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Were We Ever That Young?

Welcome to this special issue of *Counselor* on adolescents and young adults. It hasn't been very long in western thought that the period of adolescence was a unique time in human development. Prior to 150 or 200 years ago, it was believed that children and adolescents were adults in small bodies. It was believed that their thought processes, emotions, reasoning skills, intellectual abilities, wants, and needs were the same as adults. Obviously, we have changed our thinking.

Adolescence is a unique time in everyone's life. Some of us can look back on our own adolescence as a time of adventure or being carefree. Others might remember high school years, dating and relationships, and sports, while still others might remember turmoil in their lives and in their families. It was a time when we guarded the dysfunction in our family to extremes because we did not want our "reputation" spoiled. Some of us found ourselves defending the very behaviors that offended us because, after all, they were family.

To a certain degree adolescents today and our own adolescence are similar. At the same time, however, they are very different. There are many more things in America today to become addicted to. There are societal changes and social pressures that are more intense than what we experienced. Various research findings indicate that some of the greatest problems or challenges for today's adolescent include many of the following:

- Eating disorders
- Body image and self-esteem
- Physical, sexual, and emotional abuse
- Pregnancy
- Internet addiction
- Mood disorders
- Attention deficit disorders
- Bullying
- Stress
- Drinking and drugging
- Peer pressure

This special edition focuses on many of these problems. William L. White discusses the rise of recovery community organizations and introduces us to a young leader in the field. Brad Reedy writes about the field of wilderness theory. In addition to those articles, there is also the first adapted article from the *Journal of Substance Abuse Treatment* and a special interview that I conducted with Reid Wilson and Lynn Lyons on their new book, *Anxious Kids, Anxious Parents*.

This issue will also feature an article by David E. Smith, PhD, and colleagues about cannabis dependence and adolescents. This will kick off a series of articles on marijuana and the behavioral health and addiction fields. Look for parts two and three in our June and August issues, respectively.

Finally, we are very excited to introduce a new column, "Substance Abuse in Teens," by Fred J. Dyer. His writings, his research, and his presentations about teenagers have brought him national acclaim and we look forward to working with him and reading his new column.

I hope you enjoy this special issue.

Sincerely,

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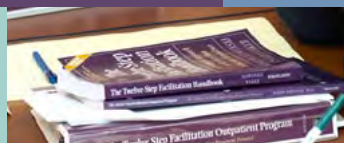

Cara Renzelli, PhD, sees a brighter future for Gateway Rehabilitation Center's patients. Dr. Renzelli, vice president of Research and Clinical Training, is also witnessing the fulfillment of an organizational goal, as Gateway Rehab advances its commitment to excellence in treating the disease of addiction.

Gateway Rehab is now home to the Kenneth S. Ramsey, PhD, Research & Training Institute. Established in December 2012 and named to honor the long-time CEO and president, it is a fitting honor to Dr. Ramsey, who recently retired.

Dr. Renzelli leads the Ramsey Institute and collaborates with staff clinicians to research and develop a curriculum including evidence-based treatment practices. "'Evidence-based' means that these treatments have sound research demonstrating their efficacy. Within the infrastructure of the Institute, we will be able to implement these practices, sustain them into the future, and ultimately improve outcomes for patients," she explains.

By the close of 2013, the young Institute assessed the training needs and interests of approximately 200 of organization's clinicians, and provided advanced training on an evidence-based practice to 125 therapists and counselors in sixteen programs.

The Ramsey Institute's first staff training featured Joe Nowinski, PhD, a University of Connecticut psychologist who is the developer of Twelve Step Facilitation (TSF), an evidence-based, manual-guided treatment that helps participants recover from addiction through Twelve Step programs.

TSF is a well-credentialed treatment that has undergone extensive peer review and was selected for inclusion in the National Registry of Evidence-Based Programs and Practices and the American Psychological Association official list of evidence-supported treatments. TSF provides clinicians with a structured approach to helping patients achieve and sustain recovery by explaining the principles and practices of Twelve Step programs and encouraging participation.

Reactions from therapists who volunteered for the initial training are positive.

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"As an organization, we believe in Twelve Step programs," says James Jones, Gateway Rehab's clinical manager of youth programs. "We believe that addiction is a biopsychosocial-spiritual disease, and Twelve Step programs are based on concepts that address the multiple components of addiction. A patient in treatment feels vulnerable, so a sense of safety and trust is essential. TSF helps by taking away the fear of the unknown. Patients know exactly what to expect," Jones stated.

Jones and his colleagues also realized that having manual-guided treatment can be liberating rather than restrictive.

Megan Day, the lead therapist at Sheffield Corrections, appreciates having a manual that she can customize. According to Day, "The program is flexible. There's room for creativity and as you learn the intricacies of it, you determine how to best apply it to your setting."

Both Richard Foster, PhD, executive vice president of treatment programs at Gateway Rehab, and Renzelli envision a future in which the Ramsey Institute will share its research and training with other institutions. "In this field, it's unusual to find a research program within a treatment facility. We believe that it will help us attract, retain, and develop the best clinicians, and we expect to increase our staff as the Affordable Care Act brings a greater demand for treatment," says Dr. Foster.

"Addiction is an extremely complex disease and the more we can offer scientifically sound treatment, and in turn contribute to the building of the knowledgebase, the more we increase the probability of helping people reach long-term recovery," concluded Dr. Renzelli.

The Little Permissions Lead to the Big Permissions:

Professional Ethics for Substance Use Disorder Counselors

Pete Nielsen, LAADC, CADC II*

Substance use disorder (SUD) counselors are charged with several important responsibilities, all of which ultimately have to do with promoting client welfare and protecting client rights. Many times I have asked myself why professionals become unethical, with all of the training and knowledge that a professional counselor has. Some professionals say the reason that many counselors are unethical is because their core characteristics are unethical. That means it won't matter how much education about ethics you give them, they are just unethical people at the core. Well, that may explain some, but it doesn't explain them all. Maybe some counselors want to be ethical, but somehow fall short. It seems as if they may slowly slip into being unethical and did not intend to. Maybe these little permissions of unethical behavior, as innocent as they may seem, become big permissions. This article will cover the counselor's responsibilities including adhering to codes of ethics, standards of practice, respecting client diversity by working in a culturally sensitive manner, and engaging in supervision, consultation, and advocacy. Counselors must also continuously attend to their own wellbeing and evaluate their own effectiveness. Many counselors don't think of self-care as the basis for being an ethical professional, but it is the most essential element.

Ethics are rules of conduct recognized in a particular profession; the shared standards of what is good practice. Ethical codes provide the structure for mandatory ethics, the minimal standard of conduct that is acceptable. Minimal ethics would be reading, signing, and following the code of ethics. Counselors may sometimes sign their code of ethics assuming that no changes have been made. As professionals we are responsible for comprehending everything we sign; if we don't pay attention to the code of ethics that a counselor signs, it could signal the start of a pattern of unethical behavior. Ideally, counselors practice aspirational ethics, which focuses on the spirit behind the code. For example, mandatory ethics permit a counselor to have a romantic relationship with a former client two years after the client's treatment ends. Aspirational ethics suggest that doing so even after two years is inadvisable. Aspirational ethics is thinking beyond the minimal requirements, thinking about situations that could potentially be unethical, and setting limits of conduct for more than what is mandated. It seems as though some counselors may look at ethics as a mandated requirement. They may grudgingly get their ethical requirements every two years. It is a similarity to a mandated client completing court requirements to keep from suffering a consequence. Aspirational ethics involves challenging yourself to learn more ways to be, and to continue to be, an ethical counselor.

The statement "If you don't have an ethical dilemma then you might be unethical" is something I tell counselors when I talk about ethical decision-making. What that statement is intended to mean is, if you're not self-evaluating your decisions, or you believe no matter what you do it is ethical, you might not be as ethical as you think. Being righteous is not the same thing as being ethical. To be ethical, you have to apply a decision-making model to a problem and make a self-evaluation. When faced

with an ethical dilemma, a situation to which there is not an ideal response, it can be useful to refer to the principles that underline most professional codes of conduct. An ethical action will respect these principles (adapted from Demask & Washington, 2008) below as much as possible:

- **Autonomy**: Respect the client's independence and self-determination.
- **Non-Maleficence**: Do not harm the client.
- **Beneficence**: Provide benefit for the client.
- **Justice**: Be fair to the client.
- **Fidelity**: Be faithful to the client.
- **Veracity**: Be truthful with the client.

As a SUD counselor, a decision-making model need not be a model learned in school that provides a framework for systematically choosing a course of action—when ethical codes do not specify how to act in a particular situation—but a functional framework that a counselor operates from. The steps of one decision-making model (adapted from Corey, Corey, & Callanan, 2011) are to identify the problem, review the code of ethics and relevant laws, consult with another professional, consider possible courses of action and their consequences, choose a course of action, and evaluate the results.

Being an ethical counselor is more than saying you are ethical. It's adapting a decision-making model, internalizing the code of ethics as your own, and striving to become a better counselor through consultation, self-care, self-evaluation, and good clinical supervision.

Professional Development

Professional development is an ongoing responsibility. Many of the counseling profession codes of ethics talk about this, and yet many counselors may not fully understand what it means. Professional development is obtained through engaging in continuing education, self-evaluation, supervision, and consultation. Becoming certified should not be the end of a counselor's education. There is an old saying that goes, "If you always do what you've always done, you get what you've always got." Counselors are responsible for staying current in their ever-changing profession. This can be accomplished by formal education, attending workshops and conferences, and reading professional journals and new books about substance abuse counseling. The California Certification Board of Drug and Alcohol (CCBADC) stipulate the minimum number of hours of continuing education required for licensure renewal. For Certified Alcohol and Drug Counselors (CADC) it is at least sixty hours every two years. Other individuals that hold other licenses such as physicians, psychologists, Licensed Professional Clinical Counselors (LPCC), or Licensed Clinical Social Workers (LCSW), have different continuing education requirements every two years. Ethical practice requires that counselors get the training necessary to stay sharp in their job, even if that means exceeding the minimum number of hours of continuing education. Good professional practice dictates that counselors should continuously evaluate their own performance. Counselors must acknowledge the limits of their knowledge and skills and take care to practice within one's scope of competence, as well as the scope of practice described in state law. A SUD counselor must address substance abuse, dependence, and/or its impact on the service recipient as long as the counselor does not use techniques that exceed his or her professional competence. Scope of competence is different than scope of practice. I have adopted this saying that helps illustrate the difference: "Just because you can does not mean you should."

