a compassionate and skilled clinician to make the intervention or visit therapeutic for the patient and enjoyable for the animal assist.

We love and loath animals, we fear and endear them to us for what we imagine them to be in the recesses of our imaginations and in the reality of our day to day interactions with them (Russell, 2003). As discussed in this article, animals incorporated into a treatment setting offer patients a chance to experience transformation and healing where sometimes human beings and words don't come easily.

Maryjo Brown, MA, LPC, *is the Clinical Coordinator Adult and Geriatric Therapeutic Services at the Spruce Pavilion Reading Hospital, and Director of PAWS for Wellness Animal Assisted Therapy Services, Reading Health Systems in Reading, PA. Maryjo has been utilizing Animal Assisted Therapy within the practice of counseling for the past fourteen years. She was instrumental in developing a volunteer network of animal assist within the PAWS for Wellness Program. Maryjo is currently in the process of establishing certification in the area of animal assisted search and rescue.*

Cheryl Knepper, MA, LPC, ATR-BC, ICCDPD, CSAT-S, *is the vice president of continuum services for Caron Treatment Centers in Pennsylvania. The programs in which Ms Knepper has clinical and administrative oversight of are Recovery Care Services for Patients and their Families, Caron Family Services, Caron Outpatient Counseling, Research and Specialty Program Development.*

References

Bardill, N., & Hutchinson, S. (1997). Animal-assisted therapy with hospitalized adolescents. *Journal of Child and Adolescent Psychiatric Nursing, 10*(1), 17–24.

Chandler, C., Portrie-Bethke, T., Minton C., & O'Callaghan, D. (2010). Matching animal-assisted therapy techniques and intentions with counseling guiding theories. *Journal of Mental Health Counseling, 32*(4), 354–374.

Fine, A. (2010). Incorporating animals into psychotherapy: Guidelines and suggestions for therapists. In A. Fine (Ed.), *Animal assisted therapy: Theoretical foundations and guidelines for practice* (3rd ed.). (pp. 169–192). San Diego, CA: Academic Press.

Fine, A., & Beck, A. (2010). Understanding our kinship with animals: Input for health care professional interested in the human/animal bond. In A. Fine (Ed.), *Animal assisted therapy: Theoretical foundations and guidelines for practice* (3rd ed.). (pp. 3–16). San Diego, CA: Academic Press.

Kruger, K., Trachtenberg, S., & Serpell, J. (2004). *Can animals help us heal? Animal assisted interventions in adolescent mental health.* Retrieved from http://www2.vet.upenn.edu/research/centers /cias/ pdf/ CIAS_AAI_white_paper.pdf.

Serpell, J. (1986). *In the company of animals: A study of human-animal relationships.* New York, NY: Basil Blackwell.

Serpell, J. (2003). Anthropomorphism and anthropomorphic selection—Beyond the 'cute response.' *Society and Animals, 11*(1), 83–100.

Shipman, P. (2010). The animal connection and human evolution. *Current Anthropology, 51*(4), 519–538.

Substance Abuse and Mental Health Services Administration (SAMSHA). (2002). *Report to congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders.* Retrieved from http://www .samhsa.gov/reports/congress2002/index.html

Werner-Wilson, R. J. J. (2000). *Developmental systematic family therapy with adolescents.* Binghamton, NY: Haworth.

THE HEALING TOUCH OF ANIMALS

Leah Honarbakhsh

Ricochet, the SURFice Dog

When golden retriever Ricochet was born, her owner Judy just knew she was going to be a service dog. In fact, she became a true "Puppy Prodigy," excelling in her training from a very young age. However, when she was fourteen weeks old, Ricochet became unresponsive to training and couldn't shake her proclivity for chasing birds—a hobby which could be very harmful to a person in need of a service dog. After struggling to find a purpose for the dog who "quit" on her, Judy discovered Ricochet's talent on a surf board and entered her in the Purina Incredible Dog Challenge. "When she came in third place," Judy writes, "something in me cracked wide open. I fell to my knees on the sand and hugged her tight. Ricochet was good at something."

Thus began the heartwarming journey of Ricochet, the award-winning SURFice dog, who helps people with disabilities, posttraumatic stress disorder (PTSD), and traumatic brain injury (TBI). Her first fundraiser was for Patrick Ivison, a fifteen-year-old quadriplegic adaptive surfer. Since then, Ricochet has raised over $300,000 for human and animal causes.

Recently, Ricochet has been helping Operation Iraqi Freedom veteran Sergeant Randy Dexter, a combat medic who spent twenty-seven months in Iraq, through the PTSD Battle Buddy Initiative. On April 5, 2005, Sgt. Dexter and his squad were hit with an improvised explosive device (IED), which killed one Iraqi man and injured several other people. Sgt. Dexter suffered a concussion and in April of 2009 he was diagnosed with PTSD. Sgt. Dexter writes that despite his treatment and participation in AA and private counseling, "somehow I just couldn't find whatever it was that I needed to stop the suicidal thoughts, substance abuse, rage outbursts, nightmares, panic attacks, and all around feeling that I had no hope for a better future." Ricochet has been able to help Sgt. Dexter, and other veterans, by using her natural ability and extraordinary intuition to sense their mood, head off panic attacks, and alert them to possible threats.

I was able to speak with Judy about her work with service dogs, and about Ricochet and her innate ability to help people suffering from physical and mental health issues.

Leah: What urged you to begin working with service dogs?

Judy: I've always liked the movie "It's a Wonderful Life" and often wondered if I made a difference in anyone's life. One day I was at a pet expo and saw a booth for a service dog organization and the opportunity to puppy raise. I thought it would be a great way to make a difference in the world before I left the planet.

Leah: That's certainly a wonderful way to make a difference. What kind of diseases and illnesses do your service dogs help people with?

Judy: My service dogs help people mostly with mobility impairment. However, now that Ricochet has been working with active duty military and veterans who have PTSD, we've become more involved in that as well.

Leah: How did Ricochet come into your life?

Judy: Well, I founded a service dog organization called Puppy Prodigies. In 2008, a breeder who works with service dog organizations allowed me to whelp a litter of her puppies with the added incentive that I would be able to keep one for my program. After an ultrasound was done, I knew there would be ten puppies. I wanted more girls in the litter because I knew I'd be keeping a girl, and wanted more pups to choose from. By the time we were up to the ninth puppy, there were only three girls. So, I took

the mother dog's face in my hands and said "Okay Josie, make the next one a girl, and let her have a piece of white fur on her chest." Out popped the next puppy, a girl with a white piece of fur on her chest! That was Ricochet.

Leah: That's truly amazing! Can you tell us a little about Ricochet's personality?

Judy: Ricochet is a pretty quiet and laid back dog, except when it comes time to chase something. She loves to run at top speed and has quite the chase instinct. If it moves, she'll chase it! She's an incredibly intuitive dog who connects with people instantly. She is always giving each person she interacts with exactly what they need, whether they know it or not. She has a tendency to mirror their emotions as well. I can usually tell what a person is feeling by the way Ricochet is acting.

Leah: So at what moment did you, and perhaps Ricochet as well, discover that Ricochet's mission was something more than being a service dog in the general sense?

Judy: The moment I knew was when she jumped on a surfboard with a boy who is quadriplegic. After I released her from the service dog role because of her chase instinct, I still wanted her to make a difference in the world. My initial plan was for her to fundraise. We knew a boy named Patrick that surfed. Patrick was run over by a car when he was fourteen months old and suffered a C4-5 spinal cord injury. That didn't stop him! He became an adaptive surfer, so I thought he'd be the perfect beneficiary of her first fundraiser. My idea was to videotape the two of them surfing side by side on their own boards so I could use the footage in a fundraising video. But, when they were approaching the shore on their own separate boards, Ricochet jumped off hers and onto Patrick's. She wanted to surf *with* him. None of us had ever done that before, so we put all our trust in Ricochet and they rode the wave like they had been surfing together forever. Since that day, she's surfed with many different disabilities and she adapts her surfing style based on their disability. I didn't teach her any of this; she does it from her own instinct. She chose this path and it's not something I would have ever thought of. I just let her "be" and this is what showed up as her mission.

Leah: She sounds like an incredible dog. Can you tell us a little bit about her relationship with Sgt. Randy Dexter?

Judy: Ricochet and Randy bonded instantly. He would bring her bacon that his wife got up to make the mornings of their sessions together; that was incredibly special. One day while we were in Walmart during an exercise to reintegrate active duty service members with PTSD—through a program called Canine Inspired Community Reintegration through Pawsitive Teams where Ricochet is certified as a therapy dog—she started alerting Randy to his anxiety and pain. She would just stop if she saw people in an aisle that she thought would evoke an anxiety response from Randy. By stopping, it gave him the opportunity to reassess the situation and decide if he wanted to go down a different aisle. The program was two hours a week for six weeks. Our therapy sessions developed into a great friendship, so we continued to see Randy and his family afterwards. Randy says Ricochet saved his life. We wanted to help others with PTSD, so Randy and Ricochet created the PTSD Battle Buddy Initiative.

Leah: In your experience with Ricochet and with your other service dogs, what have you seen that attests to the genuine benefits of animals as catalysts for healing?

Judy: I think the biggest healing benefit of animals is their intuition. They are much more in tune with people than humans are. They know exactly what you need, when you need it.

Leah: Do you think there's something specific that dogs offer in comparison to other animals?

Judy: Dogs communicate with us on a very spiritual level. They don't need human language. They love unconditionally and if you listen, they have a lot to say, even if it's not with words.

Leah: Indeed they do. Thank you for taking the time to share Ricochet's story with the readers of *Counselor* magazine.

For more information about Ricochet's work with the PTSD Battle Buddy Initiative, visit www.surfdogricochet.com/ptsd-battle-buddy-initiative.html.

Dede Beasley & Equine Therapy

Dede Beasley began riding horses at a young age, thanks to her mother, whose side of the family were equestrian experts. "As difficult as times got," Dede says, "that was one thing she never denied me, and I love her dearly for it" (Vivo, n.d.). When she was growing up, both Dede's parents were alcoholics and Dede herself struggled with eating disorders, abusive relationships, trauma, and alcoholism throughout her adolescent and young adult years. Dede found a way to combine her own recovery and love of horses in equine therapy, and has been helping others with her horses for over thirty years. As a licensed professional counselor and certified riding instructor, she has a private practice at her barn and also works at The Ranch treatment center in Tennessee. Her model is called Experiential Equine Counseling (EEC) and it involves a blend of traditional equine-assisted therapy, psychotherapy philosophies, and developmental psychology influenced by her mentor Albert Pesso, the cofounder of psychomotor therapy. Dede accepts clients of all ages and treats issues such as addictive/compulsive disorders, PTSD, and dual-diagnoses.

I got the opportunity to connect with Dede to talk about her horses and her experiences with equine therapy.

Leah: What urged you to begin working with horses?

Dede: I often joke that my connection to horses is genetic. My mother's side of the family were big equestrians, as was she. I can remember being very small looking up at the tiles around our fireplace that had horses on them and being absolutely mesmerized. I began riding lessons when I was five years old and it just went on from there.

Leah: How did you and your horses end up at a treatment center?

Dede: I have always had horses, but my promise to myself as a recovering person was to live with my horses on a farm—something I longed to do since I was a child. Twenty years ago my husband and I did just that. I have a private practice at my barn using my horses, but the treatment center I work for has always had their own herd. When The Ranch opened almost sixteen years ago, I was contacted to begin their equine program. I am grateful to a woman named Sandra Loggins, who gave them my name. She knew I did experiential and recovery work in my private practice, and that I was a licensed professional counselor who knew horses very well.

Leah: What kind of role did your own sobriety play in your decision to begin practicing equine therapy?

Dede: If I hadn't been in recovery, I could not have pulled it off! The way this feels so natural to me and the devotion I have for learning everything can only come with a purpose in life. Recovery gave that to me, and the sense of responsibility necessary to take care of it.

Leah: What specific mental and/or physical health diagnoses do you treat using equine therapy at The Ranch?

Dede: The Ranch is a dual-diagnosis center, meaning we tackle addiction and most psychiatric disorders. Codependency, grief, and loss are included in that. We are also known for the incredible trauma work we provide.

Leah: Your model for treatment is called Experiential Equine Therapy (EEC). How did that originate?

Dede: Well, when I started I was really just winging it. However, two things came to light very quickly. Firstly, there was definitely a need for educating clients on how to be with horses safely on the ground. This was an important measure I had to have in place when I taught riding lessons. Secondly, I recognized the same dynamics occurring between people and the horses that happened strictly between people in my actual office. Additionally, the same interventions—which were about meeting needs—had the same healing effect. My model picked up from there. It is simply amazing to me how language, concepts, somatic, and expressive work all occur in the equine work just as it comes about in a regular office setting between two people.

Leah: Can you tell us a little bit about the horses you have at your barn, their personalities, and perhaps their unique characteristics that help your clients?

Dede: Savvy is my twenty-seven-year-old veteran at this. She lets her needs be known and still wants to be involved in that she is demonstrative about being seen and heard. People are drawn to her because she has great integrity.

Scooter is a big, grey gelding. He adores attention and can be a bit dramatic in all his expressiveness, but he tunes in when it counts. He is the most sensitive

horse I have in that he feels if people are distracted or nervous and demonstrates this through becoming antsy. He requires clients to manage their own emotions and respect his needs as well.

Sox is a little fourteen-year-old pony with a gigantic personality. I added him to the barn to help the kids this year. He is very gentle on the ground and the kids love him. He's very funny in that he will pick up things or disassemble the barn if he can get away with it. One little girl would giggle and call him "bad Socks."

Buddy is the most recent addition. He is shy but so willing. He teaches that trust needs to be built and good things happen with time; I am always amazed how he does his part of the work in a session.

I should also mention Mandy, a pony I had to put down early this year. Some of my kids had known her very well when they first started coming to the barn. I suspected her being gone would have an impact, and it did. For children whose parents had died, there were many things asked and said over months about Mandy and wanting to go see where she was buried. I was very touched and honored to be a part of their grief.