In addition, counselors must also evaluate how their personal beliefs and concerns affect the counseling process, so that they do not pursue personal agendas with clients, thereby reducing treatment quality. An unaware counselor may not present all potentially helpful options to clients, or fail to support clients' choices of which the counselor disapproves. Many times counselors may show disappointment if their client relapses, or become angry if their client is dishonest to them. Counselors can usually recognize this as countertransference in others, but may not see it in themselves. There is a saying that relates to this subject, which is "Counselor Know Thy Self." For example, consider a counselor who believes that there is only one path to recovery for all clients, or that abstinence is the only proper goal for all clients, or that only counselors in recovery themselves can work effectively with addicted clients. Counselors are expected to monitor their own wellness and make healthy lifestyle choices because this directly affects their professional effectiveness. If personal problems threaten a counselor's effectiveness, the counselor is responsible for securing whatever assistance is needed. The National Association of Alcohol and Drug Counselors (NAADAC), states in their code of ethics (n.d.):

> *Addiction professionals, whether they profess to be in recovery or not, must be cognizant of ways in which their use of psychoactive chemicals in public or in private might adversely affect the opinion of the public at large, the recovery community, other members of the addiction professional community, or most particularly, vulnerable individuals seeking treatment for their own problematic use of psychoactive chemicals. Addiction professionals who profess to be in recovery will avoid impairment in their professional or personal lives due to psychoactive chemicals. If impairment occurs, they are expected to immediately report their impairment, to take immediate action to discontinue professional practice and to take immediate steps to address their impairment through professional assistance.*

This applies to counselors who are in recovery

from substance abuse or dependence and those who are not.

Sometimes counselors violate ethical standards not because their motives are bad, but because their judgment has become impaired from poorly managed stress. Many codes of ethics use the term "impaired." For example, the California Board of Alcohol and Drug Abuse Counselors (CCBADC) Code of Ethics, principle 3d, states the following (n.d., pp. 2):

> *The alcoholism and drug abuse counselor/registrant must recognize the effect of professional impairment on professional performance and must be willing to seek appropriate treatment for oneself or for a colleague. The counselor/registrant must support peer assistance programs in this respect.*

Are they talking about just drug and alcohol impairment? Are they talking about other impairments? The National Association of Social Workers (NASW) states in their code of ethics (1999, pp. 5):

> *(a) Social workers who have direct knowledge of a colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties that interferes with practice effectiveness should consult with that colleague and assist the colleague in taking remedial action. (b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.*

The American Association of Counselors states in their code of ethics (2005, pp. 9) that:

> *Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients.*

Should it be that any impairment potentially resulting in client harm is the standard and not just impairment due to drugs and alcohol? Also, when we think recovery can it be recovery from workaholism or internet addiction? What would that impairment look like? We should look at it from the standpoint of recovery from impairments. What has caused you enough problems in your life that interferes with your personal and professional life? This is where clinical supervision plays a helpful role in the development of the counselor and assists in the counselor's wellness as a professional.

Clinical Supervision and Advocacy

An essential tool for an ethical counselor is not only self-evaluation, but also good clinical supervision. The purposes of supervision are to promote the counselor's growth, protect the welfare of clients, monitor counselor performance, and empower the counselor to self-supervise and carry out their responsibilities as an independent professional (Corey, Corey, & Callanan, 2011). The late Dr. David Powell described four emphases of supervision: administrative, evaluative, clinical, and supportive. Administrative supervision focuses on matters such as case record maintenance and performance evaluation. Clinical supervision focuses on the clinical skills of the supervisee; someone who has authority over the counselor usually provides supervision. In peer supervision, experienced counselors provide supervision to one another. There are several models of clinical supervision. One way of categorizing them is a developmental approach, a psychodynamic model, a skills model, a family therapy model, and a blended model (Powell, 1998). In addition, Nielsen's leadership models (2008) of clinical supervision for drug and alcohol counselors can be added to Powell's blended model for a complete approach to clinical supervision. Adapting a leadership model to clinical supervision will help the clinical supervisor to develop the supervisee. Whichever model of supervision is used, the exact responsibilities of the supervisor and supervisee should be spelled out, and supervisees should be informed at the outset how their performance is going to be evaluated. Providing competent supervision requires specialized knowledge and skills that differ from those required for counseling. Clinical supervisors are held legally responsible for the actions of counselor interns they supervise. A counselor seeks consultation in order to apply the expertise of another person toward better serving a client. Consulting is another way to build competence as a professional. When this happens, the counselor learns from other professionals what they would do, which helps build knowledge and self-efficacy in the counselor. They also need to be familiar with services available in the community, such as legal services, emergency services, Alcoholics Anonymous, SMART Recovery, and other mutual-help groups. Examples of people with whom counselors might consult are a client's physician, a marriage and family therapist, or a religious leader. In order to make proper referrals, counselors need to be able to recognize symptoms in clients that require assessment by other professionals such as physicians, psychologists, or licensed professional counselors. It is good practice to be personally familiar with the philosophy, programs, and personnel of

the services to which clients are referred and to be active in the referral; for example, to make the appointment for clients rather than just provide a phone number for them to call (Kinney, 2011, p. 243). Advocacy is any activity designed to obtain a service, practical help, support, or information for a client. Advocacy requires that counselors maintain effective relationships with other professionals, government organizations, and groups in the community that might be helpful to their clients' recovery or quality of life. It is important for the counselor to come from an inquisitive place in order to receive information from the other professional and create a partnership with that professional so that they may better help clients get their needs met.

Cultural Sensitivity

Counselors are required to be respectful of clients of all cultures. Many people call this cultural competence, but for the purposes of this article we will call this cultural sensitivity. Competence would mean that someone fully understands the position or culture of another. While it is possible to be sensitive to a culture that is not your culture, it is almost impossible to be truly competent in another culture. Cultural differences exist in clients' socioeconomic status, racial or ethnic identification, gender, sexual orientation, physical and cognitive ability, and religion. The first step in culturally sensitive counseling is to be aware of one's own lack of information about other cultures and one's prejudices. When a counselor encounters

a client whose culture is unfamiliar, the counselor is responsible for obtaining the education and guidance necessary to understand their culture, and to process any feelings that could interfere with counselor empathy. Otherwise, a counselor might unintentionally behave in a racist, ethnocentric, ageist, sexist, or heterosexist manner. If the counselor is unable to work effectively with a client, a referral should be made. SUD counselors need to be comfortable acknowledging and exploring the influence of culture with individual clients, as well as not making assumptions about individual clients based on the client's cultural identifications.

What makes counseling a profession is that its members share a common body of knowledge, a code of ethics, and a concern for their peers (Bissell & Royce, 1994, p. 1). Ethics is not just a code that is followed; it is an adopted way of being and perceiving the world that puts principles in place to protect the client and the counseling profession. The title of the article is that "the little permission lead to the big permissions," which means that counselors must adhere to codes of ethics, follow the standards of practice, respect client diversity, and engage in supervision, consultation, and advocacy.

The counselor must adopt a "do no harm" philosophy and follow the four basic characteristics of a professional counselor, which are genuineness, respect, empathy, and warmth. This means that people cannot be warm, empathic counselors by day and serial killers by night. Professional conduct results in quality service to clients, personal satisfaction, protection from burning out, and enhancement of the substance abuse counseling field's visibility and reputation in the community. C

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.*

**LAADC (non-governmental license) #LNR230211 CADC II # A4006307*

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2013: The Year in Substance Abuse & Prevention Advocacy

Andrew D. Kessler, JD

I guarantee there is not a person who works in the policy arena who is sad to see the year 2013 go, unless they represent the procrastination lobby. When funding for all federal programs—let alone ones concerned with substance abuse treatment and prevention—is stagnant at best and Congress passes less legislation than at any other time in the last century, progress is hard to measure.

We can point to some successes on the advocacy front in 2013. A final rule was issued to accompany the Wellstone/Domenici Parity Act, which was passed almost five years ago. The rule gave more clarity and force to the legislation. While waiting five years for the issuance of a rule is highly abnormal, there is no telling how long we may have waited if it were not for the substance abuse treatment and prevention advocacy community's constant pressure on the White House.

A Continuing Battle

A major piece of the Affordable Care Act (ACA) that does not get much media attention is the Prevention and Public Health Fund, established to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. It is responsible for funding Screening, Brief Intervention, Referral, and Treatment (SBIRT) programs at the Substance Abuse Mental Health Services Administration (SAMHSA).

Unfortunately, the fund is constantly under attack from several directions. The HHS budget often "dips" into it, and the House of Representatives has also tried to use the fund as a budgetary offset to pay for other programs, both health-and non-health-related. According to *Washington Post* columnist Sarah Kliff "the deficit reduction package that passed in February 2012 cut $6.5 billion from the Prevention and Public Health Fund," reducing the Prevention Fund's budget by 37 percent (2013). In addition, Congress itself used these funds to keep Medicare provider payments to physicians stable and the Obama administration plans to use Prevention Fund dollars to help pay for the federal health insurance exchange—"That's 45 percent of the $1 billion in Prevention Fund spending available this year," Kliff writes (2013).

IC&RC is one of the few groups with a focus on substance abuse policy that has taken up the fight to preserve the Fund. We are an active member in the coalition to preserve the Fund, led by Trust for America's Health, and have participated in lobbying efforts to preserve it.

Budget Wrangling

Of course, nothing can happen on the policy front without a strong budget in place to support the programs that implement and enforce policies such as the ACA. To that end, IC&RC is an active participant in the NDD United coalition, which is dedicated to lifting the sequester that cripples all federal funding, especially that for Non-Defense Discretionary (NDD) agencies.

The sequester impacts every aspect of substance abuse treatment and prevention, from research to services to workforce recruitment. The ACA and the Wellstone/Domenici Parity Act will not have nearly the impact they should if the sequester continues, as local and community treatment and prevention programs will suffer if these cuts continue. Our participation in NDD United stems in large part from our involvement in the Coalition for Health Funding, where IC&RC is the only member that focuses solely on issues of addiction treatment and prevention.

Looking Ahead

The advocacy that took place in Washington in 2013 was an impressive display of our community's determination. 2014 brings continued efforts to expand coverage for consumers, especially special populations such as veterans. IC&RC will also be closely focused on the ever-changing landscape of health care and its impact on prevention, substance use treatment, and recovery professionals. As we all know, our work is far from finished.