Leah: I'm so sorry to hear that, she sounds like she was very special to a lot of people. From your experience with these horses, what would you say is the most successful benefit of equine therapy?

Dede: Every week, several people refer to the horses as "big." This has occurred for years. The experience of "big," or having a large animal around them, is also associated with a sense of awe. Since I work with a lot of trauma survivors, they have shown me in their process that horses, in their "big" presentation, tap into the limbic system, which allows people to have reparative moments in numerous ways. Just being able to lean their heads on the horse for support can often lead to crying. My standing between a scared client and the horse, if I sense that they are losing a sense of self, often brings relaxation. Then the clients have access to their body-mind and can follow through with what they desire to do: lead, pat, or push the horse back.

Leah: Would you say that horses can provide something specific to animal assisted therapy that other animals can't?

Dede: I'm a lover of all animals. Because of the previously mentioned things, I do believe horses hold a magical place in the animal assisted psychotherapy world. However, I'll tell you another piece of it. I see small children at my barn that have been removed from their homes due to horrible abuse and neglect. I've had several kids that would initially engage a pony, become very overwhelmed, and need to move away. They would seek solace from my barn cat, Cleo, and my pet duck, Mr. Duck. This was a regular part of their work and was supported totally as the kids were learning that they had choices to attach and detach. They could self-soothe and regulate their own emotions. This is the exact same need of adult clients! Over time, these kids now manage to do their own equine work, in every way, with supervision and support. Cleo is still right there and Mr. Duck comes in to hang out as well.

Leah: Are Cleo and Mr. Duck therapy animals as well?

Dede: Sure, Cleo wouldn't be left out of anything and Mr. Duck delights the kids because he tugs on their pants until they feed him from their hand.

Leah: Are there other animals that assist you in treating your clients besides Cleo and Mr. Duck?

Dede: There have been goats in the past and of course our dog, Brindle Nicole. They are involved from time to time, but the main "co-therapists" are the horses, Cleo, and Mr. Duck.

Leah: It sounds like you have a veritable zoo of animals that help you in treating your clients! Thank you so much for sharing your work with *Counselor's* readers.

For more information about Dede's work with horses at her barn and The Ranch, visit www.dedetherapy.com.

References

Vivo, M. (n.d.) *An interview with Dede Beasley, equine therapist at The Ranch*. Retrieved from http://www.recoveryranch.com/staff-stories/equine-therapist-interview/

WHEN SEX & STIMULANTS ARE FUSED: TWO BEHAVIORS, ONE ADDICTION

Robert Weiss, LCSW, CSAT-S

IF YOU DON'T TREAT BOTH, SOMETIMES THEY DON'T HEAL FROM EITHER...

The intersection of stimulant addictions and sexual behavior is drastically under-researched, as are most areas of addictive disorders in relationship to sex. It is nonetheless increasingly apparent to many addiction treatment professionals, particularly clinicians trained to assess for sexual concerns, that there is a significant subgroup of drug addicts who regularly abuse stimulants like cocaine and methamphetamine (and sometimes party drugs like Ketamine, GHB, MDMA, etc.) *almost solely in conjunction* with their sexual behavior. Many of the male addicts who present with concurrent patterns of "stimulant abuse and sexual behavior" may also abuse Viagra, Cialis, or similar drugs in order to maintain an erection for hours, even days at a time. Some present with related addictions to benzodiazepines (Valium, Ativan, Xanax, Klonopin, etc.) and/or over-the-counter cold medicines, taken to offer the addict a few hours of sleep in the midst of a stimulant run. Over time, stimulant drug abuse and sexual activity can become so tightly paired that engaging in one inevitably leads to the other. For these addicts, getting high and finding, seeking, and having sex becomes a single, paired, interrelated, coexisting, and complementary addiction.

SEX AND STIMULANTS

When stimulant drug abuse is consistently fused with the hunt for and experience of intensely arousing sex, these paired behavioral patterns become mutually reinforcing. Over time, even simple fantasies and urges regarding past sexual acts or situations become a psychological trigger to drug use and relapse. It seems unconscionable to this author that addiction specialists are not universally trained to consistently and routinely identify and address these coexisting concerns in treatment as a single issue, rather than simply and erroneously believing that getting a client "sober" (off drugs) will make the sexual issues go away or become a nonissue. To achieve lasting chemical sobriety, individuals who repeatedly demonstrate complex behavioral patterns—sex, gaming, eating, self-abuse, etc.—that have become entwined over time with stimulant and other substance abuse need integrated assessment and treatment methods. These clients need to disclose and address potential shame related to past sexual activity they engaged in when they were high, while relapse prevention plans need to succinctly anticipate, discuss, and predict their sexual urges, fantasies, and behaviors and address them for what they are—a prominent trigger to drug relapse. As previously stated, if you don't treat both, the client may not heal from either.

Current Research

A recent study, focused on men who struggle with methamphetamine abuse, strongly supports the idea that stimulant abuse and sexual activity can become so fused that drugs and sex are no longer separate addictions (Gatewood, 2009). Instead, the two behaviors combine, morphing into a single addiction to stimulants and sex, where both the drugs and the sex, abused in concert, form the addict's "drug of choice." The study indicates that for these men the leading reason for crystal meth use is sexual enhancement, as methamphetamine both lowers their sexual inhibitions and prolongs the potential duration of their sexual encounters. The study draws the conclusion that with some addicts it can be "virtually impossible" to separate sexual behavior from drug abuse. While this particular study is limited in scope, as it focuses on a specific stimulant drug (methamphetamine) and a particular population (gay men), it is not unreasonable to extrapolate these findings to other stimulant addicts. After all, the plethora of research on stimulant abuse shows remarkably consistent results, particularly in terms of how it affects overall patterns of decision-making, daily functioning, and social isolation—regardless of cultural background or the specific drug being abused (Cunha, Bechara, de Andrade, & Nicastri, 2011).

Though other research into stimulant drug addiction typically has had a broader focus than the direct connection between stimulant abuse and sexual behavior, a few studies have touched directly on the issue. For instance, one study looking at both male and female HIV-negative methamphetamine users found in part that for women, drug use and high risk sexual behaviors were significantly interrelated, with meth use directly linked to increasing instances of unprotected sex and STDs—despite the fact that women typically said they used meth as a way "to escape," "to feel more attractive," and/or "to lose weight" rather than as a sexual enhancement. For men, the stimulant-sex connection was much more direct, with males often citing "a desire to boost sexual pleasure" as a primary reason for using drugs (Cheng et al., 2009). Again, the study was limited in scope and not focused on the potential fusion of stimulant abuse and sexual activity, but it is clear from the findings that stimulant drugs and sexual behavior are inextricably linked far more often than is realized.

Yet another study, this one examining the effects of methamphetamine use on the transmission of STDs, found that meth use increased the likelihood of numerous high-risk sexual behaviors (Cheng et al., 2010). Even casual meth users, if there exists such a thing, showed an increased tendency to engage in anonymous and/or casual sex, have multiple sex partners, contract an STD within the preceding sixty days, engage in unprotected sex, and participate in sex marathons while high. Binge stimulant drug use in particular was strongly associated with unprotected sex, casual and/or anonymous sex, and

marathon sex. Cheng et al. concluded: "The combination of unprotected sex with the increased duration of (and the potentially greater number of partners during) sex marathons suggests that binge users may experience a higher risk of acquiring an [STD]" (2010). That conclusion is unsurprising. What is notable here is that once again there is documented evidence of a direct link between stimulant abuse and the desire to engage in concurrent sexual activity.

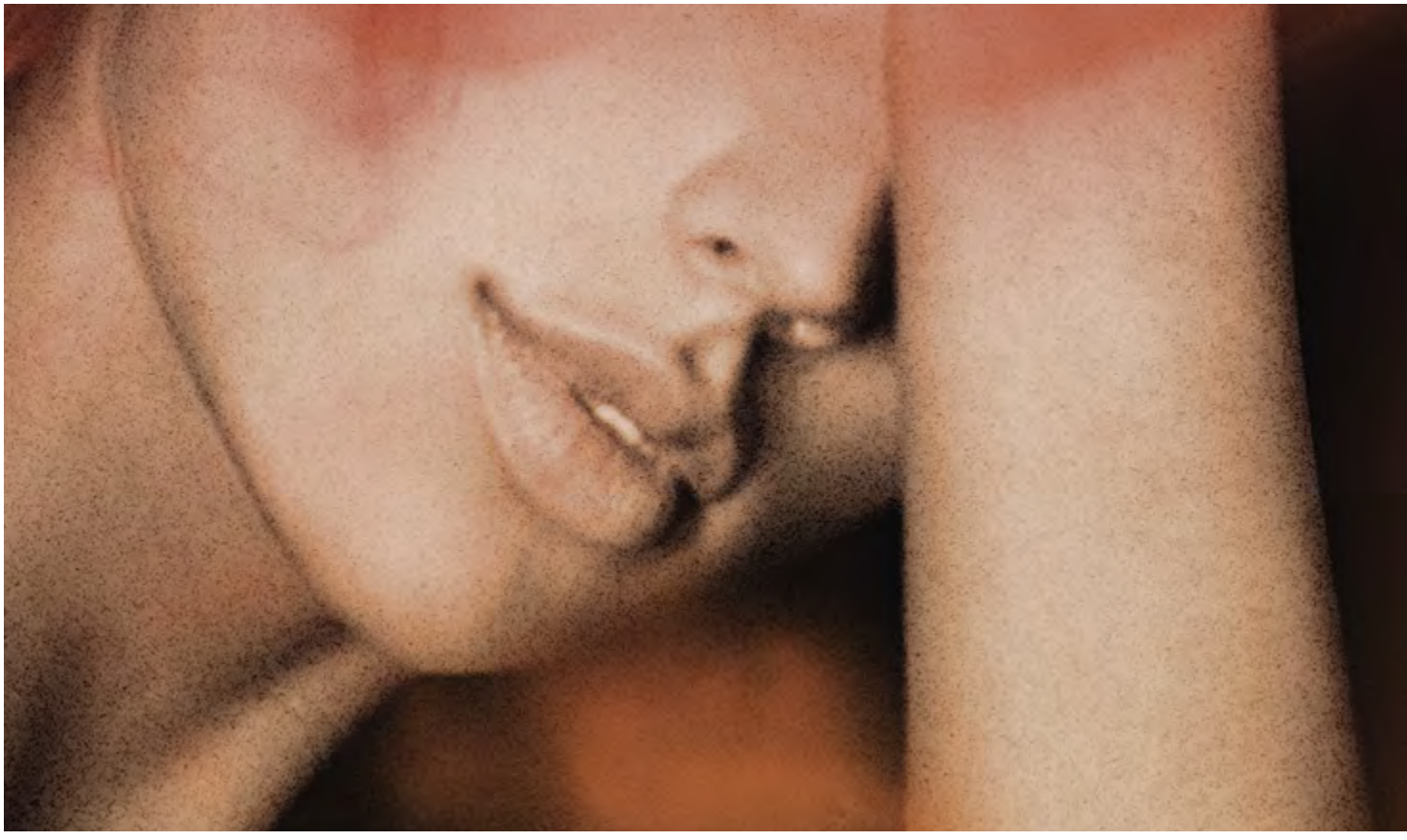
Who Develops a Stimulant/Sex Issue?

In some respects we appear to be dealing with an entirely new, or at least previously unrecognized, category of "dual" addict. Like other addicts, though intellectually intact, these individuals often have various forms of unresolved early trauma and attachment challenges. They appear to use intensity-based, often risky sexual behaviors combined with drugs in an attempt to temporarily escape underlying emotional challenges—such as loneliness, anger, and fear—and/or to deal with past trauma. The goal for the addict is to achieve a sense of emotional control over seemingly overwhelming feelings and experiences. In other words, these individuals attempt to deal with anxiety, depression, low self-esteem, past abuse, neglect, and external life stressors by dissociating with their drug of choice—in this case the fusion of drugs and sex. These are the same reasons alcoholics drink, compulsive gamblers place bets, and those with eating disorders consume a quart of Ben and Jerry's in a single sitting. The only real difference here is the dual, fused nature of the addict's preferred drug.

One typical male addict with a stimulant/sex issue is the married, heterosexual professional who has the time and resources to buy large amounts of cocaine and disappear for a night or weekend at home or in a hotel into drug use paired with prostitutes, porn, or anonymous sex with partners met online and through smartphone hookup apps. Also typical is the gay man who abuses crystal meth while having sex for extended periods in sexual environments like bathhouses or at home with strangers—met online and on apps like Grindr—who want to PnP ("Party and Play"). Bisexuals and men of both sexual orientations can isolate for days at a time with cocaine and/or meth while compulsively masturbating to online porn, seeing transgender prostitutes, or having sex with multiple partners. Female stimulant addicts will engage in many of the same behaviors, but often with more of a connection and/or relationship focus. For instance, women may use cocaine or meth in conjunction with sexual or "romantic" webcam chat and mutual masturbation, rather than simply viewing and masturbating to porn. Or they may be in a "romantic relationship" with their drug dealer or pimp. The addiction scenario varies from person to person, but regardless of sexual orientation, gender, or life history, for these addicts the fusion of drug addiction and problematic sexual activity is always there. If the addict engages in one behavior, he or she will also, without fail, engage in the other.

Doubling Down

The dual addiction of stimulants and sex is often double-trouble in terms



of risks and potential consequences. For starters, these addicts struggle desperately to achieve long-term chemical sobriety. Many of these individuals present in treatment with a history of chronic relapse. They have tried over and over to get clean from cocaine, meth, and other party drugs, only to fail miserably—directly or indirectly related to their continued search for a sexual high. While these well-intentioned addicts may stop using stimulants for a time, they still want and seek the thrilling, super-intense, days-on-end sex enjoyed when using—not understanding that without the drugs this kind of sexual high is simply not possible. When they return, now sober, to the people and places that offered those mind-blowing sexual encounters they inevitably pick up drugs, and before they know it they are once again awash in the stimulant-sex tsunami. I cannot emphasize strongly enough the difficulty these individuals have maintaining chemical sobriety. Of course, this is hardly surprising as cocaine and methamphetamine are two of the most difficult substances to get sober from. When these substances are used in combination with the neurochemical charge of sexual intensity, the challenges of long-term recovery increase exponentially.