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"This (Crack Cocaine) I Can Quit Anytime"

Maxim W. Furek, MA, CADC, ICADC

"I tried the painkillers, but after a couple of weeks I felt like a piece of furniture. It makes you feel like you don't want to do anything. This (crack cocaine) I can quit anytime. I'm ready."
—Gil Scott-Heron (1949–2011)

In the 1983 motion picture *Scarface*, Al Pacino, portraying drug kingpin Tony Montana, thrust his face into a mountain of powdered cocaine—a scene forever etched onto our cinematic psyche. White, powdered cocaine has long been associated with the rich and powerful, those who might indulge in privileged and extravagant binges. However, crack cocaine is different; it has the reputation of being the lowest of drugs, used by pathetic crack addicts begging for more. Today, crack has incongruously and unexpectedly appealed to individuals in the highest of positions.

Toronto Mayor Rob Ford admitted he has smoked crack cocaine, but insisted he's not an addict and defiantly avowed he would stay in office and run for reelection in 2014. Speaking just days after Toronto's police chief confirmed that police recovered a copy of a video that two media organizations said shows the mayor smoking the drug, Ford admitted: "Yes I have smoked crack cocaine . . . Probably in one of my drunken stupors, probably approximately about a year ago" he told reporters outside his office (French, 2013).

The existence of the crack video was first reported in May 2013, by media blog *Gawker* and then by the *Toronto Star*. Questions were also raised about Ford's ties to alleged drug traffickers, and pitted him and his brother, also a member of Toronto city council, against Bill Blair, the city's chief of police. Police documents released later showed that Ford had been under surveillance for months as part of an investigation into the media reports about the video and other matters. More documents were expected, due to a series of court challenges by local media outlets (Martell, 2013).

Ford acknowledged the need to curb his drinking but contended that he was neither an alcoholic nor a drug addict. "No, I'm not an addict and no, I do not do drugs. I made mistakes in the past and all I can do is apologize, but it is what it is and I can't change the past," he said. "If I am an addict I could not show up to work every single day and you know I cannot miss work," he argued (Fox News, 2013).

In an eerily similar scenario, Washington, DC, Mayor Marion Barry was caught smoking crack in 1990, just another moment in his series of questionable behaviors. As observed by local media, "Barry also was seen with various women who were not his

wife, and was accused of repeatedly calling a twenty-three-year-old model, Grace Shell. The culmination of a series of embarrassing incidents was an FBI sting that caught Barry on a videotape smoking crack cocaine at the Vista Hotel with a female acquaintance" (Marchenese, Segan, & Henderson, 1998). Barry spent the next six months in jail for his crime, but remained a popular political force and was reelected mayor for a fourth term in 1994. He currently sits as a city councilor.

Crack Cocaine

Crack is a form of powdered cocaine hydrochloride that has been processed to make a rock crystal, also called "freebase cocaine," that can be smoked. Cocaine hydrochloride is dissolved and boiled in a mixture of water and ammonia or baking soda. When that cools into a solid substance, small pieces or rocks are formed. The crystal is heated to produce vapors that are absorbed into the blood stream through the lungs. The term "crack" refers to the crackling sound produced by the rock as it is heated.

One difference between powdered cocaine and crack cocaine is in the method of administration. Powdered cocaine is a water-soluble salt, which means that the drug user can snort, eat or inject it in order to get high. Freebase or crack cocaine, a cruder form of cocaine, is not water-soluble and therefore cannot be eaten or snorted. Because crack cocaine is the non-salt form of the drug and not water soluble, the only means of administration is by smoking.

The intensity and duration of cocaine's pleasurable effects depend on the way it is administered. Injecting or smoking cocaine delivers the drug rapidly into the bloodstream and brain, producing a quicker and stronger but shorter-lasting high than snorting. The high from snorting cocaine may last fifteen to thirty minutes, while the high from smoking may last five to ten minutes. In order to sustain their high, people who use cocaine often use the drug in a binge pattern—taking the drug repeatedly within a relatively short period of time, at increasingly higher doses. This practice can easily lead to addiction, a chronic relapsing disease caused by changes in the brain and characterized by uncontrollable drug-seeking no matter the consequences (NIDA, 2013).

Freebasing is extremely dangerous. The cocaine reaches the brain within seconds, resulting in a sudden and intense high. However, the euphoria quickly disappears, leaving the user with an enormous craving to freebase again and again. The user usually increases the dose and the frequency to satisfy this craving, resulting in addiction and physical debilitation (CSAP, 1994).

A brief history and overview of cocaine hydrochloride were explored in a recent article in *Psychiatric Times*: "Cocoa leaves have been used for centuries in that mountainous part of the world for extra energy, and we used them to help reduce altitude sickness. From cocoa leaves came the ingredients to make cocaine, which connect to modern psychiatry. Freud famously used cocaine for a while, and the crop is now a major source of revenue and substance abuse" (Moffic, 2013).

That kind of substance abuse radically changed in the mid-1980s, when crack cocaine began to appear in urban areas of the country. The drug became popular because it allowed dealers to stretch a cache of cocaine further and sell the produced rocks to users who could not afford to buy pure coke. *Cocaine.org* maintains that "crack cocaine is actually more powerful than powder cocaine, causes physical dependence to set in more quickly, and is far more dangerous than the powder counterpart" (2013). Powdered cocaine, pharmacologically identical to crack, is considered more mainstream and acceptable, while crack continues to bear the stigma of a poor man's drug.

That status has changed in a studied paradigm shift. According to research from Carl Hart, a Columbia University professor who studies the harmful effects of crack, most crack users are white males (like Toronto Mayor Rob Ford) and are employed. The typical crack user is no longer the inner city "crack head" of popular imagination, he said (Goldman, 2013).

Statistics of Use

Thirty-seven-year-old Florida Republican Congressman Henry "Trey" Radel, celebrity chef Nigella Lawson, and NBA basketball player and K*hloe and Lamar* reality star Lamar Odom are among the millions of individuals who have used cocaine. From 2003 to 2007, the number of cocaine users ranged from two million to 2.4 million. In 2012, 1.6 million Americans used all forms of cocaine, including crack, according to the latest statistics by the federal government's Substance Abuse and Mental Health Services Administration. Other drugs have been much more popular. During 2012, 18.9 million people used marijuana and 6.8 million abused prescription drugs (US Department of Justice Drug Enforcement Administration, 2013).

In 2012, there were 639,000 persons aged twelve or older who had used cocaine for the first time. This averages to approximately 1,800 initiates per day. This estimate was similar to the statistics for 2008 to 2011, which ranged from 623,000 to 724,000. The annual number of cocaine initiates declined from between 0.9 million or one million in 2002 through 2007 to 639,000 in 2012.

According to the 2013 National Drug Threat Assessment Survey, the trend of lower cocaine availability in the United States that began in 2007 continued in 2012 (US Department of Justice Drug Enforcement Administration, 2013). Seizures at the Southwest border and price and purity data also indicate decreased availability of cocaine. During 2012, only 7,143 kilograms of cocaine were seized, a decrease of 58 percent.

Dangerous Substances

Both cocaine and crack are dangerous substances. Len Bias, selected by the Boston Celtics as the second overall pick in the 1986 NBA Draft, died in 1986 from cardiac arrhythmia induced by a cocaine overdose. His death traumatized the collective sporting world. *Sports Illustrated* writer Jack McCallum observed: "The timing of

his death was shocking, existentially horrific. The NBA draft had been held only forty hours before he died, and Bias had been there, in New York, one of the prime attractions, the smiling Sure Thing wearing a Celtics cap. Then it all went away. The New Kid on the NBA Block was suddenly, and startlingly, the Dead Kid on the Block" (2011).

Crack, which can also cause death, nevertheless maintains an appeal that some find irresistible. The number of initiates of crack cocaine ranged from 209,000 to 353,000 from 2002 to 2008 and declined to 95,000 in 2009. The number of initiates of crack cocaine has been similar each year since 2009 (e.g., 84,000 in 2012). In 2012, 76.2 percent of the 0.6 million recent cocaine initiates were eighteen or older when they first used. The average age at first use among recent initiates aged twelve to forty-nine was twenty years old. The average age estimates have remained fairly stable since 2002 (US Department of Health and Human Services, 2012).

Psychological effects of crack abuse include depression, anxiety, schizophrenic-like behavior, hypersexuality, psychosis, paranoia and violence (Casa Palmera, 2010). Guy Heinze Jr. had been smoking crack cocaine on August 29, 2009, when he went on a bloodstained Georgia rampage, beating his father and seven others to death. Officials said that he killed his first victim in a dispute over a bottle of prescription painkillers he attempted to steal and then killed the others to avoid getting caught. In November 2013, Heinze was sentenced to life in prison with no chance of parole. Prosecutors charged Heinze with "malice murder" (Bynum, 2013).

Shifting Status

The status of crack shifts and changes yet somehow remains the same. Rocco Castoro, the editor-in-chief of Vice magazine stated "Crack is really, really potent and it never really went away. It's always been a thing in the pop culture and among celebrities" (Goldman, 2013). He continued to say that "Crack lost some of its stigma when crystal meth, an even more debilitating drug used by the poor, became popular" (Goldman, 2013). Despite its danger and sordid reputation, crack cocaine has attracted rich and famous celebrities including Charlie Sheen, Russell Brand, and the late Richard Pryor.

Pryor had the dubious recognition of being anointed "crack's poster child," having lived through the drug's horrors. While freebasing cocaine in 1980, Pryor suffered a punishment afforded only to the damned. His body was severely burned, his quality of life relegated to a place of mere presence. He survived, existing within the confines of an antiseptic smelling hospital room, an armada of health care professionals trying to bring him back from the brink:

> *Several times a day doctors and staff at the Sherman Oaks Community Hospital Burn Center in Los Angeles moved Richard Pryor into a whirlpool bath, where hot water and antiseptics washed over his body. After the bath they painted the third-degree burns covering his torso with a silver sulfa cream to fight infection. Twice a day, for up to two hours at a time, they slid the injured comedian into a 'hyperbaric chamber'—a cylinder that can triple the normal atmospheric pressure and force pure oxygen into the body to help speed healing . . . they operated to remove dead tissue from his body and fluid from his lungs.* (People, 1980).

Whitney Houston furthered the discussion by declaring that she was above crack. She was too good, too sophisticated to be smoking crack. But that was another lie, another untruth told by an addicted superstar grasping at anything that might anchor her rudderless free fall into the pit of hell. One of Houston's lowest moments was when she foolishly accepted an invitation in 2002 to be interviewed by Diane Sawyer, ABC's veteran anchor and skillful interviewer. Sawyer had little interest in discussing Houston's latest album; she was interested in exploring the rumors that Houston had been in rehab for crack addiction. A seemingly addled Houston denied that she was addicted to crack. "I'm not addicted," she said. "I have a bad habit." Houston further tried to explain, "First of all, let's get one thing straight. Crack is cheap. I make too much money for me to ever smoke crack. Let's get that straight, OK? I don't do crack. I don't do that. Crack is whack" (Crugnale, 2012).