There are other long-term dangers for this addict, mostly stemming from the fact that stimulant addicts, as well as sex addicts, when high, exhibit poor judgment and regrettable decision making, especially around sex. While disinhibited by stimulant drugs, safe sex loses priority, especially among individuals accustomed to marathon sessions with multiple partners. This propensity for unsafe sex while abusing stimulants greatly increases the addict's risk for unwanted pregnancy, and also for contracting and/or transmitting HIV, hepatitis, and other STDs. Even worse, addicts in long-term relationships can easily infect unsuspecting partners; in particular those individuals who think their spouse's problems are solely drug-related.

Treating the Stimulant/Sex Issue

Prior to this year, there was no drug and alcohol or sexual disorders treatment center with a program dedicated to addressing stimulant abuse fused with sexual behavior. Thus, individuals with this dual issue typically entered treatment for cocaine or methamphetamine abuse, only to have their concurrent sexual activity either minimized—due to staff and client discomfort with and/or ignorance of the subject—or written off as something that needn't be examined or addressed because "it only happens when using." What many drug programs fail to recognize is the fact that the sexual behavior only happens when the person is using is far less important than the fact that the sexual behavior *always* happens when using, and, further, the client always uses when he or she is being sexual in certain settings. Thus, these addicts—individuals with an extensive history of abusing stimulants and sex simultaneously—have ended up being treated for only half their problem. Their shame and secrets about past sexual behaviors have not been addressed in a safe setting, separate from other drug addicts who don't share these issues, nor have they been educated as to how they might be able to engage in post-treatment sober sex while managing the trigger to use. As such, many addicts with the stimulant/sex issue have exited perfectly good substance abuse treatment programs not having done a detailed sexual inventory or any work anticipating sex as a primary relapse trigger.

To address the very specific needs of this population, the newly opened Stimulants and Sexual Disorders Program (SSDP) at Promises Treatment Centers in Malibu, CA, has implemented the first drug treatment program designed to simultaneously address the treatment needs of addicted individuals whose stimulant abuse and sexual acting out are fused. In addition to traditional drug treatment approaches such as cognitive behavioral therapy, group therapy, and Twelve Step involvement, the SSDP integrates much needed neurobiological and medical components specifically aimed at controlling the urges and cravings that so often lead to stimulant-sex relapse—especially during the critical early stages of recovery. Most notably, the program incorporates cognitive restructuring techniques or "brain training," which is a treatment commonly utilized to aid those with brain injury, dementia, and similar concerns. Brain training has also proven effective in improving short-term memory loss—a problem that contributes directly to impulsivity and indirectly to the formation and maintenance of stimulant addiction.

Addressing healthy sexuality is also a necessity when treating addicts with a stimulant/sex issue because, to them, "sober sex" is often a mystery. They simply have no idea (or no appealing idea) how to engage in sexual activity without also using drugs. As such,

treatment of these addicts must include a significant relapse prevention focus centered on how to approach sexual activity as sober individuals. When appropriate, this segment of treatment should include spouses and partners, who, like the addict, need education on which sexual activities are and are not acceptable, along with advice on how to deal with their newly sober partner and how to protect themselves if relapse occurs.

Hope for the Hopeless

As mentioned above, individuals who have fused their stimulant abuse with sexual behavior often present with a lengthy history of relapse. Many have expended significant financial and other resources in an attempt to find and maintain sobriety, only to fail, oftentimes repeatedly, when the unrecognized, untreated, sexual half of their addiction pops up. Sometimes these individuals have lost hope of ever finding long-term sobriety, health, and a happy life. Many arrive in treatment yet again, seeking at best a respite from their drug use, a period of safety during which they can recharge their batteries before returning to the world and reengaging with their problematic behaviors. This revolving door is the antithesis of true recovery.

Only by recognizing and fully addressing the fusion of these individuals' stimulant abuse and sexual behaviors can clinicians construct and implement treatment regimens that entirely, rather than partially, meet the needs of these heretofore hopeless addicts. Treating stimulant abuse and concurrent sexual behaviors simultaneously is the best shot we have to help these individuals gain the necessary insight into the full nature of their addictive patterns, reduce their guilt and shame, identify and combat triggers for relapse, support their spouses, and (re)engage in patterns of sober, healthy intimacy and sexuality. Treating individuals with fused stimulant/sex behaviors in this holistic way, by deeply examining and anticipating the entire spectrum of their problem, provides these addicts their best opportunity to develop and maintain engaged, productive, drug-free lives. C

Robert Weiss, LCSW, CSAT-S, *clinical psychotherapist and educator, is the founding Director of the Sexual Recovery institute and Director of Sexual Disorders Services for Elements Behavioral Health, whose programs include The Ranch in Tennessee, Promises Treatment Center and Sexual Recovery Center in California. Robert is the author of three books on sexual addiction and an expert on the juxtaposition of human sexuality, intimacy and technology. He has provided sexual addiction treatment training internationally for psychology professionals, addiction treatment centers and the US military. A media expert for* Time, Newsweek, *and the* New York Times, *Rob has been featured on* CNN, The Today Show, Oprah *and* ESPN *among many others. He is author of* Cruise Control *and coauthor of* Untangling the Web and Cybersex Exposed *with Dr. Jennifer Schneider, media expert to* CNN, The Oprah Winfrey Network, Dr. Drew *and the* Today Show.

References

Gatewood, T. (2009). *Attitudes and motivating factors for methamphetamine use among HIV+ men who have sex with men.* (Thesis presented to the Faculty of the School of Social Work). California State University, Los Angeles.

Cunha, P. J., Bechara, A., de Andrade, A. G., & Nicastri, S. (2011). Decision-making deficits linked to real-life social dysfunction in crack cocaine-dependent individuals. *American Journal of Addiction, 20*(1): 78–86.

Cheng, W. S., Garfein, R., Semple, S., Strathdee, S., Zians, J., & Patterson, T. (2009). Differences in sexual risk behaviors among male and female HIV-seronegative heterosexual methamphetamine users. *American Journal of Drug and Alcohol Abuse, 35*(5): 295–300.

Cheng, W. S., Garfein, R., Semple, S., Strathdee, S., Zians, J., & Patterson, T. (2010). Binge use and sex and drug use among HIV(-) heterosexual methamphetamine users in San Diego. *Substance Use and Misuse, 45*(1–2): 116–133.

THEORETICAL PERSPECTIVES FOR WORKING WITH AOD CLIENTS: CHOOSING YOUR BEST PSYCHOTHERAPY MATCH

David Patterson, PhD

Plenty of theories could be discussed in relation to the most and least appropriate to guide program development for clients who are addicted to alcohol and other drugs (AOD). A clinician does a disservice to clients by blindly pursuing every client's issues through the dogma attached to a specific, single theory. In order for clinicians to provide sound services, they have to obtain as much knowledge about as many theoretical perspectives as possible. While many different theories are not well suited for AOD clients, it is valuable to understand theories and their relationship to psychotherapy approaches. For the least appropriate theories, this article will discuss Sigmund Freud's psychoanalytical theory of personality along with Rollo May's theory. Again, to say that these two theories have no place in AOD psychotherapy would be misleading. Although there are many more appropriate theories, it is vital to have an understanding of all of them. This paper will also discuss James Prochaska's transtheoretical stages of change and Carl Rogers' theory of personality as the most appropriate for people who experience AOD addiction.

Please be aware that this article will be a very limited, focused discussion. There is no way that this effort could ever speak at the level intended to indicate that it has fully obtained the knowledge required to implement all of the therapeutic activities within each of the theories. Both personal and professional beliefs, along with some of the theorists' original perspectives, will be included.

The first step is to define theory and how that plays into therapy. Sometimes it seems that they could be one in the same; however, theory is considered as a perspective about human behavior and therapy is the clinical activity applied in relation to changing human behavior.

Freud's theories and his writings have both fascinated and caused great debates. While Freud's work specifically pertaining to the Ego, Id, and Superego are somewhat understandable, it would take a large amount of dedicated time to comprehend his overall body of work. The same statements could be made regarding Rollo May's work on existential psychology. May's point that existentialism is not a system of therapy, but an attitude toward therapy, could be applied to whatever therapy one brings to his or her therapeutic session. The work of Freud and of May, while interesting, seem to be the least pliable when working therapeutically with AOD addicts.

Freud's Theory of Personality

Freud's theory of personality is very complex, specifically structures concerning the persistent functional units of the id, ego, and superego. From Freud's perspective, the basic dynamic forces motivating personality were Eros (life and sex) and Thanatos (death and aggression) (1963). These are instincts expressed in fantasies, desires, feelings, thoughts, and actions. It is his belief that people constantly desire immediate gratification—mainly sex and aggression. This natural impulse results in social conflicts due to social rules regarding appropriate behaviors. Without some type of internal control—which Freud identifies as defense mechanisms—our society would result in chaos. Due to our defense mechanisms, we are constantly unaware of our desire to rape, ravage, and be savages.

Defenses keep people out of danger and punishment. They also keep the person from experiencing anxiety and guilt over the constant desire to break social rules. The properly operating defense system keeps the person unconscious of his or her existence. The heart of the Freudian personality is the person's unconscious conflict surrounding the sexual and aggressive impulses, social rules established to control these instincts, and the person's defense mechanisms'

attempt to control the impulses in order to minimize guilt and anxiety. Some safe impulses are gratified occasionally, however. The reason for a normal personality, compared to an abnormal or neurotic, lies somewhere in the malfunctioning defense mechanism. According to Freud, that neurosis occurs when the unconscious conflicts become too intense and painful, and the reluctant defense mechanisms become too restrictive. The stage of life in which the conflict begins to happen—such as oral, anal, phallic, or genital—is critical in determining the personality.

The oral stage spans from birth to about eighteen months and focuses on oral pleasures. The child's greatest pleasure is to suck on a satisfying object, which could be a breast. Freud would consider this oral, sucking stage as "sexual" and the child is dependent on the parent to satisfy this intense, urgent sexual gratification. The parent's response to this need determines the child's personality. Depriving or over-indulging the baby could result in the child not maturing to the next stage properly. There's no winning here; by not providing enough oral satisfaction to the baby, it may remain fixated at the oral stage in constant search for that object which was in short supply. Too much oral satisfaction could result in the baby remaining in the oral stage, continuously in search of satisfaction and gratification.

The anal stage spans eighteen months to three years and centers on the pleasures of the anus. Before this stage, the child could relax his anus muscles and "go" at will; now the child must begin to be in control. As in the oral stage, a too demanding or overindulgent parent can cause personality problems in the anal stage. The main problems in this stage are power struggles such as sleeping, eating, and dressing. Individuals who had demanding parents, resulting in the child holding on or clinching his or her anus, could end up as a person who may hold onto their money. Contrarily, a parent who allowed the child to go whenever the pressure was felt could have a grown child that lets things go, like money, being prompt, or details.

The male genitalia stage, or phallic stage, was generalized to women. During the ages three to six both sexes are very interested in their own genitals. They are also interested in the opposite sex and their genitals. The main consideration is not the genital area itself, but the object of their sexual desire. The boy desires the mother and is scared of his father's seemingly competitive spirit. The boy constantly fears that his father will end the competition by cutting off the boy's penis. In the phallic stage, girls resent their mothers for not giving them a penis. Freud's main point about this stage is the parent's response to the child; just like the prior stages, overindulgence could result in vanity and overrejection in anxiety.

The important thing about the stages is that we are more vulnerable if our conflicts and fixations occurred earlier in life. When a fixation occurs early on, the person would be more dependent on more immature defenses for dealing with anxiety. Also, the more intense our conflicts are earlier in life, the more vulnerable we are in coping with adult stress and conflicts. When an individual is confronted with an event such as a sexual affair, there is a stimulus to an impulse, which they have been trying to control since childhood. The unconscious reacts to the current event as if it were a repetition of a childhood experience. The result could be a number of reactions due to their entire defensive system being out of balance. Their system has operated as a delicate balance of keeping impulses and anxiety at a safe level; at this point the person is willing to spend any amount of energy to keep these impulses from coming into consciousness (Freud, 1963).

Freud's Therapy and the Therapeutic Relationship

Freud's therapeutic process of making the unconscious conscious comes directly from past events. Responding to the environment in a healthier way requires a consciousness of how our responses derive from the unconscious, that is, conscious rising. Freud would work toward free association in therapy sessions; the patients would let their minds go without any defenses, thereby exposing their instincts. It is still very scary for patients to allow raw instincts into consciousness, because they have been dangerous to expose. After several years of controlling these instincts, it takes more than just Freud's suggestions to "let yourself go." With the therapist's help, the patient has to raise his/her consciousness in order to bring relief. Forming a working alliance helps the patient face possible terror in recalling detailed dreams and childhood memories.

Freud's approach does not work with every behavioral problem. Those who cannot regress or come back from this process are less appropriate patients. Inappropriate candidates might include schizophrenics, manic-depressive types, or borderline personalities. There are four basic procedures to psychoanalysis: confrontation, clarification, interpretation, and working through (Freud, 1963). These are attempted when analyzing the patient's resistance to free-associating and the transference, the unconscious redirection

of feelings from one person to another, that emerges as the patient regresses.

Although this article identifies Freudian theory as least appropriate for AOD clients, Freud's analysis of the therapeutic relationship is vital for therapists to understand. He believes that the working relationship between patient and therapist needs to be non-neurotic, rational, and realistic. This type of relationship is mandatory before therapy can result in any gains. The trust between the patient and therapist allows the negative transference reactions to be dealt with appropriately during psychoanalysis.

When there is not a therapeutic relationship, transference comes into play. The patient experiences feelings toward the therapist that actually apply to significant people in the patient's past, and most times, those past feelings, impulses, and displacements are shifted to the therapist. The past conflicts are not resolved, but are relived through the current relationship with the therapist. Unfortunately for the patient, this process remains unconscious. The therapist's job is to remain balanced between caring and depriving enough to work through this, while allowing the patient's transference to react. Therapists must also be aware of their own unconscious process, or counter transference. The therapist must be healthy enough to separate what is unconsciously coming from the patient and him/herself. This requires that the therapist receive about five years of psychoanalysis.

Does It Work with AOD Addicts?

The answer to that question depends on who is asked. A true psychoanalyst would say it works very well with just about everyone. On the other hand, it might be common for professional therapists to dabble in this theory and somewhat enjoy it, but not consider it to be much help by itself. The main problem with Freud's approach is the same as any other theoretical approach: how to measure success and what it actually looks like. Because Freudian theory states that the unconscious has to become conscious, it takes a long time to be trained and to work through the process. The time required to go through this process would never work in today's AOD treatment facility.

The approach is also risky. Freud would seem to always connect sexual aggression to every problem. More broadly, psychoanalysis is too subjective and unscientific; it cannot be linked to observable behavior to be objectively measured and validated. However, Freud's work has stood the test of time and continues to be taught in colleges and universities. While it is problematic to use some of his approaches, AOD therapists deal with transference issues all the time.

Rollo May's Theory of Personality

There are obvious differences between Freud and May, beginning with their training and education. Freud was trained in Europe and earned a MD. May on the other hand was trained in the US as a theologian and clinical psychologist. No evidence suggests that Freud ever suffered from the neuroses he treated in others. May seemed to have suffered personally as well physically, which influenced his theory. Having come down with tuberculosis and being confined in a sanatorium for two years would seem to impact most people. May's own existential struggles contributed to his writings. Although I am stating that this theory would be inappropriate for AOD clients, I think his own suffering could be compared to the recovering alcoholic becoming a professional counselor. Although it does not take suffering from a disease to be able to treat it, it could help during the therapeutic process having been where your clients have been.

May's definition of existentialism centers on the existing person and emphasizes the human being as he is emerging, or becoming (May, 1977). Existentialists do not see the theoretical perspective as a structure resulting in a specific therapy; rather, existentialism is an attitude toward therapy (May, 1977). Existentialists do not agree with the term personality as related to a fixed set of traits located within an individual. May also goes beyond the individual's inner dimensions and connects the individual to their world, rejecting dualism, which assumes a split between the mind-body experience and environment.

To understand the person, one has to understand to the person's world. According to May (1977), we all live in three levels of the world: us in relation to the biological and physical aspects of our world (being in nature), the world of persons socially (being with others), and in our own world (being for oneself). Each of our personalities exists differently at each level. During the process of creating a healthy existence, each of us attempts to pick the best way to be in nature, with others, and for ourselves. Existentialists believe the best choice is to be authentic and that being honest and open allows us to be spontaneous with others and ourselves. We do not have to fear that we portray something we are not; being authentic ensures that when people care for us they truly are caring for us, and not something they are acting out falsely. This will allow for healthy relationships because we can trust that everyone else is authentic and not saying something because they think it is what we want to hear.

According to existentialists, pathology happens when people are not authentic, that is, lying to oneself and others. Lying is an attempt to avoid nonbeing, or death. This is similar to the person who could not come to terms with the passing of her mother after spending the last eight years of her life in a nursing home with Alzheimer's disease. When she finally died, the daughter wanted to bring charges against the home, due to her belief that her mother was in good health. Somehow, she believed the nursing home was at fault. Reading and trying to understand May's position would help the daughter understand that she was avoiding and lying to herself and others.

May's Therapy and the Therapeutic Relationship

Of course, if lying is the problem, the solution is becoming honest. Therapy has to focus on everything that is missed by lying to oneself and others, along with how lies close off everything to being, or living. The first part of May's therapy greatly encourages the authentic relationship with the therapist. While Freud would encourage the patient to begin speaking about whatever comes to mind, May's session would encourage the patient to be whatever he or she wants to be. Patients should express freely and honestly whatever they are experiencing presently. The therapist should try to understand the world of the patient without imposing any theoretical or personal preconceptions. Most of the therapist's feedback clarifies the patient's own language.

Freud would remain somewhat aloof with his patients focusing on transference issues. May, however, encouraged the therapist to understand the patient's world or being in the world. Without understanding this, any theoretical or technical understandings are worthless. By engaging the patient in an authentic discussion, the patient becomes aware of the ways in which he/she avoids an encounter.

Does It Work with AOD Addicts?

Who knows? Since it is not a technique, it would be hard to measure success. Existentialists would not participate in reducing people into statistical experiences. Also, being in the world with others and trying to measure individual's experiences as they relate to each other would be quite difficult. As with Freud, some things within May's theory could fit nicely in an AOD program. Therapists should have a way of thinking about therapy, as May puts it. However, as it related to AODs, Carl Rogers' way of thinking fits better.

Most Appropriate for AOD Services

The two theories that will be discussed as being most appropriate for this population are Carl Rogers' theory of personality and James Prochaska's transtheoretical stages of change. Carl Rogers laid the groundwork for motivational interviewing (MI), a therapeutic process of increasing motivation for change.

Carl Rogers' Theory of Personality

Carl Rogers' main idea about humanity is that every one of us has one ultimate motivating force: self-actualization. He defines self-actualization as the inherent tendency of the organism to develop all its capacities in ways that serve to maintain or enhance the organism (Rogers, 1959). According to Rogers, we are born with a positive valuing process that enhances and maintains those positive things in our lives and we value negatively those experiences that stagnate our growing potential. These internal processes are part of our inherent design, and we trust that they intend to serve us well. Rogers concludes that our world is made up of our own making (our reality) and that, in order for others to understand our reality, they must attempt to place themselves in our frame of reference (1959). Once we understand ourselves, we seek positive regard for that self from others. People learn to need to feel loved, prized, and accepted and these feelings become so positive that they turn into the most important thing in becoming a person.

For instance, if a parent provides a child's behavior with a positive reflection, then the child views that interaction positively and sees how positive he is. If the parent responds negatively to a behavior, then the child views the loving relationship with the parent as weakening. Before long, as the child grows, he sees himself through the lens of how others regard them. This results in having a condition of worth, as those outside the self see the person as worthy.

Someone with maladjusted conditions of worth is threatening to one's self. Everyone deserves full self-actualization, becoming a whole person, and if our behavior is conflicted between the self we like and the self we dislike, then we have a divided personality, resulting in dysfunction (Rogers, 1959).

Rogers' Therapy and the Therapeutic Relationship

The most important ingredient for therapy, according to Rogers, is the therapeutic relationship. As stated earlier, Rogers' therapy and his beliefs about the therapist's relationship with clients are the foundation of motivational interviewing's techniques. He uses terms such as unconditional positive regard (e.g., showing complete support and acceptance), empathy, and genuineness. The therapeutic relationship offers empathy and genuineness as a means to allow the patient to achieve self-actualization. The emphasis on genuineness also recalls the previous section on existentialism, which also have similar connections with Rogers' ideas.

If the therapist does not succeed in these relationship issues, Rogers' therapy falls apart. Because of his theory of personality and people seeking self-actualization, if the therapy session's atmosphere does not provide unconditional positive regard for the client, then harm will continue.

Does It Work with AOD Addicts?

How could being empathetic and genuine with clients not work? It surprises me how little empathy many AOD "professionals" have for their clients. Historically, this field has held the belief in the necessity of breaking a person down to the lowest levels and then building them back up with, unfortunately, the same techniques used to break them down. Other health professions would never attempt this strategy. If someone walked into a hospital with a mild heart problem, the clinician would not wait until a massive heart attack before taking the problem seriously.

James Prochaska's Theory of Personality Change

What I really like about Prochaska's transtheoretical model is that it started with a comparative analysis of all of the main theories and psychotherapies in an effort to seek what each had to offer; it is an integrative theory. Prochaska created five criteria for the model. First he wanted a sophisticated integration that respects both the fundamental diversity and essential unity of psychotherapy systems. Second, the model should emphasize empiricism by measurable variables and then be validated. The third criterion was to account for how people change without therapy, due to the fact that many people with clinical disorders are able to change without the help of professionals. Fourth, the model should prove successful in generalizing a broad range of human problems. Finally, the transtheoretical model should encourage psychotherapists to be innovators, rather than simply borrowing from other systems (Prochaska, 2003).

Stages of Change

Five stages of change have been conceptualized for a variety of problem behaviors. The five stages of change are precontemplation, contemplation,

preparation, action, and maintenance. One of the many reasons for using Prochaska's model in an AOD program is its natural connection with the Twelve Steps of Alcoholics Anonymous (AA). While there will be a discussion of this therapy later, some of the Twelve Steps of AA will be listed below to show how they would fit with the stage.

Precontemplation

This is the stage in which people do not intend to take action in the foreseeable future, usually, the next six months. People may be in this stage because they are uninformed or underinformed about the consequences of their behavior. Or, they may have tried and failed to change a number of times and have become demoralized about their ability to change. Both groups tend to avoid reading, talking or thinking about their high-risk behaviors. Other theories often categorize them as resistant, unmotivated or not ready for treatment. The fact is that traditional therapeutic programs are often not designed for individuals in the precontemplation stage and typical treatment services are not matched to their needs.

Contemplation

Contemplation is the stage in which people intend to change in the next six months. They are more aware of the pros of changing but are also acutely aware of the cons. This balance between the costs and benefits of changing can produce profound ambivalence, which can keep people stuck in this stage for a long time. Those finding themselves in this stage are characterized as chronic contemplators or behavioral procrastinators. These people are also not ready for traditional action-oriented programs and could account for many treatment dropouts.

Preparation

This is the stage in which people intend to take action in the immediate future, usually measured as the next month. They have typically taken some significant action in the past year. These individuals have a plan of action, such as joining a health education class, consulting a counselor, talking to their physician, buying a self-help book or relying on a self-change approach. These are the people that should be recruited for action-oriented programs, such as smoking cessation, weight loss, or exercise programs.

Action

Action is the stage in which people have made specific and overt modifications in their life-styles within the past six months. Since action is observable, traditional therapy often equates action with behavior change. In the transtheoretical model, however, action is only one of five stages. Not all modifications of behavior count as action in this model. People must attain a criterion that scientists and professionals agree is sufficient to reduce risks for disease. In smoking, for example, reduction in the number of cigarettes was counted as action, or switching to low tar and nicotine cigarettes. According to the model the consensus is clear: only total abstinence counts. The action stage is also the stage where vigilance against relapse is critical.

Maintenance

Maintenance is the stage in which people work to prevent relapse but do not apply change processes as frequently as in the action stage. They are less tempted to relapse and increasingly more confident that they can continue their change.

Prochaska's Therapy and the Therapeutic Relationship

In Prochaska's therapy there is an attempt to combine the process of change and the stage. Once the stage of change is identified in a client, then the process of change is applied. Prochaska has specific recommendations for the process of change during each stage. For instance, if a client was in the precontemplation or contemplation stage, then the therapist would attempt to raise the client's consciousness. Helping the client become more aware of the problem and get some emotional relief would move the person into the next stage. Environmental reevaluation and self-reevaluation

are used in the contemplation stage specifically. As clients become more aware of the problem, they are more open to reevaluating beliefs. The preparation stage utilizes self-liberation due to the client's readiness for change. They need to know that they have autonomy to change their lives, which is associated with self-efficacy. The action and maintenance stages use contingency management, counterconditioning, and stimulus control.

The transtheoretical psychotherapist is an expert on change. Because some of Prochaska's research studied how people changed without seeking professional services, the therapeutic relationship is based on the assumption that people have the capability to change. According to Prochaska, the relationship with the client depends on the client's current stage of change. For example, the relationship with precontemplators should be that of a nurturing parent who allows for independence. Contemplators would benefit from the therapist taking a Socratic or teacher position, in which the therapist would encourage insight into the problem's conditions. Working with clients in the preparation stage is like coaching a specific game plan. A consultation relationship would be used for the maintenance stage. This is another reason to use some of the skills of motivational interviewing.

Does It Work with AOD Addicts?

Yes, and with others as well. Over twenty years of data collection document the success of using this approach. The Centers for Disease Control and Prevention, American Lung Association, and World Health Organization use it, along with many others. One of the most important data from this research is developing interventions that match the client's stage of change. One of the reasons that clients may drop out of treatment prior to completion, usually within the first week, is the treatment intervention not matching the client's stage of change. Unfortunately, many treatment facilities operate under the assumption that any client entering treatment services is in the action stage, which is a problematic approach to treatment. One of the good things about using this theory is that, once the client's stage of change is identified, there are plenty of opportunities to use many theoretical-based approaches. This theory does not force the therapist into an inflexible idea of the problem or its solution.

Conclusion

There are a variety of transtheoretical approaches that could have been discussed, both supportive and less than supportive for addicted individuals. One of the many positive attributes of Prochaska's theory is that it allows for a variety of other theoretical approaches. Adaptability to the client's needs seems to be an important criterion for evaluating theories. Finding and working within a theoretical framework is not mandatory to be an effective therapist. However, lacking basic knowledge related to the historical and theoretical context of professional therapy is part of the responsibility of providing effective and professional services. It is vital for professional AOD workers to move beyond what might be required theoretical studies in college courses and drill down into other theories that best match your own clinical approaches, as well as what is best for sound clinical services.

David A. Patterson, PhD, *joined the Brown School in 2012. Dr. Patterson has over fifteen years of providing clinical, addiction-related services and is currently an Associated Researcher with the University at Buffalo's Research Institute on Addictions and the Buffalo Center for Social Research. He investigates best practice implementation in human services organizations, specifically investigating worker and organizational characteristics and their roles in implementing and disseminating empirically-supported practices. His research has been funded by the National Institute on Alcohol Abuse and Alcoholism along with state and university funds.*

References

Freud, A. (1963). *The ego and the mechanisms of defense.* New York, NY: International University Press.

Freud, S. (1953). The interpretation of dreams. In *Standard edition* (Vols. 4 & 5). London: Hogarth Press.

May, R. (1977). *The meaning of anxiety.* New York, NY: Norton.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addicted behavior.* New York, NY: Guilford Press.

Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: *Preparing people to change addicted behavior* (2nd ed.). New York, NY: Guilford Press.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*, 390–395.

Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of therapy*. Malabar, FL: Krieger.

Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W. R. Miller, & N. Heather, (Eds.), *Treating addictive behaviors: Process of change.* (pp. 3–27). New York, NY: Plenum.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102–1114.

Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (2002). *Changing for Good*. New York, NY: Quill.

Prochaska, J. O., & Norcross, J. C. (2003). *Systems of psychotherapy: A transtheoretical analysis* (5th ed.). Pacific Grove, CA: Brooks/Cole.

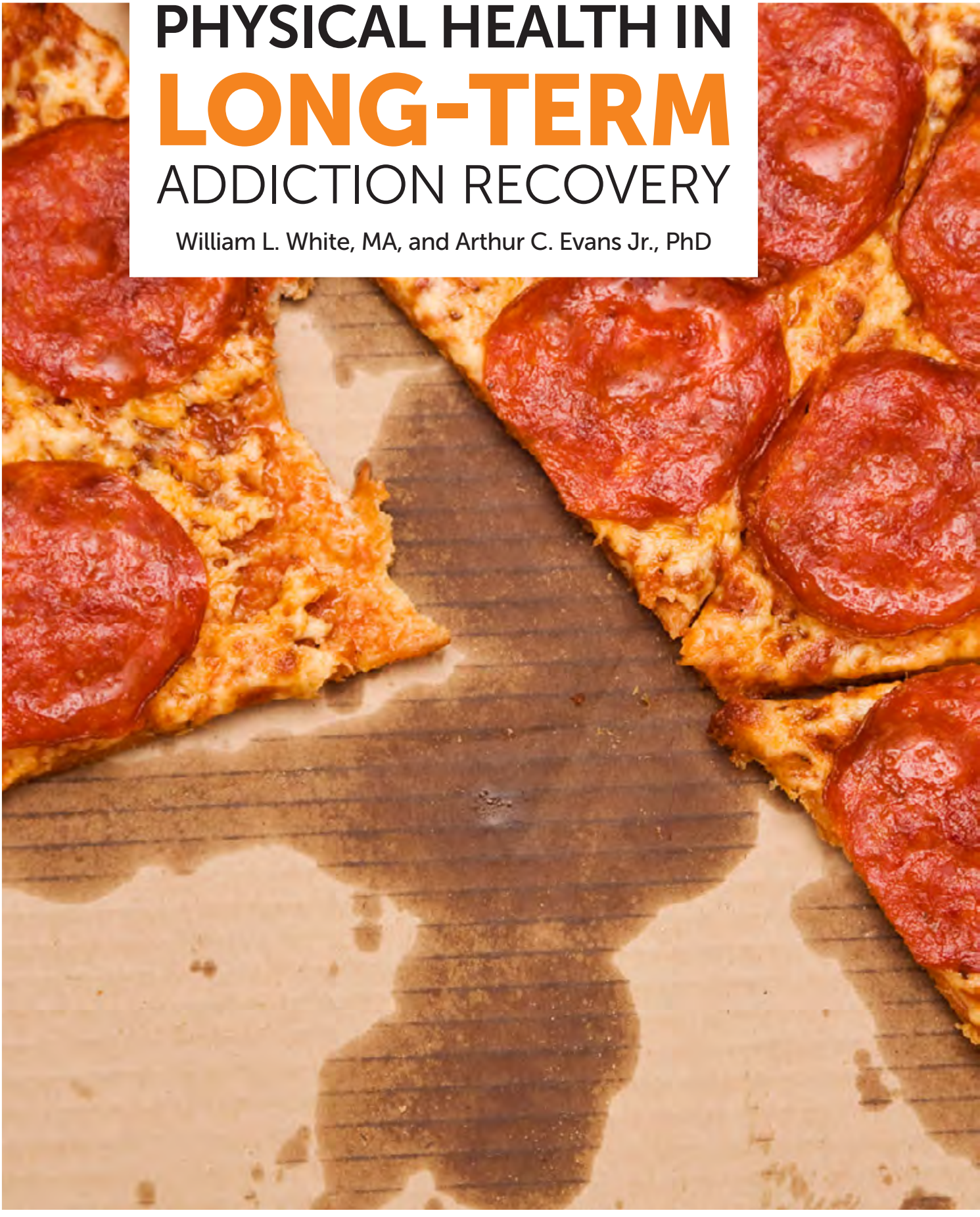
Rogers, C. R. (1951). *Client-centered therapy.* Boston, MA: Houghton Mifflin.

Rogers, C. R. (1961). *On becoming a person.* Boston, MA: Houghton Mifflin.

Rogers, C. R. (1980). *A way of being.* Boston, MA: Houghton Mifflin.

PHYSICAL HEALTH IN LONG-TERM ADDICTION RECOVERY

William L. White, MA, and Arthur C. Evans Jr., PhD



The threats to health that accrue during active addiction have been widely communicated in popular media and scientific literature. But how does the health of people in recovery from addiction compare to the health of those who have not experienced such challenges? The answer to that question has remained something of a mystery, but results of a health survey recently published in the *Journal of Psychoactive Drugs* outlines findings of import to every addiction professional (White, Weingartner, Levine, Evans, & Lamb, 2013). While one might assume that physical and emotional health rapidly improves following recovery initiation and stabilization, the results of this latest survey reveal a much more complex and ominous picture. In this article, we will outline the major findings of this study and discuss its clinical and policy implications.

The Philadelphia Recovery and Health Survey

In 2010, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) contracted with the Public Health Management Corporation (PHMC) to incorporate recovery-focused items into PHMC's 2010 Southeastern Pennsylvania (SEPA) Household Health Survey of Philadelphia and four surrounding counties. The survey results revealed a recovery prevalence rate in the adult population of 9.45 percent (11.4 percent for Philadelphia and 7.5 percent in the four surrounding counties)—recovery defined in the survey as once having but no longer having an alcohol or drug (AOD) problem. This recovery prevalence rate is comparable to national surveys that have reported rates of remission from substance use disorders, meaning the percentage of adults who meet lifetime criteria for a substance use disorder but did not meet such criteria in the past year (Compton, Thomas, Stinson, & Grant, 2007; Dawson, 1996; Dawson et al., 2005; Dawson, Stinson, Chou, & Grant, 2008; Hasin & Grant, 1995; Hasin, Stinson, Ogburn, & Grant, 2007; Hasin, Van Rossem, McCloud, & Endicott, 1997; Kessler et al., 1994; Robins, Locke, & Regier, 1991; see White, 2012 for review). The Philadelphia and national studies confirm the presence of a large population of people—more than twenty million in the US—who have resolved a significant AOD problem. This large population of people quietly and invisibly living out their lives in long-term recovery defies the pessimism about addiction recovery fueled by the media obsession with celebrities recycling through rehab or dying of drug overdoses.

More troubling within the survey findings was the health profile of people in recovery. In the Philadelphia survey, people in recovery, compared to citizens not in recovery, were twice as likely to describe their health as poor, and they reported higher rates of asthma, diabetes, high blood pressure, obesity, and past-year emergency room visits. They were also more likely to report lifetime smoking (82 percent vs. 44 percent), current smoking (50 percent vs. 17 percent), exposure to smoke in their residence, no daily exercise, and eating fast food three or more times per week. In terms of resources to address health concerns, people in recovery compared to the general population reported greater family/social isolation, lower income, less insurance coverage, and less likelihood of past year health screenings, primary health care, and dental care.

Health Management in Addiction Recovery

The DBHIDS/PHMC survey was one of the first community population surveys to measure the comparative physical health of people in addiction recovery. Its findings confirm the burdensome legacies that can be brought into the recovery process—legacies that when unattended, can undermine personal health and quality of personal and/or family life for years to

come. The findings also reveal the roles, past and present, that nicotine addiction plays in the health problems of people in recovery, and they reveal the limited natural resources available to many people in recovery to address these problems. So what do these findings reveal about the state of professional care for AOD problems in the United States?

At a systems level, they expose a model of care that functions as an emergency room to provide acute biopsychosocial stabilization, but that is not designed to provide long-term health management for people in recovery. The management of other chronic health disorders, such as asthma, diabetes, hypertension, and cancer, is viewed as requiring the management of global health over a prolonged period, if not for life. This would include management of co-occurring medical conditions, diet, exercise, and psychosocial stressors. It is time—no, past time—the treatment of the most severe and complex AOD problems was reconceived in this same way. Such approaches would move beyond brief episodes of symptom amelioration like recovery initiation and diagnostic remission to the promotion of global health and quality of personal, family, and community life in long-term recovery. Of course, that process has already begun in the United States via the shift from models of acute care to models of sustained recovery management. Addiction professionals are playing important leadership roles in these systems transformation processes.

There is a long history of conceptualizing addiction as a medical disorder warranting medical treatment, but individuals and families in addiction treatment in the United States spend very little time with physicians and other medical personnel. The DBHIDS/PHMC survey findings suggest that every person entering recovery should have an ongoing relationship with a primary care physician who is knowledgeable about addiction recovery and who can serve as an ongoing consultant on the achievement and maintenance of health and wellness. It also suggests the need for addiction professionals and recovery support specialists to serve as a source of collateral encouragement and guidance in this long-term health management process. It is time we broadened our vision beyond what we can subtract from people's lives in the short run to encompass what can be added to enrich those lives in the long-term. We envision a day in the not-too-distant future when primary care physicians and other primary healthcare personnel, addiction professionals, and other recovery support specialists will form integrated teams to support individuals and families through the course of long-term addiction recovery.

At a clinical level, it is also time we defined recovery to encompass smoking cessation. People in self-proclaimed addiction recovery are dying in great numbers not from the addictions that brought them to treatment or to the meeting rooms of mutual aid groups but from their addiction to nicotine. They are dying of the conceptual blindness that sees no contradiction between present nicotine addiction and claimed recovery status. Through our silence, addiction professionals and peers in recovery participate in these deaths—a form of collective enabling for which we will be judged harshly in historical retrospect.

Measuring Recovery Prevalence and Health

The DBHIDS/PHMC survey demonstrates how communities can imbed recovery-related questions within local health surveys to measure recovery prevalence by discrete catchment areas like zip codes or census tracts, and to evaluate the health and service needs of individuals and families in addiction recovery. Such survey data can be incorporated into larger processes of recovery resource mapping. In Philadelphia, for example, the vision is to achieve a more strategic allocation of community resources by comparing alcohol and other drug problem indicator data and recovery resource data by city zip code. The goal is to mobilize and sustain needed recovery support resources as close as possible to where such resources are most needed. Does your local community conduct periodic health surveys? Could you suggest the

health management in long-term recovery and our need as addiction professionals to explore the roles we can best play in this aspect of long-term recovery management. At a systems level, this latest recovery survey underscores the potential for the tri-directional integration of addiction treatment, mental health, and primary health care services aimed at a singular vision: the long-term recovery and wellness of affected individuals and families. Requests for a copy of the full survey results may be sent to bwhite@chestnut.org.

inclusion of recovery prevalence and health questions within the survey? We would be happy to talk with you about how this was achieved in Philadelphia.

Closing Reflections

At a personal level, the Philadelphia recovery survey is a call for each person in recovery to take command of his or her own health. Such ownership includes a physical inventory of the legacies of addiction and making amends for the injuries and neglect inflicted on one's own body. At a professional level, the Philadelphia survey reinforces the need for assertive

William L. White, MA, *is Emeritus Senior Research Consultant at Chestnut Health Systems, past-chair of the board of Recovery Communities United, and a volunteer consultant to Faces and Voices of Recovery. He has a master's degree in addiction studies and more than forty years of experience in the addictions field. He has authored or coauthored more than 400 articles, monographs, research reports, and book chapters, alongside seventeen books, including Slaying the Dragon - The History of Addiction Treatment and Recovery in America. His latest book, coedited with John Kelly, is Addiction Recovery Management: Theory, Research and Practice. Bill's collected papers can be found at www.williamwhitepapers.com*

Arthur C. Evans Jr., PhD, *is the Commissioner of the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Philadelphia, PA, and past Deputy Commissioner for the Connecticut Department of Mental Health & Addiction Services (DMHAS). He has also held faculty appointments at the University of Pennsylvania School of Medicine, Yale University School of Medicine, and Quinnipiac University.*

References

Compton, W. M., Thomas, Y. F., Stinson, F. S., & Grant, B. F. (2007). Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry, 64*(5), 566–576. doi:10.1001/archpsyc.64.5.566

Dawson, D. A. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research, 20*(4), 771–779. doi:10.1111/j.1530-0277.1996.tb01685.x

Dawson, D. A., Grant, B. F., Stinson, F. S., Chou, P. S., Huang, B., & Ruan, W. J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction, 100*(3), 281–292. doi:10.1111/j.1360-0443.2004.00964.x

Dawson, D. A., Stinson, F. S., Chou, S. P., & Grant, B. F. (2008). Three-year changes in adult risk drinking behavior in relation to the course of alcohol-use disorders. *Journal of Studies on Alcohol and Drugs, 69*(6), 866–877.

Hasin, D. S., & Grant, B. F. (1995). AA and other help-seeking for alcohol problems: Former drinkers in the US general population. *Journal of Substance Abuse, 7*(3), 281–292. doi:10.1016/0899-3289(95)90022-5

Hasin, D. S., Stinson, F. S., Ogburn, E., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry, 64*(7), 830–842. doi:10.1001/archpsyc.64.7.830

Hasin, D. S., Van Rossem, R., McCloud, S., & Endicott, J. (1997). Differentiating DSM-IV alcohol dependence and abuse by course: Community heavy drinkers. *Journal of Substance Abuse, 9*, 127–135. doi:10.1016/S0899-3289(97)90011-0

Kessler, R., McGonagle, K., Zhao, S., Nelson, C., Hughes, M., Eshelman, S., & Kendler, K. (1994). Lifetime and 12-month prevalence of DSM-II-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51*, 8–19.

Robins, L. N., Locke, B. Z., & Regier, D. (1991). An overview of psychiatric disorders in America. In L. N. Robins & D. A. Regier (Eds.), *Psychiatric disorders in America: The epidemiologic catchment area study*. New York: The Free Press.