Another popular singer, Amy Winehouse, was videotaped smoking crack in 2008. Winehouse's drug problems, initially a family affair, became a public affair after her father-in-law, Giles Fielder-Civil urged fans to boycott her music until Winehouse and her husband sought treatment for their addiction. Fielder-Civil told the BBC that he believed his son and daughter-in-law used cocaine, crack cocaine, and possibly heroin, and added: "Georgette and I both believe that they are drug addicts, and they don't believe they are. I think they believe they are recreational users of drugs, and they are in control, but it seems to Georgette and I that this isn't the case" (Corcoran, 2007).

"At the moment, they don't admit there's a problem, so we do urge other people to help them recognize their own problems," Giles said. He was also quoted by the British Broadcasting Corporation *Radio Five*: "Perhaps it's come to the point where, and I wouldn't want any harm to come to Amy or Blake, obviously, but perhaps it's time to stop buying records" (Aceshowbiz, 2007). Mr. Fielder-Civil added that Winehouse should not be eligible to win awards for her music: "This isn't a personal affront against her, but we shouldn't be condoning her addiction by rewarding her with these particular awards," he said. Winehouse had been nominated for a Mercury Music Prize, an MTV Video Music Award and four Mobo awards for

her 2006 album *Back To Black* (BBC, 2007).

Winehouse's death had an impact on an array of individuals, some critical, some forgiving. British comedian Russell Brand told *The Spectator* how the singer's death affected him: "What was so painful about Amy's death is that I know that there is something I could have done. I could have passed on to her the solution that was freely given to me. Don't pick up a drink or drug, one day at a time. It sounds so simple, it actually *is* simple, but it isn't easy—it requires incredible support and fastidious structuring. Not to mention that the whole infrastructure of abstinence-based recovery is shrouded in necessary secrecy. There are support fellowships that are easy to find and open to anyone who needs them, but they eschew promotion of any kind in order to preserve the purity of their purpose, which is for people with alcoholism and addiction to help one another stay clean and sober" (Brand, 2013). Brand regretfully admitted that he was unable to effectively communicate that advice to the troubled singer.

Gil Scott-Heron

Whitney Houston and Amy Winehouse were not the only entertainers entrapped by crack addiction. Referred to as the "Godfather of Rap" and the "black Bob Dylan," musician Gil Scott-Heron fused spoken-word poetry of politically charged themes with flute and minimalistic percussion. At the age of sixty-two he died, destitute and broken, much of his life associated with his addiction to crack. In an attempt to explain and rationalize his habit, Scott-Heron confessed in a *New Yorker* article: "'Ten to fifteen minutes of this, I don't have pain,' he said, as he lit a glass crack pipe" (Sisario, 2011). "I could have had an operation a few years ago, but there was an 8 percent chance of paralysis. I tried the painkillers, but after a couple of weeks I felt like a piece of furniture. It makes you feel like you don't want to do anything. This (crack cocaine) I can quit anytime. I'm ready" (WLS-TV, 2011).

Like Houston and Winehouse, Scott-Heron's addiction became a matter of public record. "In interviews Mr. Scott-Heron often dodged questions about drugs, but the writer of the *New Yorker* profile reported witnessing Mr. Scott-Heron's crack smoking and being so troubled by his own ravaged physical appearance that he avoided mirrors . . . That image seemed to contrast tragically with Mr. Scott-Heron's legacy as someone who had once so trenchantly mocked the psychology of addiction. 'You keep sayin' kick it, quit it, kick it, quit it!' he said in his 1971 song 'Home Is Where the Hatred Is.' 'God, did you ever try to turn your sick soul inside out so that the world could watch you die?'" (Sisario, 2011).

The world watched as Gil Scott-Heron slowly died, listened as he boasted that he could put down the crack pipe and quit his habit at any time. Scott-Heron never did. He never conquered his demons, never reached that place of sweet, blissful abstinence. He died a genius and a junkie, a station in life that he accepted, but regrettably one that defined who he had become. C

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Moms Are Key: The Importance of Reaching Out

Barbara Theodosiou

Just recently the White House Office of Drug Control Policy (ONDCP) held a conference on drug addiction policy reform. They announced a grand coalition of policy makers, law enforcement, and treatment professionals—they even included recovery organizations. The only groups not involved were parent advocacy groups.

After the conference, Duana Wilkins, the executive director of parent advocacy group The Addict's Mom (TAM), posted the following on Twitter: "Thanks to #DrugPolicyReform for the excellent conference on US Drug Policy . . . but where are the parents? Parents are integral to reform." Her tweet has been retweeted and quoted by many groups and individuals on addiction sites and social media. One of the very first to quote her was Rafael Lemaitre, the communications director of the ONDCP. Lemaitre even specified that "parents are key" in his retweet.

So, if parents—and to be specific to our organization, moms—are the key, where are they? Why aren't they involved on a greater scale? If anyone should be on policy boards, or advocating for drug addiction reform and awareness, it should be moms. Moms are on the frontlines of the drug addiction battle and they have a better view of this epidemic than anyone. So I ask again, where are they?

Reading the hundreds of messages and emails we receive daily at TAM, I can tell you where most of them are. They are in their homes, sitting silently behind closed doors, wondering, waiting, and worrying. They spend hours analyzing what they have done wrong, what to do next, and how to keep their "family secret" and "shame" a private matter. There are no step-by-step guidelines for how to help their addicted child. They blindly follow the book of "Gut Intuition," they believe they can undo their children's choices and fix their child with a Band-Aid. A mom believes her love is enough and that she can conquer this temporary setback in her child's life. She initially believes that by "just saying no" and by continuing to do what worked in the past, drug problems will go away. Due to myths and misperceptions, moms have become additional victims in this drug epidemic, and they have been ignored.

The TAM team, in reaching out to mothers lost and alone, discovered that through education our moms quickly become activists, not enablers. As our moms become educated and aware, they learn to not only "raise the bottom" for their addicted child, but to raise their own bottom as well. They soon become the ones seeking help both for themselves, as a family member of an addict, and for their children. Often it is stated that education is the key to keeping children off drugs, but it is also the key to providing stable, healthy homes while a child is going through active addiction. It is no different than the team of dedicated professionals treating a child suffering from any another chronic, life-threatening disease.

As the founder of TAM and the mother of two drug-addicted sons, I know the importance of reaching out to other mothers and sharing without shame. I have found that our experiences, our successes, and our failures bring us together as one. I know how important it is to provide information to an addict's mom, because an educated mom is an empowered mom. However, TAM cannot do this alone. We need dedicated addiction specialists, policy makers, and community leaders to reach out, educate, and involve parents—this is how positive change is fostered. We have seen mothers join our support group and speak about how they need to help their child, not realizing the enabling process that is involved. Within weeks, this same mother still loves the addict, but she now hates the addiction by denying those same enabling behaviors. This is a powerful change for moms, in treating the addiction and taking control of their own personal lives. It can take a mom several years to figure this out when she is left alone with no assistance.

After becoming educated and proactive moms, our members have discovered they are no longer willing to be drawn into the chaos and downward spirals that manifest during the disease of addiction. They have been given the tools and

the knowledge to manage their family disease, to break the damaging emotional roller coaster of addiction. More importantly, they are sharing without shame with others and educating them how to break the cycle as well. Our moms are minimizing the enabling process by choosing to be proactive instead of reactive. They are learning how to concentrate on having healthier relationships in their own lives, which brings back a sense of normalcy. These educated moms are determined to reach out and share their experiences with others who have just walked up to their own starting line. Addiction in a family is a race and it is our job as mothers to stay one step ahead.

Our members have grown into a small army of determined moms who realize they are strong, mentally healthy individuals. Our moms are no longer coming to our group just to share without shame; they are coming to demand action. TAM is opening local chapter groups throughout the United States and encouraging moms to get involved in legislation, petitions, community drug forums, and event planning. TAM is also collaborating with many other parent advocacy groups and organizations to consolidate efforts to mobilize our members and their communities into action. In September 2013, TAM created and sponsored a national event, "Lights of Hope," which was endorsed by SAMHSA, successfully uniting over twenty thousand participants. Furthermore, we are growing from a support group to a national nonprofit organization. This has all been accomplished by a small group of dedicated addict's moms.

A small growing organization, which is often misperceived as just a support group of dysfunctional mothers, has become a strong, motivated voice championing drug addiction awareness and policy reform. Now, think about what would happen if we partnered with leaders in the field of addiction. Visualize what could be achieved if moms were brought into the equation by the policy makers, law enforcement, and treatment professionals who are the main decision makers in drug addiction policy.

Tremendous benefits would be gained if empowered mothers were invited to participate as liaisons to local agencies within their communities. After all, moms are the ones who are dealing with the day-to-day processes of addiction, including dealing with the symptoms, medical care, treatment options, chaos, and oftentimes life and death situations. What better community advocate than a mom who is in the know and able reach out to others by sharing her experiences and providing support, education, and hope? TAM feels that by encouraging moms to become activists, the addiction cycle would stop much sooner. Other moms have already learned that they are not alone and there truly is someone who understands their pain. The support and knowledge learned is for everyone because we're all going through this horror together; the disease of drug addiction really can happen to any family at any time.

Utilizing moms as liaisons by including them in the network of addiction treatment professionals, asking them to serve on policy committees, and helping them work with local education boards and community groups gives the mothers of addicts a voice and brings back a sense of healthy control. For many it gives them an opportunity to make something good out of something so bad. It allows parents to become participants rather than spectators in a process the affects the family so profoundly. It also sends a strong message stating that parents aren't always the problem, but can certainly be a part of the solution in solving the epidemic of drug addiction in our nation.

This is going to require some willingness on the part of addiction treatment professionals. It takes time, effort, and determination, but the value in doing so is immeasurable. With further education and compassion focused in the proper direction, the voices of The Addict's Mom will be loud and will be heard, no longer hiding behind the stigma. When our moms are able to take the energy from their past efforts to help their child and redirect that energy toward fixing policy and legislation, the results will be astounding.

Unlike many addiction treatment professionals, law enforcement agencies, policy makers, or community action groups, TAM has additional motivation to become involved. Our moms are motivated by the greatest force of all; the love they have for their children. Our experience shows that all they need to become empowered is to share their personal experiences and gain the support of others. I can think of no better advocate for addiction than the one who has walked the path, stood by the hospital bedside, sat in the court room, nervously answered the phones, loved her child so much she told them to leave, prayed nightly for their safety, and truly learned the meaning of "One Day at a Time."