White, W. L. (2012). *Recovery/remission from substance use disorders: An analysis of reported outcomes in 415 scientific studies, 1868–2011.* Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Intellectual disAbility Services Mental Retardation Services and Northeast Addiction Technology Transfer Center.

White, W. L., Weingartner, R. M., Levine, M., Evans, A. C., & Lamb, R. (2013). Recovery prevalence and health profile of people in recovery: Results of a Southeastern Pennsylvania survey on the resolution of alcohol and other drug problems. *Journal of Psychoactive Drugs, 45*(4), 287–296. doi:10.1080/02791072.2013.825031

COMPARING PATIENT IDENTIFIED HEALING & SATISFACTION FACTORS: DIFFERENCES AFFECTING TREATMENT SERVICES

DAVID T. SMITH, PHD, LICSW

In his most recent book *Clean*, David Sheff highlights the ongoing "evidence gap" between methods employed in addiction treatment and related outcomes (2013). Fees for residential treatment range as broadly as services; a single residential treatment episode can cost between $10,000 and $80,000 per month and include such amenities as private chefs offering "biotic" diets, designer pharmaceutical regimens, yoga, massage, recovery coaches, and a host of internet-based follow-up services and apps. Yet scarce outcome data indicates which, if any, of these variables or in what concentrations might prove beneficial or effective.

Focus surrounding treatment outcomes is also shifting, with outcome measurements mirroring those in higher education. Both students and patients have been transformed into "consumers," with abstinence-based outcome measures displaced by measures of "satisfaction." This tends to be a short-term, consumer-driven construct; a superficial measure of treatment efficacy, one which does not indicate causative or curative factors at work during the treatment process. Our prior experience with historical or retroactive outcome measurement only confirmed already well-documented difficulties with outcome data; it did not reveal what actually helped patients during treatment or why, let alone what led to posttreatment success, knowledge of which would benefit patients and clinicians.

We recently addressed this challenge through reversing the outcome measurement process by asking residential patients over one year—during their treatment stay—to identify and rank factors they perceived as most healing, then comparing them to what they identified as most satisfying. This comparison produced definitive results; patients universally indicated that their perception of what healed them during residential treatment was not necessarily what satisfied them. This finding led to a reexamination of our allocation of clinical resources, training, and treatment curriculum.

TOP 10 RANKED PERCEIVED HEALING FACTORS

	Overall Rank n=876	Gender	
		Male n=581	Female n=295
Groups/group therapy	59%	57%	62%
Staff: support and care	54%	51%	58%
Sense of community, fellowship, support, & friendship	42%	35%	55%
Homework assignments and packets	21%	14%	53%
Education on addiction/ disease, understanding own addiction	20%	23%	14%
AA/NA meetings	19%	18%	21%
Family week	18%	16%	23%
Lectures/ CD lectures	11%	11%	11%
Recreation time (exercise, activities)	8%	10%	4%
Safe, sober, healthy being away from environment	6%	7%	3%

Secondly, we underestimated the depth and specificity of patient knowledge of healing during the treatment process; patients know more about what heals them than we thought. A secondary finding affected our assessment and treatment planning processes.

Survey Method

We modified a mixed method patient satisfaction survey, used to gather monthly performance data across five global domains—overall treatment services, intake and admissions services, counseling services, family counseling services, and medical care—by asking patients with an average length of stay between twenty-two and twenty-four days to identify and rank their perceptions of the top three healing factors during their residential treatment episode. The qualitative construct of healing factors was chosen as it is a universal internal construct; all patients are familiar with it while it surreptitiously accords with the disease model of addiction, another well-known internal

construct implying concepts of healing, wellness, and health.

Between 2012 and 2013, 876 of 1130 residential treatment patients (77.9 percent) completed surveys prior to discharge, 585 of them were male and 295 were female. The quantitative section of the survey employs a fifty-six-item, five-point Likert scale assessing patient satisfaction and perceived "staff helpfulness and perceived interest" in patients across the above domains. An additional qualitative open-ended section was added, asking patients to identify and rank their perceptions of the top "most healing" and "most satisfying" elements of their treatment experience with one being the highest and three being the lowest. After the initial coding and content analysis, NVivo qualitative software revealed the most frequently identified patient healing and satisfaction invariant constituents, or responses, both overall and by gender. The corresponding tables indicate the top ten identified healing and satisfaction factors overall. Due to space limitations, response differences between males and females were omitted with the exception of one similarity addressed in each table.

Patient Identified Healing Factors

Group therapy was identified by 59 percent of all patients as the single most commonly identified healing factor during residential treatment. This has clear implications for the amount and frequency of group offerings, the scheduling and design of the therapeutic milieu, and staff training in the effective principles of group management. Secondary factors influencing this healing element include group location, structure, and curriculum. Next, 54 percent of patients identified "staff support and care" as the second highest ranked healing factor in residential treatment. The ability of staff to convey this perception consistently to patients includes factors such as the timing and presentation of patient and staff communications, client management, and addressing issues related to community integrity and safety.

The design, integrity, and stability of the therapeutic community cannot be overstated as 42 percent of patients ranked "sense of community, fellowship, support and friendship" as the third most important healing factor. This generalized perception relates to a number of independent variables including the reinforcement of principles of therapeutic community in staff training and scheduling, and the conscientious design of intracommunity activities. The remaining

TOP 10 RANKED PATIENT SATISFACTION FACTORS

	Overall Rank n=876	Gender	
		Male n=581	Female n=295
Staff presence	72%	73%	73%
Community experience, community support and fellowship	47%	42%	58%
Meals and food	36%	45%	18%
Groups	28%	29%	25%
Recreation	19%	24%	11%
AA/NA meetings	19%	17%	22%
Education, knowledge learned about self and addiction	17%	15%	22%
Family week	11%	11%	12%
Structured program and busy echedule	8%	8%	7%
Lectures and films	8%	6%	11%

ranking of healing factors by patients includes treatment methods, patient education, speakers, Twelve Step meetings, family programming, and nonjudgmental communication. Patients identified these factors by recall with a level of detail and percentage frequency we had suspected, but did not anticipate.

Patient Identified Satisfaction Factors

Seventy-two percent of patients identified staff presence as the most satisfying factor of their residential treatment stay. Administrators and supervisors need to pay as close attention to facility staffing patterns as the patients do. Meals and food were identified by 36 percent of patients as significantly satisfying, along with recreational activities by 19 percent of patients. Group therapy was identified by patients as only the fourth most satisfying factor, which is surprising given its rank as the top healing factor. Patients did indicate correlations between both sets of factors which are reviewed below.

Comparison of Healing and Satisfaction Factors

Patients clearly differentiated between what they perceived as healing and/or satisfying in several cases. Staff presence was perceived as satisfying, yet distinct from the perception of staff support and care; it is satisfying to have staff "seen," but only healing if staff communicates a perception of support and care to patients. Group therapy was not as satisfying to patients as it was healing. Group work is difficult and involves taking on patient denial and resistance; however, even though patients did not find it extremely satisfying, they did rank it as the top healing factor. Meals and recreation were not mentioned by patients among the top ten healing factors, but they comprise two of the top five satisfaction factors. Our meals are typically high carb and high calorie; patients found them satisfying but omitted them altogether from healing factor rankings. Patients also identified structure and scheduling as satisfying but again did not identify either as healing. One factor patients agreed was both healing and satisfying was a general sense of community support and fellowship, as this factor was ranked among the top three among both responses. There were also close correlations in healing and satisfaction among education, family programming, Twelve Step meetings, and lectures as patients found them simultaneously satisfying and healing.

Healing and Satisfaction "Metafactors"

A further comparison of specific healing factor rankings between male and female response rates reflected traditional gender differences. Females ranked the sense of community fellowship and support, family week, and homework assignments more highly than males, indicating a preference for relational elements of residential treatment. Yet several factors were also ranked equally overall and by gender which we labeled metafactors as they appeared to transcend anecdotal gender differences. These metafactors included group therapy, support, and care demonstrated by staff, Twelve Step meetings, lectures, and education regarding addiction. Both males and females

ranked these healing factors similarly overall which may raise questions about the range and intensity of today's popular gender specific programming.

Summary

Residential treatment patients clearly demonstrated the ability to differentiate between what they believe healed them and that which satisfied them during residential treatment. Additionally, the level of detail patients provided on recall about the above factors, left out of this article for brevity, including groups, activities, staff, and details and nuances related to treatment programming were remarkable. The results revised our limited view of patient capacity, intuition, and comprehension of treatment factors during the treatment process. The study revealed that patients are keenly aware of not only the structure of the treatment environment, but they clearly differentiate and demonstrate knowledge of what factors heal them as opposed to what satisfies them. Review of our internal "clinical" conversations revealed in many cases superficial discussions about patient satisfaction. We have since made an effort to shift our clinical focus to reinforce what patients identify as healing rather than what merely satisfies, though both are important indicators of program performance. C

David Smith, PhD, LICSW, *is the Executive Director at New Beginnings at Waverly, a Minnesota co-occurring addiction treatment program. David has been a healthcare consultant, professor of Community Psychology, and author of clinical and technical articles on healthcare trends affecting delivery of addiction treatment services and clinical competencies.*

References

Sheff, D. (2013). *Clean: Overcoming addiction and ending America's greatest tragedy.* Boston, MA: Houghton Mifflin.

RELATING CLINICAL ASSESSMENT CONSIDERATIONS TO EHR MEANINGFUL USE

PART I

LAVERNE H. STEVENS, PHD, NCC, LPC

Today a person can go to a computer anywhere in the world and securely retrieve real-time information related to their personal finances, travel history, purchases, and more. This has been made possible because of advances in the use of information technology in almost every industry. However, the most life-saving information is not as accessible. For example, when a person walks into a substance abuse treatment facility or any doctor's office, none of their personal medical information such as diagnoses, treatment history, allergy alerts, medications, or insurance information has been readily accessible to either the patient or to the new treatment provider. Hours can be spent on an initial intake interview, and this process is repeated every time the client is referred to another provider for additional services.

The use of technology in the healthcare arena—including mental health and substance use disorders—has been sluggish and often inefficient when compared to other fields. According to the Institute of Medicine (IOM) Quality Chasm report, the US health care system functions at far lower levels than it could and should, because the system lacks an effective electronic health information infrastructure (Institute of Medicine, 2006, p. 57).

Strengthening the Health Information Infrastructure

With the goal of promoting shared electronic health records, reducing health care costs, and improving health care in the United States, the Health Information Technology for Economic and Clinical Health (HITECH) Act, which is part of the American Recovery and Reinvestment Act (ARRA) of 2009, authorized programs to strengthen America's health information infrastructure. Under the HITECH Act, eligible health care professionals can qualify for Medicare and Medicaid incentive payments when they adopt and meaningfully use certified electronic health record (EHR) technology to improve the efficiency, quality, and safety of health care.

EHRs can have value in both physical and behavioral health settings, but the benefits depend on how the technology and the information are used. Standards have been set by the Centers for Medicare & Medicaid Services (CMS) Incentive Programs to define meaningful use (MU) of electronic health records and to determine eligibility for the financial incentives.

In behavioral health care, only physicians (under Medicare and Medicaid) and nurse practitioners (under Medicaid only) qualify an agency to receive the incentive payment, but other providers must be just as involved in the actual implementation. Mary Givens, the MU Program Manager for Qualifacts Systems, Inc., says, "Behavioral health professionals such as the Licensed Professional Counselor

(LPC), Licensed Clinical Social Worker (LCSW) and Certified Addictions Counselor, might assume that MU has no relevance for them, but they play a vital role in MU by providing real-time information to electronic health records inside and outside of their agency or practice" (2013). Givens works to help providers get certified for meaningful use by educating them about the incentive program and helping eligible professionals attest and receive their payment. She adds, "The effective use of EHR has the potential to change the way our treatment system delivers services to consumers" (Givens, 2013).

In the first of this two-part series on relating clinical assessment considerations to EHR meaningful use, we examine the underpinnings and benefits of MU in general. Part two will look at the uniqueness of MU for behavioral health providers, specific clinical and evaluation applications of MU in behavioral health settings, and ways to use the collected data to improve client care in the treatment of substance use disorders.

Consensus on Healthcare Quality Improvement

A strong infrastructure is essential for supporting clients in the self-management of their care; supporting providers in the delivery of evidence-based clinical care; coordinating care across clinicians, settings, and time; facilitating performance and outcome measurement; and educating clinicians (Aspden, Corrigan, Wolcott, & Erickson, 2004; National Committee on Vital and Health Statistics, 2001; Thompson & Brailer, 2004).

The Quality Chasm report (Institute of Medicine, 2006) identifies six areas in which the US health care system needs improvement. The report calls for a focus on a health care infrastructure that is:

- safe—avoiding injuries to patients from the care that is intended to help them;
- effective—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit;
- patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
- timely—reducing waits and sometimes harmful delays for both those who receive and those who give care;
- efficient—avoiding waste, in particular waste of equipment, supplies, ideas, and energy;
- equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

These are the principles upon which the meaningful use standards of ARRA and HITECH are based.

Clients and providers will benefit from EHR in numerous ways. For example, when a new client comes to a residential substance abuse facility, the client may have already received a full assessment at another facility. If a robust evidence-based assessment was already administered, with EHR the new provider could have immediate access to the client's referral status, priority population status, background information, substance use diagnosis and treatment history, mental health diagnostic impressions, risk-behaviors, physical health and medical information, history of traumatic victimization, environmental strengths and weaknesses, vocational status and history, as well as their current and lifetime legal involvement, and other collateral information. With electronic access to that assessment narrative, the new provider could also have insight into the client's readiness to change and motivational factors, potential for relapse or continued use, and recovery environment risk factors in one concise report. Providers would then know more about the consumer and their health history even before the initial meeting. Problems can be diagnosed earlier and the coordination of care among doctors, hospitals, and across health systems, would become more efficient, resulting in potentially better treatment outcomes.

Meaningful use of EHR also means greater consumer empowerment; it will help clients take a more active role in their healthcare and in the health of their families. They will be able to receive electronic copies of their medical records and share their health information securely over the internet with their family members. In behavioral health care, this is particularly useful because collateral sharing from parents, guardians, and spouses can be very important sources of information for coordinating care and for measuring severity, change, and treatment effectiveness.