About The Addict's Mom:

The Addict's Mom provides educational resources, as well as much needed support and a safe place for members to "Share without Shame." Over twenty thousand members have joined The Addict's Mom in the past six years and the organization is taking action by helping moms get involved in legislation, signing petitions, planning events and other functions, as well as starting chapter groups nationwide. The Addict's Mom has already started a national event "Lights of Hope," which was endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA) this past September and had well over twenty thousand participants.

For more information, visit http://addictsmom.com, or visit The Addict's Mom on Facebook at www.facebook.com /addictsmom.

Barbara Theodosiou *is the founder of The Addict's Mom, a national organization dedicated to helping mothers of addicted children. She also speaks before groups and in schools on addiction and public relations. She has produced highly successful events with hundreds of attendees, featuring well-known motivational and business speakers like Senator Debbie Wasserman Schultz, Tom Antion, Stephen Pierce, Debbie Allen, Craig Duswalt, Maurice DiMino, Tracy Repchuk, and Les Brown. Barbara is a respected and sought after media guest who has appeared on many media outlets, and was named "Top 100 Outstanding Women of Broward County 2009" and was the recipient of the "2013 Behavioral Health Advocacy Award."*

A Divine Intervention

Rev. Leo Booth

"Remember to welcome strangers in your homes. There were some who did that and welcomed angels without knowing it."
—Good News Bible (Hebrews 13:2)

It's good to let people know what we are creating in our lives; especially achievements and happenings that have a spiritual flavor. In January, I coauthored a book titled *A Guide to Spiritual Awakenings*. It is doing very well, and I wanted to share a short excerpt with you.

A "divine intervention" is something that happens in your life that creates a major change in your thinking—a new understanding of your relationship with God.

Divine intervention forges a connection with the Divine that produces a change in your awareness or behavior. This change may be prompted by an idea, concept, or suggestion concerning how the Divine interacts with creation from any number of sources. You may resist this new concept at first, but a divine intervention is an undeniable encounter or experience with God that enhances what you believe, possibly changing your understanding of God forever.

A divine intervention often comes from outside your everyday experience; a personal experience of God, hearing God's voice, a message in a dream, or an encounter with an angel. The divine experience may also come through nature; contemplating a gorgeous sunset, the vista from the top of a mountain, the beauty of the desert, or the vastness of the ocean.

The divine intervention may also come from within you. You begin to look at life differently, understand a religion or philosophy differently, seek a new awareness of how God works in this world, or experience a moment of transition into a new idea.

Having a Momentous Experience

A divine intervention affects everything because it changes how you view and understand life. It is such a momentous experience that nothing is the same afterwards.

A divine intervention:

- Alters your relationship with God and the Divine
- Creates a spiritual awakening that enhances your understanding of others; family, friends, associates, strangers, and people from other lands
- Changes your understanding of who you are, often leading to a holistic perspective of self
- Allows your body, the physicality of your being, to become an agent of the Divine. The flesh is no longer considered sinful or blemished, but a manifestation of God
- Allows your brain, the engine of the mind, to become a creative partner with God, enabling new discoveries in art, science, and medicine
- Allows your emotions to reflect the essence of God's love, healing past relationships that have been challenged by toxic experiences or unhealthy teachings

The body, brain, and emotions come together to demonstrate the divine nature of being human—the essence of God.

A divine intervention is generally perceived in a single moment in time, a definite experience on a certain day, in a particular year. However, a divine intervention is also

an ongoing process—one that's been happening from the beginning of time. Divine interventions combine to reinforce the history of God's long and creative relationship with humans on this planet.

An Angel Called Teddy

One of the most delightful divine interventions involves Jasmine and her teddy bear called Teddy. God has used angels from the beginning of time to minister and act as intermediaries, delivering messages to Abraham, Jacob, Moses, Elijah, Daniel, Mary, Joseph, Muhammad, and many more. In Jasmine's story, an angel uses her teddy bear to deliver a powerful message:

Angel: "No. God is not angry. He sent me to you. He cares about you. He also loves Teddy. That's why He is using Teddy as an instrument to bring you peace and joy."

Jasmine: "Yes. The room does feel peaceful. I hear your gentle voice in the silence of my mind. It's all so peaceful."

Angel: "Jasmine. I want you to know something. God is love. He is pure love."

Jasmine: "Not if you're a sinner. I've heard what happens if you do bad things. He can punish you forever. I remember hearing that He even punished His son for my sins. Everyone's sin. The preacher said this nearly every week."

Angel: "Well, the preacher is wrong. God loves you. God loves the people in the church. He also loves the people in the synagogue, in the mosque, in the temple, the people who live on the streets, and the people who don't believe in Him because of people like your preacher. God is on everyone's side. This important message got lost in translation for many reasons that we don't need to discuss now, but the preacher is wrong. Punishment does not exist in the heart of God. God's love is what you experience from Teddy."

Alcoholics Anonymous

Sometimes you understand a divine intervention through a suggestion or idea given to you by someone else. Millions of people can attest to the transformative power of the program called Alcoholics Anonymous (AA).

The classic example is an alcoholic who felt powerless for years, knowing that tragedy follows each time he takes that first drink. Finally, he realizes that if he doesn't pick up that first drink then the craving will eventually cease.

The alcoholic suddenly finds himself able to control his desire for alcohol.

The background to this story, indeed the foundation to the philosophy expressed in Alcoholics Anonymous, involves men with a drinking problem helping those who were drunk; one sober alcoholic helping an alcoholic still drinking.

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Spring Cleaning for Wellness and Recovery

John Newport, PhD

As a writer, I am well aware of my tendency to let clutter accumulate on my desk and throughout the rest of my office. Generally I postpone clearing off my desk until the fire department declares my office a fire hazard!

By coincidence, as I type this column I am in the midst of unpacking the piles of boxes from our most recent move, clearing off my desk, reorganizing, and decluttering my office. This is truly a gargantuan task which, much to my wife's chagrin, I have put off for the past eighteen months through sheer procrastination. I rationalize that as a creative spirit I find my writing, various community activist projects, and just soaking up the sun to be much more fun and "productive" than rolling up my sleeves and tackling the more mundane aspects of contributing to making our home a truly inviting and relaxing abode.

Adhering to an honored tradition among writers to advise readers to "do as I say, not as I do," I firmly believe there is both a practical and spiritual side to the annual ritual of spring cleaning. Indeed, the act of directing focused attention to cleaning out the clutter in our living space seems to inspire us to focus on letting go of the excess baggage we have been carrying around in both our heads and hearts for far too long a time.

For those of us in recovery—and we're all in recovery from something—I believe the spring season provides an ideal opportunity to take inventory and do a bit of "spring cleaning" in regard to both our thought patterns and behaviors, as they impact our prospects for enjoying a truly fulfilling life in recovery. Below are some suggestions you may wish to consider.

Nutritional Spring Cleaning

It is a well-known fact that the typical American puts on five to seven pounds during the holiday season. What is not so well-known is that this amounts to a net average gain of one and a half pounds each year, reflecting excess poundage that is not taken off. While at first glance this may seem like no big deal, consider the following. If you begin this pattern at age eighteen, by your thirty-eighth birthday you will have put on thirty extra pounds. By the time you reach age forty-eight you will have experienced a total weight gain of forty-five pounds—enough to place you in the obese category with its attendant risks associated with type 2 diabetes, heart disease, and a variety of other unpleasant ailments. By the way, you'll be in good company here as a full one-third of adult Americans are considered obese. The solution is to make an earnest, immediate commitment to cut back a bit on the calories while concurrently increasing your level of physical activity.

Fitness Spring Cleaning

Give yourself a fitness tune-up! Every spring I take my '89 Toyota Camry in for a tune-up, or at least an oil change. Is this working? All I know is that I am now the proud owner of a "classic Camry" with 330,000 miles on the odometer. I've also saved tons of money, unlike my friends who slack off on the maintenance and trade their cars in every couple of years.

That being said, it is sad but true that we take better care of our cars than our own bodies. Why not step out into the fresh spring air and treat yourself to a fitness tune-up? Of course this goes hand in hand with the above recommended weight loss clean-up. Ask yourself—or

better still, your spouse or your best friend—am I truly giving my body the daily exercise that it needs and deserves in order to promote optimal health and wellbeing?

This is not rocket science. You simply need to adopt a form of exercise that you will enjoy, otherwise you won't stay with it, and commit to devoting the next month or two to building up to a thirty-minute exercise session that you will engage in at least five times a week. Make this a fun part of your daily routine!

Addiction Spring Cleaning

Take a good hard look at your nicotine addiction and substitute addictions. As I discuss in my book, *The Wellness-Recovery Connection*, between 70 to 85 percent of practicing alcoholics and addicts are also addicted to nicotine. Many, perhaps the majority, are heavy smokers and the majority of this group carries their nicotine addiction over into their recovery. In truth, nicotine addiction is the leading cause of death among people in recovery.

If you have tried to quit on numerous occasions only to relapse, don't despair; you're in good company, including yours truly. Persistence pays! For immediate state-of-the-art assistance in kicking the habit, do a Google search for the free Stop Smoking Quit Line serving your area. These Quit Lines are generally offered in affiliation with state health departments. You can also visit www.smokefree.gov for information and tips on quitting.

Now is also a good time to take inventory concerning where you stand in regard to dangerous substitute addictions that can undermine your prospects of enjoying a high quality life in recovery. Substitute addictions include eating disorders—including anorexia, bulimia, and just plain over-eating—sexual addictions, gambling addiction, and compulsive workaholism, to name a few. Identify the substitute addictions that are prominent in your life and seek skilled help in conquering them. If you are in doubt as to whether a particular substitute addiction applies to you, talk this over with a trusted addictions counselor, your primary physician or another trusted health advisor.

Spiritual Spring Cleaning

This is, in my opinion, the most important aspect of our spring cleaning for wellness and recovery. We need to block aside the time to ask ourselves: What grudges and resentments toward others am I still clinging to, and what other self-defeating attitudes and behaviors am I carrying that are holding me back from experiencing a truly rich and rewarding life in recovery? After taking inventory, we then need to identify which of these spiritual "skeletons in the closet" we are willing to tackle at this point, and implement appropriate action to release this baggage. By all means seek out help in conquering these demons—particularly valuable sources of help can include a trusted sponsor, clergy-person, addictions counselor or therapist, together with a trusted partner and/or friend who will not reinforce your natural tendency to rationalize holding on to this spiritual baggage.

The following example from my own experience may be of help. As a writer, counselor, and addictions professional, I am painfully aware of my inclination to be extremely critical toward both myself and others around me. A few years back, the priest at the church my wife and I attend recommended that for Lent we choose to give up a persistent negative behavior or thought pattern that we would like to be free of. Aware of the critical side of my nature, I wrote down on a card "I am releasing my critical tendencies and replacing them with compassion and appreciation." I added this to my affirmation cards, which I review at the beginning of each day.

In closing, I hope this column has stimulated you to undertake your own spring cleaning for wellness and recovery. I would be pleased to hear of your undertakings in this area, and can be reached at drjohnwellness@hotmail.com.

Until next time—to your health!

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The Year of the Horse

Sheri Laine, LAc, Dipl. Ac

Happy belated Chinese New Year! The Year of the Horse began on January 31, 2014.

Ancient Chinese legend tells us that at the start of the New Year, Buddha invited all the animals to a party. Twelve animals attended, so he named each year for one of the animals. Each person born in that particular year is thought to share similar personality traits that that animal.

Those people lucky enough to be born in the Year of the Horse tend to be skillful with money, cheerful, perceptive, talented, and very good at creating with their hands. The horse is a favorite animal of the Chinese. Horses, after all, were the mode of transportation before automobiles; they are not only the symbol for traveling, but also a sign of speedy success and nobility.

When trained, Horses do well in all of life's pursuits. They are naturally lucky when it comes to careers and resources. However, without training, Horses are thought to be wild and will lack destination.

Horses are competitive, trustworthy, and very social. They love to strut their stuff—think of show horses prancing in the ring, or race horses parading in the paddock. Individuals born in the Year of the Horse are said to care about how they dress and speak.

Horses belong in the "fire" group of the five elements. Fire is connected to heat, hot, and red. Red is related to love; the horse is treated as the romantic star in the Chinese horoscope. Red is also associated with fire, which is thought to drive away bad luck. Interestingly, in Feng Shui, it is considered a wise choice to incorporate shades of reds, pinks, or other warm skin tones in the bedroom to stimulate romance and sensual energy.

This year symbolizes fast action and the readiness to be alert in one's life. In order to succeed, it is imperative that our physical, mental, and spiritual house is in order. We need to use this time to be the best we can be by choosing to eat the healthiest of meals, keeping fitness levels a top priority, getting enough sleep, and taking care of our mind and spirit. By taking lifestyle goals seriously each and every day, we create success and happiness in our lives and the lives of others who share our presence.

Big breakthroughs are available to all during the Year of the Horse. If there is something you have been thinking about doing, being, or having in your life, now is a great time to push those thoughts into reality.

Acupuncture treatments are one effective way to support yourself in the pursuit of change. Acupuncture needles conduct electromagnetic energy waves within the body via meridians that form invisible nets inside and outside of the body. These magnetic currents carry with them blood, oxygen, and *Qi* or life force, which change and recharge our systems.

Following an acupuncture regimen, our ability to act is enhanced, our thinking becomes clearer, and answers to cloudy questions become more accessible. Wellbeing is greatly enhanced, as is our general energy.

Return to nature this year. Spend as much time as possible enjoying the great outdoors in all its beauty and splendor. Using nature as a place to meditate can be very restorative to our spirits. Find your spot in the sun and allow yourself some time to go within this year.

Follow the light to your dreams.

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Mentorship, Part II: When Heroes Fall

David J. Powell, PhD

In the last issue of *Counselor*, I wrote about mentorship and urged individuals to mentor the next generation of leaders in the field. People entering the field need to find mentors they admire and ask to be mentored by them. However, all of us are human and occasionally fall from grace. This article will explore what happens when heroes fall.

We've seen it in politics when senators, mayors, and presidents make regrettable mistakes and are skewered in the press. When religious and spiritual leaders fail, we quickly dethrone them, though many are resurrected after a brief period of penance. Corporate leaders do stupid things, though they rarely are returned to their former throne. We are all human and make mistakes. Mentors eventually will say or do something that will astonish a mentee, calling into question the prior knowledge and wisdom imparted.

The movie "Bill W." portrays both the icon he was to alcoholics as well as the man, who was not above human distractions and errors. Sheldon Kopp's book, *If You Meet the Buddha on the Road, Kill Him*, cautioned patients that therapists do not, and cannot, give answers (1982). Counselors are not gurus, not Buddhas. They are just other human beings struggling to learn how to live, just like the patient. A book by Ernest Kurtz and Katharine Ketcham, *The Spirituality of Imperfection*, reminds us that no one is perfect (1993). This is such a simple but profound truth and is the first step toward understanding the human condition. When we deny our essential imperfection we deny ourselves and our own humanity. The spirituality of imperfection is rooted in the rich traditions of the Hebrew prophets, Greek thinkers, Buddhist sages, and Christian disciples. As the songwriter Leonard Cohen says, "There's a crack in everything, that's how the light gets in" (1992).

In mentors, there are cracks too; that's how the light gets in and goes out. As humans we tend to put people on pedestals, then either the person on the pedestal dethrones themselves by making egregious mistakes or we inevitably feel the need to dethrone them, to bring them down closer to our size. Our usual process begins with a man, or woman, with a message. They start a movement and eventually we build monuments to them. Even monuments can be thrown down. Recall the image seared into our minds of Saddam Hussein's statue toppled in Baghdad.

What's this got to do with mentorship? Mentors, be human. You'll make mistakes. Two of the best phrases I have learned in life are "I don't know, what do you think?" and "I could be wrong." I have made many mistakes as a mentor, none more memorable than a recent mentor-mentee relationship with a trusted protégé. After two days of training together, he asked for feedback on how he was doing. I foolishly was brutally frank and said words that were burned into his mind and my memory. After teaching a class about giving constructive feedback in supervision, I did just the opposite with him. It was a classic example of how *not* to give feedback. I was justifiably dethroned in his eyes. I gave the excuse that I was tired and apologized profusely afterward, but the damage was done. I only hope to this day that he was able to see that revered mentors make mistakes and are human. We sometimes say and do stupid things!

Mentees, allow your mentors to be flawed. Do not put them up too high on a pedestal lest you, or they, feel the need to be dethroned. In fact, look for their mistakes as that is where you will find their greatest wisdom and experience. How have they benefited from the mistakes they have made in life? Ask them, "If you could do it over again, what would you do differently?" If they falter, watch how they pick themselves up again and recover. It is not how you fall that matters, it is how you get up and stand again.

In the book *Bad Therapy*, authors Kottler and Carson ask master clinicians about mistakes they made in therapy over time (2002). William Glasser, the author of *Reality Therapy*, writes that he has made so many mistakes that he doesn't know where to begin (1975). All great leaders and mentors have been imperfect. One of my heroes was Henri Nouwen, the Yale theologian and noted author who struggled throughout his life with depression, contemplating suicide at times. Educator and author Parker Palmer writes eloquently, in his book *Let Your Life Speak*, of his life-long struggles with depression (1999). We are all flawed, even our heroes. That's how the light gets in.

As I look back on my nearly fifty-year-long career, there are many things I'd like to do over again, in the light of what I now know. I would like a do-over in certain aspects of my life. Unfortunately, life is like learning a song. You learn the lyrics and the tune. But, unlike a song, you usually cannot "sing the tune over again." Soren Kierkegaard, the Danish philosopher and theologian, wrote "We live life forward and understand it backwards."

When seeking a mentor, do not look for perfection in that person. Look for someone who is authentic, can laugh at themselves, is human and humble, and does not wish to be put on a pedestal. When being a mentor, be real, with all of your flaws.

David Whyte has a wonderful poem, "The Faces at Braga," that describes these flaws in us (1990).

In monastery darkness by the light of one flashlight the old shrine room waits in silence

While above the door we see the terrible figure, fierce eyes demanding, "Will you step through?"

And the old monk leads us, bent back nudging blackness prayer beads in the hand that beckons.

We light the butter lamps and bow, eyes blinking in the pungent smoke, look up without a word,

see faces in meditation, a hundred faces carved above, eye lines wrinkled in the hand held light.

Such love in solid wood! Taken from the hillsides and carved in silence they have the vibrant stillness of those who made them.

Engulfed by the past they have been neglected, but through smoke and darkness they are like the flowers

we have seen growing through the dust of eroded slopes, then slowly opening faces turned toward the mountain.

Carved in devotion their eyes have softened through age and their mouths curve through delight of the carver's hand.

If only our own faces would allow the invisible carver's hand to bring the deep grain of love to the surface.

If only we knew as the carver knew, how the flaws in the wood led his searching chisel to the very core,

we would smile, too and not need faces immobilized by fear and the weight of things undone.

When we fight with our failing we ignore the entrance to the shrine itself and wrestle with the guardian, fierce figure on the side of good.

And as we fight our eyes are hooded with grief and our mouths are dry with pain.

If only we could give ourselves to the blows of the carver's hands, the lines in our faces would be the trace lines of rivers

feeding the sea where voices meet, praising the features of the mountain and the cloud and the sky.

Our faces would fall away until we, growing younger toward death every day, would gather all our flaws in celebration

to merge with them perfectly, impossibly, wedded to our essence, full of silence from the carver's hands.

–David Whyte, *Where Many Rivers Meet* C

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.*

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Individualize Treatment, *Really* Individualize It

Michael J. Taleff, PhD, CSAC, MAC

I rarely get the opportunity to introduce a MacArthur Foundation award recipient. Her name is Susan Murphy, she is a statistician, and she is making a definite impact on addiction treatment.

She has created a set of statistical methods to promote better clinical treatment decisions. These methods do not merely center on making a single decision about what treatment will be used in a program; that is the traditional approach, and it often begins and ends with a selected intervention in an established program format. Murphy's methods include a format for making a sequence of decisions over a period of time. Clinical interventions are measured and adjusted several times within a certain time period. The ultimate goal is to provide personalized treatment for the client that will produce better outcomes.

Brief Overview

In this month's column we will review two of these new processes. One is called "adaptive intervention" (AI) and the other called "sequential multiple assignment randomized trials" (SMART). These methods are specifically designed to make clinical decisions or evaluate the course of treatment for individuals who, in our case, have chronic addiction problems. These decisions select the best course of action based on how a client is doing at certain points in treatment. It's like having your hand on the pulse of a client's behavior and depending on the pulse making treatment adjustments accordingly.

There are some new terms to understand, so we will only address the basics and provide some diagrams courtesy of Dr. Murphy and her colleagues. Since this is just an introduction to her models, we will dispense with the statistics.