Support and Program Monitoring

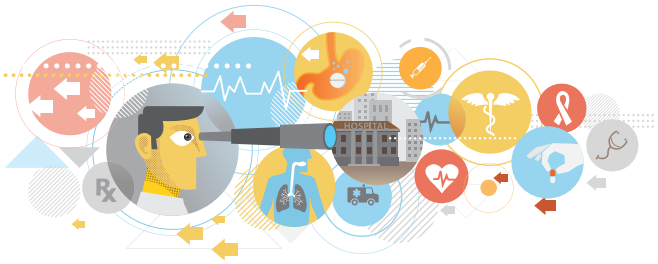
In 2014, MU implementation will enter its second stage of incentive qualification. Dr. Michael Dennis, Senior Research Psychologist and Lead Developer of the GAIN at Chestnut Health Systems says, "This stage of Meaningful Use implementation will really bring added value to clinical staff because the focus is on advanced clinical information exchange" (personal communication, February 1, 2013). Dennis has been involved in developing evidence-based assessments for substance use treatment for over twenty years. He adds that "Reducing the entry of duplicative data is useful, but the real return on investment in EHR comes from improved clinical decision support and program monitoring. Achieving this fuller return on investment for EHR requires the use of standardized and evidenced based assessment protocols" (personal communication, February 1, 2013).

For Clinical Decision Support, the meaningful use of EHR can incorporate evidence-based assessment information and make it more client-centered, reliable, valid, and efficient, with specific recommendations and referrals individualized for each client. For example, sexual victimization and trauma are often unreported to substance use professionals, and when unaddressed they can result in poor treatment outcomes. If information of this nature is captured by just one biopsychosocial assessment that is shared via the use of EHR, all of the consumers' service providers—over a range of fields—can access and incorporate the information into the client's individual service plan and begin to address salient issues earlier in the treatment process.

MU also has significance for program planning and evaluation systems. Multifaceted complex decisions can be supported, as well as decisions about what kinds of treatment groups would provide the most equitable, effective, and culturally-sensitive care for local clients. If, for example, a local Intensive Outpatient Program (IOP) has access to electronically shared data that shows a regional increase in inpatient or emergency admissions for a particular drug among a particular demographic group, the IOP can use that data to plan programs, services, and groups that are responsive to those trends.

The ability to reuse data in multiple forms and contexts applies not only to health records (e.g., screening, assessment, diagnosis, treatment planning), but also across systems and administrative documentation, such as billing or state reporting systems, with the potential to reduce time and costs. Shared EHR can also be used to track outcomes and measure the effectiveness of programs within state, county, and regional treatment systems.

The second article in this two-part series will identify how the distinctive characteristics of health care for mental health and substance-use conditions create unique clinical considerations for data use and sharing, and present a case study of how one treatment program was transformed by using technology-based intake and assessment data for clinical decision supports and program planning functions.



***LaVerne Stevens, PhD**, is a Licensed Professional Counselor, Master Addictions Counselor and Board Certified Coach. She is in private practice as the owner and clinical manager of New Seasons Counseling, Coaching and Consulting, LLC, in Peachtree City (Atlanta), GA*

References

Givens, M. (2013). Clinical decision rules are only as valuable as the data. Retrieved from http://www.muforbh.com/clinical-decision-rules-are-only-valuable-data

Institute of Medicine. (2006). Improving the quality of health care for mental and substance-use conditions: Quality chasm series. Washington, DC: National Academies Press.

Aspden, P., Corrigan, J. M., Wolcott, J., & Erickson, S. M. (Eds.). (2004). Patient safety: Achieving a new standard for care. Washington, DC: National Academies Press.

National Committee on Vital and Health Statistics. (2001). Information for health: A strategy for building the National Health Information infrastructure. Retrieved from http://ncvhs.hhs.gov/nhiilayo.pdf.

Thompson, T. G., & Brailer, D. J. (2004). The decade of information technology: Delivering consumer-centric and information-rich health care framework for strategic action. Retrieved from http://www.hhs.gov/onchit/hitframework.pdf

AD INDEX

At the Crossroads: Connection and Interface in Animal Assisted Interventions

1. All of the following are benefits of animal assists, except:

Ⓐ Animals increase self-control and decrease aggressive/self-harm behaviors
Ⓑ Animals reflect self-worth and nurture forgiveness
Ⓒ Animals provide comfort and diminish cravings through physical touch
Ⓓ None of the above, these are all valid benefits

2. True or False. *The Handbook of Animal Assisted Therapy* helps counselors certify their own animals for work as animal assists.

Ⓐ True Ⓑ False

3. In order to select an animal for training, which of the following was not listed as something that needs to be considered?

Ⓐ Species/breed
Ⓑ Tolerance for training
Ⓒ Age
Ⓓ Temperament

4. True or False. Attributing human feelings, thoughts, beliefs, and values to animals is a process known as anthropomorphism.

Ⓐ True Ⓑ False

5. Which of the following species were not listed as a common animal assists?

Ⓐ Llamas
Ⓑ Birds
Ⓒ Guinea pigs
Ⓓ Both A and C

When Sex and Stimulants Are Fused: Two Behaviors, One Addiction

1. True or False. A recent study showed that while sex and drug addiction can become fused, they should be treated as separate conditions

Ⓐ True Ⓑ False

2. Which of the following is not a listed reason for methamphetamine abuse, as stated by addicts in a recent study?

Ⓐ Wanting to lose weight
Ⓑ Wanting to boost sexual pleasure
Ⓒ Wanting others to use as well
Ⓓ Wanting to feel more attractive

Please print clearly and mail with a $20 payment to: (check payable to HCI)

U.S. Journal Training, Inc., CE Quiz • 3201 SW 15th Street, Deerfield Beach, FL 33442

Name _____ Amount enclosed $_____ ❑ Check ❑ VISA ❑ MC

Address _____ Card No. _____

City _____ State_____ Zip _____ Security Code _____ Exp. Date_____

Phone ( ) _____ Name (exactly as it appears on card)_____

E-mail address _____ Authorized Signature_____

Type of License/Certification _____

I certify that I have completed this test without receiving any help in choosing the answers.

Signed _____ Date _____

Make checks payable to Health Communications, Inc. Please allow 3 to 6 weeks for notification of your results and your certificate of completion (if you pass). You may want to keep a copy of this quiz as a record for your licensing board. U.S Journal Training, Inc., is an approved provider for continuing education home study by: NAADAC Approved Education Provider Program (#000194); CFAAP/CAADAC Provider (#OS-86-057-0514); CAADE Provider (#CA93031-7152); CABD of Behavioral Sciences (#PCF78) for MFTs and LCSWs; and National Board of Certified Counselors (#5130). NBCC approval is limited to the sponsoring organization and does not necessarily imply endorsement of individual offering. U.S. Journal Training, Inc., maintains responsibility for the program. U.S. Journal Training, Inc., provider #1143, is approved for social work continuing education by the Association of Social Work Boards (ASWB) www.aswb.org, through the Approved Continuing Education (ACE) program. U.S. Journal Training maintains responsibility for the program. (Social work practice categories are intermediate to advanced levels.) For questions, please contact Lorrie Keip-Cositore at (800) 851-9100 ext. 220.

3. All of the following are treatments that are used at the Stimulants and Sexual Disorders Program, except:

Ⓐ Cognitive Behavioral Therapy (CBT)
Ⓑ Group therapy
Ⓒ Neurobiological treatments
Ⓓ None of the above, these are all valid treatments

4. True or False. The sex and stimulant addict presents counselors with a completely new category of dual-addict.

Ⓐ True Ⓑ False

5. All of the following are listed examples of possible sex and stimulant addicts, except:

Ⓐ The married, heterosexual professional maleg
Ⓑ Individuals attempting to deal with anxiety and low self-esteem
Ⓒ The gay man who abuses crystal meth
Ⓓ None of the above, these are all valid examples

Theoretical Perspectives for Working with AOD Clients: Choosing Your Best Psychotherapy Match

1. Which of the following was not one of the worlds listed in May's theory?

Ⓐ Our world (being in nature)
Ⓑ World of persons (being with others)
Ⓒ Our own world (being for oneself)
Ⓓ None of the above

2. Which two psychoanalysts' approaches were deemed inappropriate for AOD clients?

Ⓐ Freud and Rogers
Ⓑ Prochaska and May
Ⓒ Rogers and Prochaska
Ⓓ May and Freud

3. True or False. "Self-Actualization" is the ultimate motivating force in every person, according to Prochaska.

Ⓐ True Ⓑ False

4. Which of the following was not listed as one of Prochaska's Stages of Change?

Ⓐ Precontemplation
Ⓑ Motivation
Ⓒ Action
Ⓓ Preparation

5. True or False. According to Rogers, the most important part of therapy is the therapeutic relationship.

Ⓐ True Ⓑ False

LEARNING OBJECTIVES:

At the Crossroads: Connection and Interface in Animal Assisted Interventions

- Animals can be extremely beneficial in therapy because of our deep connection with them, because we attribute human thoughts, beliefs, values, and feelings to them, and because they are wonderful catalysts for symbolic change, expression, and exploration.
- There are several things to consider when selecting an animal for animal assist training. Some of these are the animal's breed, species, temperament, personality, tolerance for training, and attentiveness to a handler.
- Some requirements that enhance animal assist qualities in animals are socialization in training classes and completing AKC Canine Good Citizen training. The final requirement for becoming an animal assist is an evaluation of temperament and obedience in service settings. Certification can be obtained through organizations such as Pet Partners, Therapy Dogs International, and Therapy Dogs, Inc.
- Some of the benefits animals provide to mental health and treatment are as follows: animals serve as social facilitators, reflect self-worth, nurture forgiveness, diminish addictive cravings, support emotional regulation, establish empathy, and increase self-control.

When Sex and Stimulants Are Fused: Two Behaviors, One Addiction

- Even though the link between sexual behavior and stimulant abuse is somewhat under-researched, it has become apparent through some recent studies that there is indeed a subgroup of drug addicts who abuse stimulants almost solely in conjunction with sexual behaviors.
- A recent study showed that that the leading reason for crystal meth abuse in men who were studied was sexual enhancement. The study concluded that for some sex and stimulant addictions, it is almost impossible to separate the two behaviors. Other studies continued to find links between substance use and sexual behavior, particularly in men and women abusing methamphetamine.
- The long-term dangers for the sex and stimulant addict are much more dangerous, as poor decision making and judgment can result in unsafe, unprotected sex, which in turn can result in contracting or transmitting HIV, hepatitis, and other STDs.
- The Stimulant and Sexual Disorders Program at Promises in Malibu, CA, uses a combination of group therapy, Twelve Step involvement, Cognitive Behavioral Therapy (CBT), and neurobiological treatments designed to control cravings, in order to treat these dual-addicts.

Theoretical Perspectives for Working with AOD Clients: Choosing Your Best Psychotherapy Match

- The psychoanalytic theories of Freud and May are not appropriate for use with AOD clients because measuring success and discovering what success would look like is very difficult with the kinds of treatments their theories suggest.
- The theories of Rogers and Prochaska are more beneficial for use with AOD clients because their ideas about being genuine with patients, showing empathy, and matching the client's state of change are proven methods to build efficacious therapeutic relationships and client success.
- The importance of the therapeutic relationship is stressed by each theorist. Freud mentioned the importance of keeping the relationship realistic and non-neurotic, while May believed in the importance of keeping conversation honest and authentic. Rogers' therapeutic relationship focuses on the significant difference empathy and positive regard can make, and Prochaska puts emphasis on knowing how to behave with a client in specific stage of change.
- Having knowledge of theories that are different, new, unheard of, and even those that may or may not be useful for clinicians in a certain field is extremely beneficial in order to provide the best possible treatment.

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.

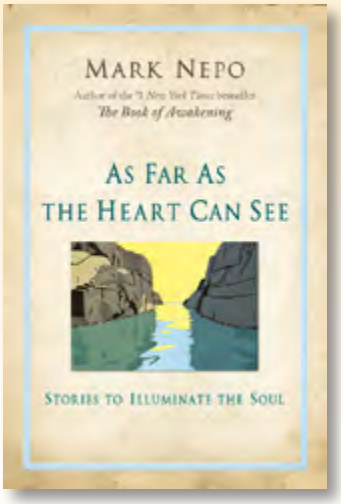
CE quizzes are available online at www.counselormagazine.com. It's quick and easy, no stamp needed!

From RESOLUTION

Every person has the ability to grow from the trauma of divorce

The role divorce plays on emotional stability can be devastating for many men and women—anger, resentment, and a sense of loss often linger. This practical book provides insight through this most vulnerable stage of life.

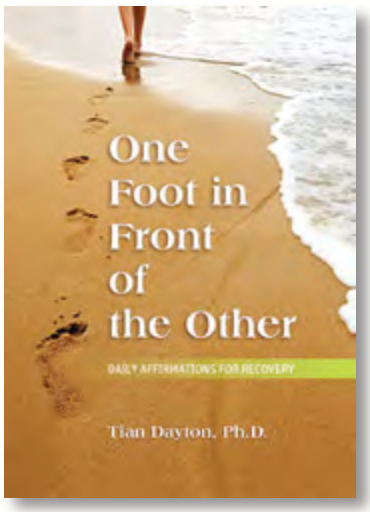
Item #6670 ~~$12.95~~ **$10.36**



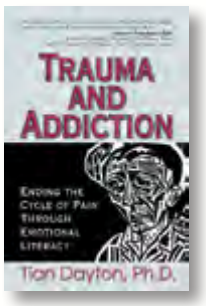
From the bestselling author of *The Book of Awakening*

This guidebook in the form of stories and parables by poet/philosopher Mark Nepo is for anyone who seeks a deeper experience of being alive, searches for the spiritual self, and endeavors to tap into innate wisdom.

Item #5712 • ~~$15.95~~ **$12.76**



365 days of wisdom to ground, guide, and renew the spirit.