Adaptive Intervention: The Basics

While there has been a history of individualizing treatment based on the notion that clients differ in their response to interventions (Lei, Nabun-Shani, Lynch, Oslin, & Murphy, 2012), Murphy has raised the bar with a formal, more prescribed model designed to improve clinical decisions and achieve better outcomes. In our case, it evaluates the course of treatment for individuals coping with substance abuse, but it can also be applied to issues such as depression and obesity (Murphy, Collins, & Rush, 2007a; Murphy, Lynch, Oslin, McKay, & TenHave, 2007b). With AI, clinicians can assess whether they should continue with the treatment they started, enhance it with additional interventions, increase the intensity of treatment, switch to a different type of treatment, or step-down the interventions at critical points in treatment (Almirall, Nahum-Shani, Sherwood, & Murphy, 2013). It is essentially a way to fine-tune treatment to a client's response with a particular intervention, do it on the run, and do it over a specific treatment period.

There are generally four parts to an AI (Almirall et al., 2013; Lei et al., 2012; Murphy et al., 2007b):

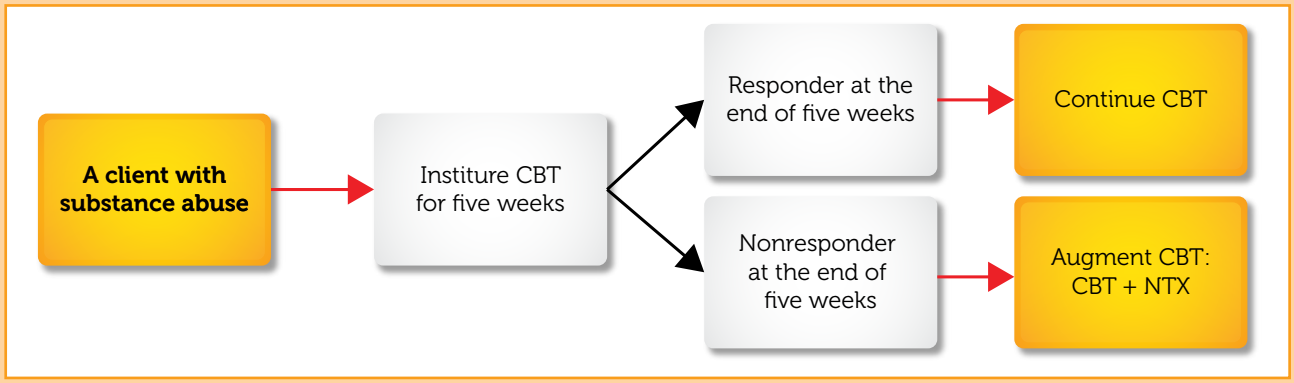
Critical Decisions

These are points about which counseling interventions you might provide first, and if such interventions don't work, what to provide second. For example, a first-line treatment for someone who has few comorbid issues, and has a history of being counseling compliant might be a cognitive behavioral therapy (CBT) approach. This could be instituted for five weekly sessions in an outpatient program (see Figure 1).

Treatment or Intervention Options

At each decision point, you will need some other treatment selections. Those options might include different counseling approaches, different modes

FIGURE 1. ADAPTIVE INTERVENTION EXAMPLE



of delivery, or different combination of interventions. For figure 1, that other option will be naltrexone, but it could be any other empirically-based treatment.

Tailoring Variables

Here you will try to pinpoint what intervention should be altered based on the client's response to it, and which intervention is the best for whom. Think of "tailoring variables" as the client's response or nonresponse to a particular intervention. As in our example, if a client does not do well with CBT, that would be the client's response or tailoring variable.

Decision Rule

These are a sequence of decision rules. There is one rule per critical decision. This decision links the client's ongoing performance with options and recommendations. Think of it as guide that outputs a new intervention, or says stay with what you have (Lei et al., 2012). For example, if the client is doing well with CBT, the decision rule would be to continue with CBT as no change is needed. If the client is not doing well with CBT, then the decision rule would be to augment it with naltrexone or any other empirically-based treatment.

The first red arrow is a critical decision point or first-line treatment. The second red arrows are second-line treatments with two different tactical options. Treatment options are other intervention options that might include motivational interviewing (MI), a Twelve Step approach, or in this case naltrexone (NTX). The tailoring variable is the client input, or response/nonresponse, at the end of week five. The decision rule links a client's performance with intervention options, like continue CBT or augment it with NTX.

Visualize the whole AI as a decision-making process that helps you decide when and how treatment should be modified. AI involves adapting and readapting treatment for the client, not just instituting one method of treatment or varying slightly from that method.

Sequential Multiple Assignment Randomized Trials (SMART)

At first glance, SMART looks daunting. Just try to grasp the concepts. Should you decide to try an AI, keep in mind that SMART is the research arm that aims to improve the quality of AIs or clinical decisions. SMART is presented simply to see how this research arm is accomplished. While SMART is primarily for researchers, understanding its basic functions is still useful.

While the capabilities of adaptive interventions are good, they still need a little help making solid clinical decisions. That's where SMART comes in. A sequential multiple assignment randomized trial is designed to inform and give high-quality data to the AI decisions.

Recall that standard clinical trials are a one-shot affair—institute treatment A, observe results B. SMART, on the other

hand, is a clinical trial that lasts several months. It incorporates randomization at certain decision points to diminish bias, and refines adaptive treatments a number of times to see what happens following each decision point (Murphy et al., 2007b). This is where it is a little different from standard clinical trials. SMART observes the effectiveness of certain treatments not just once, but many times. Then, based on the outcomes of a SMART, you can transfer findings to specific clinical decisions.

Essentially, you first gather a group of subjects as you would in any clinical trial. You then administer a drug, or in our case a therapy, to that group and observe the effects. In SMART, if there is no response from the group, you randomize the group, administer other therapies, and observe again. This is where SMART stands out. It changes treatment many times, not just once.

A hypothetical SMART is presented below (Chakroborty & Murphy, 2013). It looks somewhat the same as the AI example, but this SMART is a clinical trial, conducted over long periods and incorporating a randomization process, as would occur in any good clinical trial.

To be classified as a responder or a nonresponder to the initial treatment intervention requires nonresponders to experience more than two heavy drinking days during a two-month period. Again, differences from AI and this SMART are the randomization process, and also that the SMART runs over long periods of time, sometimes months.

Data from the SMART rigorously evaluates the effectiveness of the AI. It can estimate an optimal AI, which in real situations can lead to a maximum number of nondrinking for drug using days.

Summing Up

This was a very basic introduction to AI and SMART. It didn't include some fairly rigorous statistical analysis that can be associated with these processes. I just wanted to familiarize you with this important work—it is quite frankly some of the most exciting stuff to hit the addiction field in a long time. It points to our future and the powerful need to understand research and statistics as it applies to everyday clinical work. Essentially, Dr. Murphy is applying statistics directly to everyday clinical decision-making.

Improved precision and individualizing of clinical decisions comes from the AI approach. There is diminishing room for guess work, hunches, or gut feelings by utilizing AI. Guess work, hunches, and gut feelings are fraught with bias, and bias makes for poor treatment. The precision that comes from utilizing AI will change the way we do treatment.

There is lot more to learn, but if this arouses your curiosity at all, please use the references below to dive deeper into this fascinating subject.

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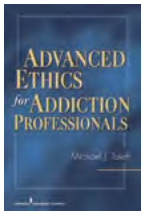

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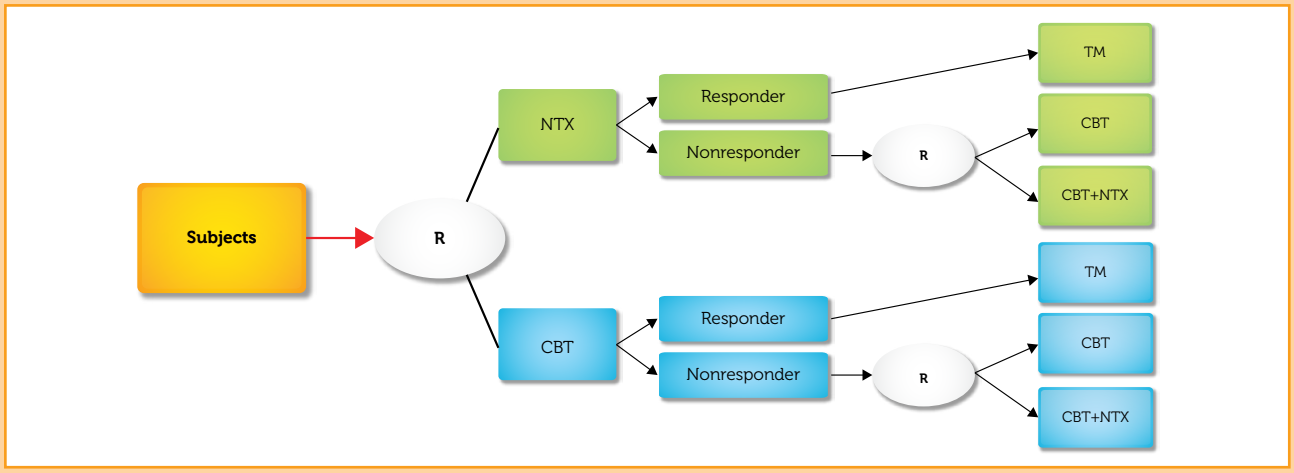
FIGURE 2. HYPOTHETICAL SMART



Abbreviations: NTX = naltrexone CBT = cognitive behavioral therapy TM = telephone monitoring R = randomization Initial two treatments = green CBT = blue.

Adolescent Substance Abuse, Violence, and Poverty

Fred J. Dyer, MA, CADC

The study of adolescent substance use, violence, and poverty has an ecological basis—that is, the causes and risks are multidetermined and multifactorial. While many adhere to a genetic etiology for substance use, the genotype develops within a phenotype and is influenced by the surrounding and immediate systems. Interestingly, substance use, violence, and poverty connect and are interrelated. Hawkins, Catalano, and Miller (1992) provide and delineate seventeen risk factors for adolescent substance use, one of which is extreme economic deprivation. Furthermore, it is not difficult to generalize about how family dynamics—associated with family alcohol and drug use patterns and behavior—can serve as modeling for at-risk behavior for adolescents

To understand the relationship among adolescent substance use, violence, and poverty, one must understand the risk factors and the corresponding motivation for adolescent substance use. For centuries, it has been known that people living in poverty, regardless of race or ethnicity, have the poorest health (Krieger, 1993; Adler et al., 1994; Yen & Syme, 1999). It is no surprise then that poverty is also linked to poor mental health and to the initiation into increased substance use.

From a public health perspective, there are two types of poverty. The first is relative poverty, referred to as the working poor, where individuals do not have the money to take care of their basic needs, possibly only rent or a mortgage. The second type is abject poverty, or homelessness. Poverty limits choices and opportunities; it affects self-esteem, self-concept, and causes individuals to make choices they would not otherwise make.