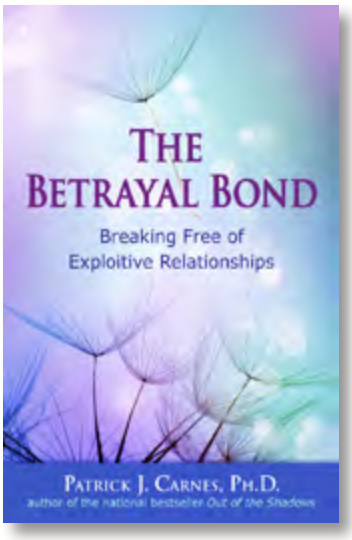


Begin the New Year with nationally renowned trauma and recovery expert Dr. Tian Dayton as she shares inspired readings for daily self-renewal. Readers will earn how to build courage, self-esteem and resilience by putting one foot in front of the other, moment-by-moment and day-by-day.

Also by Tian Dayton, *Trauma and Addiction*

Item #788X • ~~$14.95~~ **$11.96**

Item #7516 • ~~$12.95~~ **$10.36**



Exploitive relationships create trauma bonds; Dr. Carnes explains how to safely extricate from them.

Trauma bonds are chains that link a victim to someone who is dangerous to them; in *The Betrayal Bond*, Dr. Carnes gives an in-depth study of these relationships; why they form, who is most susceptible, and how they become so powerful. It is a book that will prove its value again and again for its reference work, inspiration and insight.

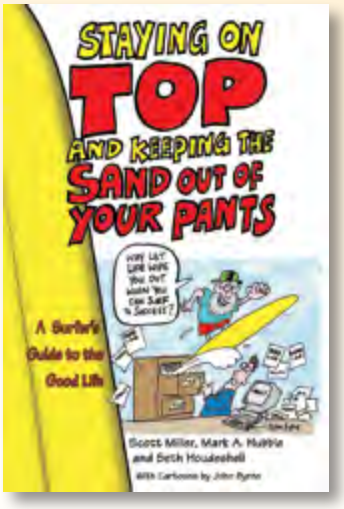
Item #5262 • ~~$13.95~~ **$11.16**

HCI *The Life Issues Publisher* Health Communications, Inc.®

(800) 441-5569
www. hcibooks.com

Order Today!

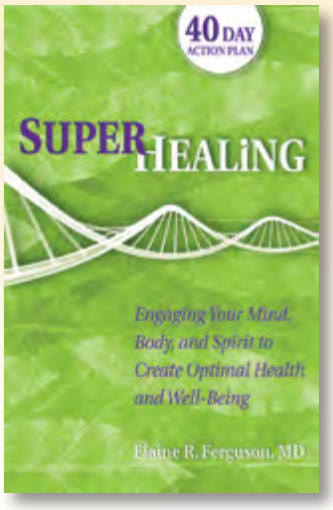
To RENAISSANCE



Discover the "*Good Life*" with surf master Alva

Using surfing as a metaphor for motivational and self-improvement concepts and written in accessible, everyday language peppered with surfer slang, Scott Millerís entertaining and enlightening book proves that one thing you can be sure of is that the good life is available right now.

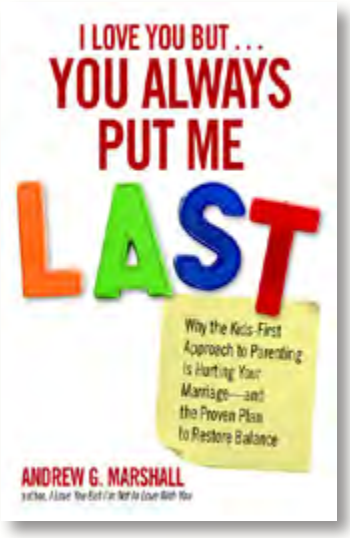
Item #0332 • ~~$10.95~~ **$8.76**



Explore the latest findings in scientific research for optimal health and disease prevention

The impact of the mind-body connection on overall health has been widely recognized. Dr. Ferguson uses an integrative approach to healing as a way of eradicating the limitations that lead to diseases and imbalance.

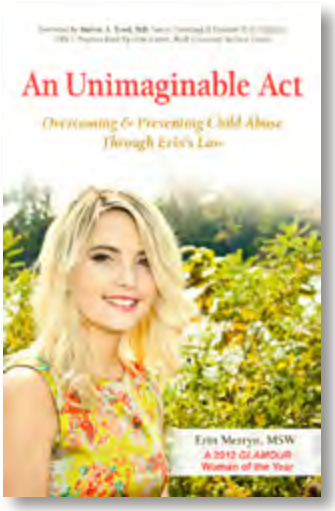
Item #7529 • ~~$14.95~~ **$11.96**



New from Andrew Marshall: Unconventional strategies that really work!

As a marital therapist, Marshall spent almost thirty years helping couples resolve complex issues and arguments and then fall in love again. And while his strategies may be somewhat unconventional, he has helped hundreds of married couples restore the proper balance of priorities to keep the respect, joy, and love alive while raising wonderful children.

Item #7901 • ~~$15.95~~ **$12.76**



Glamour magazine's 2012 Woman of the Year breaks the silence with a call to action.

Child sexual abuse is called the "Silent Epidemic" because virtually no one knows about it except the victims and abusers. But Erin Merryn is out to change all of that.

"Erin's Law" requires that all public schools implement a prevention-oriented child sexual abuse program; it has been enacted in seven states and pending in many others. *An Unimaginable Act* is Merryn's brave journey to overcome and prevent the child abuse epidemic.

Also by Erin Merryn: *Stolen Innocence* and *Living for Today*.

Item #7561 ~~$14.95~~ **$11.96**

20% Off List Price

(800) 441-5569
www. hcibooks.com

HCI
The Life Issues Publisher
Health Communications, Inc.®

One Foot in Front of the Other

Tian Dayton, PhD

Reviewed By Leah Honarbakhsh

From the prolific, engaging, and award-winning author Tian Dayton, PhD, comes *One Foot in Front of the Other: Daily Affirmations for Recovery*. This, her sixteenth book and second book of affirmations, is a healing and inspiring book written specifically for those in recovery. It serves as a message of hope and a reminder that they are not alone on their journey.

One Foot in Front of the Other is a powerful little book that presents readers with a full year of affirmations, touching upon the specific struggles and obstacles that people in recovery face every day. As Dr. Dayton states, "Life is a challenge for even the strongest among us; we all need tools for living." Everyone faces anxieties, fears, and doubt in life, but those experiences are significantly magnified by the problem of addiction in oneself, a family member, or a friend. Dr. Dayton's new book provides readers with the confidence, the determination, and the strength to face each day.

One Foot in Front of the Other features moving quotes from a number of prominent figures such as Confucius, Margaret Mead, Elisabeth Kubler-Ross, Paul Coelho, Stephen Hawking, Maya Angelou, and Thich Nhat Hanh, among others. Additionally, each month is accompanied by a specific lesson from Sanskrit prayers, Islamic fables, and short passages from noted authors Kahlil Gibran, Kaye Cunningham, Mary Stevenson, and Erma Bombeck. Dr. Dayton's extensive experience with addiction and trauma issues is evident in the expertly-written and thought-provoking passages that she selects and writes. She infuses her writing with the latest research and wisdom garnered through her thirty-five years of experience in the treatment fields which makes *One Foot in Front of the Other* stand out from other books of affirmations.

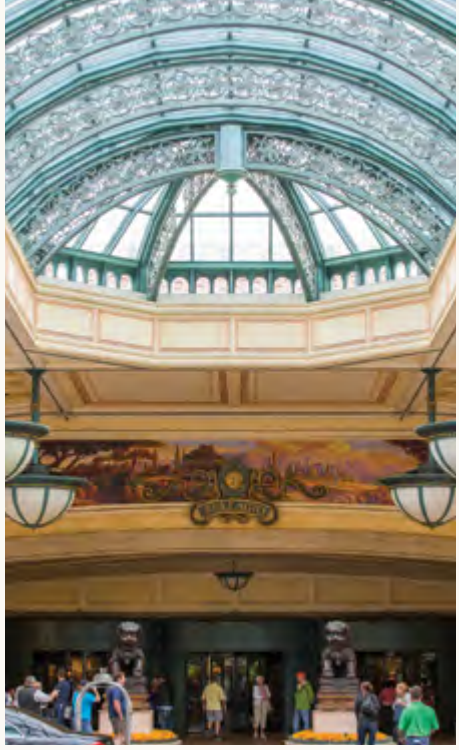
Affirmations—intentional thoughts and emotions—are a useful tool to help guide readers towards a meaningful and mindful life. By living one day at a time and going forward with one foot in front of the other, readers can live fully in the present and enjoy the many gifts life has to offer. This book is an excellent tool for counselors and treatment professionals that can be used to facilitate the Twelve Step mantra of "one day at a time." Dr. Dayton herself states that "the tools of living that we learn in recovery and Twelve Step rooms, along with the positive attitudes for living one day at a time, provide us with a foundation for living that strengthens each and every day."

These inspired readings provide user-friendly and straightforward wisdom from an expert source, which makes *One Foot in Front of the Other* an excellent staple of recovery-oriented self-care. C

A SIX MONTH SNEAK PEEK

January	Focuses on such issues as emotional sobriety, keeping things simple, and feeling worthy
March	Addresses the fear of change, having faith, and being powerless vs. helpless
May	Focuses on triggered memories, saying thank you, and optimism
August	Touches upon issues such as negative thinking, being authentic, and letting go
October	Addresses kindness, resentment, and knowing oneself
December	Focuses on issues like realistic expectations, love, and self-care

Tian Dayton, MA, PhD, TEP, *is the director of the New York Psychodrama Training Institute and executive editor of the* Journal of Psychodrama, Sociometry and Group Psychotherapy. *She is the recipient of the Mona Mansell Award, the Ackerman/Black Award, and the Kipper Scholar's Award for her contributions to the fields of addiction and psychodrama. She serves on the advisory board of the National Association for Children of Alcoholics and is the author of fifteen books and is a* Huffington Post *blogger. Dr. Dayton is the creator of the Internet's first interactive self-help website, emotionexplorer.com. Learn more at tiandayton.com.*



Don't miss our keynote speaker Dr. Claudia Black.

4TH ANNUAL

LIFESTYLE INTERVENTION

NATIONAL CONFERENCE

October 6–8, 2014

BELLAGIO HOTEL • LAS VEGAS, NV

★ Earn up to 18 CEUs

USE CODE **CM2014** - AND SAVE - **20% OFF** REGISTRATION

lifestyleintervention.org
Call **800.508.1489** to register.

The 4th annual conference returns with a continued focus on process addictions. LIC 2014 will offer a specialized track geard towards professionals who work with those dealing with sex addiction. Join us in Las Vegas this October and learn from renowed author and sex addiction expert, Dr. Claudia Black.

The Lifestyle Intervention Conference offers an opportunity to bring professionals together to provide solutions & tools for intervention and treatment to help the 72 million Americans dealing with a process addiction. Created with the intention of building a network of resources, LIC brings peers together to spur meaningful dialog and further education across various platforms of treating those plagued by addiction. The Lifestyle Intervention Conference continues to be the most critical, industry-changing event to impact the mental health and wellness communities in decades.

Connect with us on social media

@LIConference | Lifestyleintervention | @LIConference | #2014LIC

CENTRAL RECOVERY

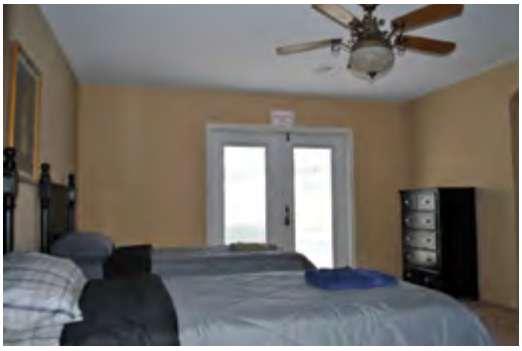
A Family of Companies Dedicated to Recovery from Addiction

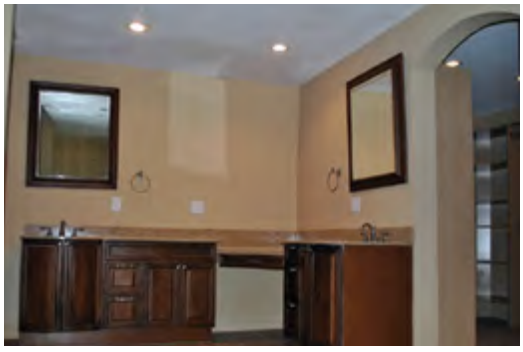
Mel Pohl, MD, FASAM
Medical Director

Dr. Pohl is certified by the American Board of Addiction Medicine (ABAM), and a Fellow of the American Society of Addiction Medicine (ASAM). He is a clinical assistant professor in the Department of Psychiatry and Behavioral Sciences at the University of Nevada School of Medicine. He was elected by his peers for inclusion in Best Doctors in America® from 2009 to 2011.

Johanna O'Flaherty, PhD
Chief Executive Officer

Dr. O'Flaherty is a Nationally Certified Addiction Specialist (Advanced Level) and a Certified Employee Assistance Professional (CEAP). She recently served as the Vice President of Treatment Services at the Betty Ford Center. Dr. O'Flaherty is also a Certified Trainer for Critical Incident Crisis Debriefing Programs.





Residential Treatment at Las Vegas Recovery Center: Part of CRT's Continuum of Care

The Central Recovery companies are dedicated to providing dignified and effective treatment of addiction for individuals and their families. With this objective in mind, we are proud to introduce residential treatment as part of our tradition of excellence in providing a full continuum of addiction treatment care. Our residential treatment program includes the following services:

- One-on-one sessions with primary counselor (at least weekly or as indicated)
- Educational groups (daily)
- Process groups (twice per day)
- Offsite twelve-step support group attendance (five times per week)
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria, IIR
- Family sessions as clinically indicated
- Recreational activities (weekly)

800.721.4278 • lasvegasrecovery.com

CRT
CENTRAL RECOVERY TREATMENT