It is necessary for those working with adolescents to understand the adolescent's affective response to poverty. Accordingly, Green (1993) espouses three affective responses. The first is rage. Young people growing up in poverty and around violence are very angry about what feels like everyone's inattention to their plight. Even though most become accustomed to their surroundings, they remain aware that violence can erupt around them at any time and know that, at the slightest deliberate or inadvertent expression, gesture, or word, they can be shot or stabbed. This leaves them with a constant edginess.

The second response is distrust. Trust derives from supportive, intimate relationships with parents, peers, and other adults. Further, chronic cumulative trauma, either within the family or in the neighborhood, impairs the establishment of interpersonal trust. Some researchers believe that the most common characteristic of youth exposed to poverty and violence is the virtual absence of any ongoing, supportive, intimate relationships—not with parents, not with teachers, not with peers, and not with adults in the neighborhood.

The third response is hopelessness. Teenagers growing up in poverty and

around violence frequently question whether they will survive into adulthood.

Given the affective responses to poverty by adolescents, it is not a big leap to observe how substance use might be used as a coping mechanism, along with a peer motive. Poverty in the United States is concentrated in urban and rural areas (Herbers, 1986). The relationship between poverty and violence in poor neighborhoods and communities is not a complicated one. Poor neighborhoods and communities have few resources and suffer from considerable distress and disadvantage, in terms of high unemployment rates, homelessness, substance abuse, and crime (US Department of Health and Human Services, 2002). Some adolescents may respond to their condition of poverty by using alcohol and/or drugs to change their mood. The use of these mood-altering substances is associated with aggression and can trigger aggressiveness in the adolescent user, who may not be aware of this association.

Although violent behavior may be associated with the use of any drug (Parker & Auerhahn, 1998), certain substances appear to be more commonly aggression stimulating than others—alcohol, Phencyclidine (PCP), amphetamines, sedatives, hypnotics, and cocaine. Cohen (1985) succinctly describes the mechanisms for drug-violence interactions. Some of his conclusions are:

- Specific actions of particular drugs may involve belligerence and hostility.
- Drug-induced aggression varies by dosage.
- The set and setting of the drug modifies and can even overwhelm the pharmacologic effect of the substance.

There are a number of pathways that drug-induced violence might take, for example. The drug might diminish ego controls and release submerged anger; impair judgment; induce restlessness, irritability, and impulsiveness; or produce a paranoid thought disorder. In addition, an intoxication or delirious state might result in combativeness, hyperactivity, or violence; a user's drug-induced feelings of omnipotence and bravado may promote dangerous behavior; or unpredictable and uncharacteristic behavior may be associated with amnesic and fugue states (Potter-Efron, Potter-Efron, & Carruth, 1990).

The association between adolescent violence and poverty can also be explained through brain development. Studies reveal that the brain does not fully mature until age twenty-five or twenty-six, and this maturation is embryologically from the bottom up and the inside out. The limbic system of the brain focuses on affective regulation, and the prefrontal lobe focuses on prioritizing, discernment, executive functioning, and planning. Metaphorically thinking of the human brain as a car, the limbic system represents gasoline, and the prefrontal lobe represents the brakes. The challenge is to assist the adolescent in regulating his or her affect to engage in prosocial affective regulation, along with developing alternative thinking skills to whatever negative situations or circumstances he or she is confronting. The adolescent must have positive, pro-social adults in his or her life, who can provide emotional corrective experiences that help facilitate resiliency. It is vital for those working with adolescents to not only attend to their substance use but also to connect to their familial, here-and-now needs as well. This is where partnerships and collaboration with other agencies and services—mentoring programs, after-school programs, drug and alcohol prevention programs, SAP programs, faith-based services, healthy choices/smart choices programs—can assist in diminishing this threat to youth who face, and who may succumb to, poverty and its devastating consequences. We know that adolescent drug use is often about being connected to peers and escaping the negative effects of poverty. We also know that substance use does not accomplish any long-term, prosocial adaptive results for managing future negative situations.

Bob Dylan, in one of his greatest rock hits (1965), had this to say, "When you ain't got nuthin' you got nuthin' to lose." In fact, adolescents who succumb to alcohol and drugs to cope with whatever conditions they face end up losing. Our job as youth advocates, professionals, and those who want to see kids excel is to make sure that prevention and treatment practices are comprehensive, collaborative, individualized, primary, and family-focused.

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Ask the LifeQuake Doctor

Dr. Toni Galardi

March is such an interesting month in that for most of the country it is a transition month between winter and spring. As we move into spring, you might want to ask yourself what has been dormant and wanting to emerge as a new part of yourself. All change requires a bit of chaos where things have to deconstruct before they reconstruct into a new form. How are you dealing with the chaos in your life?

Dear Dr. Toni:

I was discharged from my previous therapist because I concealed certain information from her. I read your column sometimes while waiting in her office. I don't know what to do, so I am writing you. I am a forty-three-year-old married woman with two children. My husband and I have been married for twenty years, but I have been unhappy and unfulfilled on our marriage for at least five of those years. He works long hours, makes very good money, and when he is not working he is obsessed with parenting our children. Last summer I became close to a man in our community who is also married with children. We have been having an affair for four months. I sent him to see my therapist and both of us concealed that he was having an affair with me. He says he cannot leave his children but he loves me very much.

My husband is begging me to give him another chance. Our kids know we are having problems and my teenage daughter is begging me not to leave their father and break up our family.

What should I do? Thanks for any feedback you can give me.

–Desperate and Confused

Dear Reader:

You have been married most of your adult life. The prospect of being on your own and breaking up your family is a huge

thing to consider, especially when there are children. If you add the potential break up of another family, this could be seismic. Many lives are being affected by the choices you are making now.

Ask yourself honestly, would you be leaving your husband if the other man was not in the picture? Are you comparing the rush and excitement of an affair with the everyday routine that comes with marriage? You say that you were in therapy and your lover was seeing the same therapist. Have you and your husband attempted to resolve the issues of intimacy with a marriage counselor?

The true test of whether you are leaving for the right reasons will be if you choose to go out on your own regardless of your lover's choices. If you can do that, here are two alternatives I would suggest:

See a new therapist and focus on personal fulfillment. If your children are growing up, perhaps it is time to discover a new vocation and purpose for your life. Do some soul searching. Delve into your part of why the marriage failed as well.

Once you are on your own for awhile, if you continue to see the married man, refrain from being exclusive with him. Open yourself up to dating others. It will help with the love addiction you might have with him.

Lastly, move into transparency. Lying to your therapist and your husband about this affair will promote a habit of continuing to lie. Of all things, tell the truth to yourself, get quiet every morning, and ask your higher wisdom to show you how to move forward in your evolution. You will trust yourself and the course that your life is taking much more if you do.

Dear Dr. Toni:

I moved to a new community with my husband and son five years ago. It has been difficult to adjust to the new community. I was an executive recruiter, but I am not working now and have too much time on my hands. I have been drinking every afternoon before my husband comes home. This is a new behavior for me.

To make matters worse, when I did reach out to a group of women at this small exclusive gym I belong to, I was ostracized. The women who go to this gym are upper middle class, mostly blonde, and extremely well toned. I come from the east coast. I am probably thirty pounds overweight. I feel judged by them and excluded. What should I do to make more friends? I love to dance and like those classes at the gym.

–Lonely

Dear Reader:

Clearly, your life lacks a purpose and you are filling this emptiness with alcohol. Quit the gym you are at and do some research. If you are only going to the dance classes, go check out dance classes in your community and see which ones resonate. I would also research other gyms to find one that feels the most comfortable to you.

Lastly, I would suggest looking into some career counseling on what might be emerging as a new passion or vocation of destiny. For someone who does not have a history of alcoholism, an onset of alcohol dependence may be due to feeling a lack of engagement with fulfilling work. It is difficult to adjust to a new location and sometimes a job or becoming an entrepreneur may help with assimilating into your new community.

Good luck!

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.*

SPECIAL INTERVIEW WITH REID WILSON, PHD, & LYNN LYONS, LICSW, ON *ANXIOUS KIDS, ANXIOUS PARENTS*

ROBERT J. ACKERMAN, PHD, AND LEAH HONARBAKHSH

ANXIOUS KIDS, ANXIOUS PARENTS is an essential guidebook for parents who have children with anxiety disorders. The book aims to help parents identify worried and avoidant behavior, encourage change, and facilitate resilience in their children. *Anxious Kids* begins by explaining the useful and appropriate times to worry—the fight or flight response—and continues to explore issues such as anxiety in a parent, the importance of flexibility in life, how to not get overinvolved, and how to tackle bad behaviors that occur as a result of anxiety. In addition, each chapter includes a section titled "Time to Take Action," which provides parents with useful, step-by-step methods for developing the necessary skills to help their anxious child. *Counselor* editor Dr. Robert J. Ackerman spoke with authors Reid Wilson, PhD, and Lynn Lyons, LICSW, about the book and their work with anxiety disorders.

Dr. Ackerman: First of all, I would like to congratulate both of you on your book and particularly on the quality of it. I enjoyed the tips you provide for parents; it's a great feature and it really brought the message home for me. Let me start by asking you this: Do you think kids are more anxious today than when we were kids?

Dr. Wilson: Yes. I don't think there are more anxiety disorders necessarily, but I think that greater stimulus is around today. The noise, the video games, the hovering parents who convey fear into the kids . . . all of that contributes to it.

Lynn: I get asked that question a lot. I think the obvious answer, as Reid stated, is "yes." If you look at the statistics, it used to be that twenty kids would get diagnosed with anxiety disorder and now we're looking at about one in eight kids—some research even states that it's as high as one in five kids. I think there's probably more awareness about it now, but I think that kids and adults have been anxious for a long time and it was just handled differently.

The level of anxiety has increased in families for a few reasons. One reason is that there's so much more information and so much more awareness of things to be anxious about. So, I think that if you tended to be a worrier twenty years ago, you could keep it in check a little bit. Bad things still happened, but they weren't so in-your-face. Since I've been a parent, the last fifteen years, the amount of information that we get about all the bad things that could possibly happen is just so much greater than it used to be. You worried before, but I think that now you have a lot more to really sink your teeth into.

Worry loves a great imagination and with all the news and the constant deluge of information we have now, the imagination really gets to take over.

Dr. Ackerman: Speaking of the "hovering parent," or the "helicopter parent" that Reid mentioned, do you think parents are more anxious today than perhaps in our day?

Dr. Wilson: Well, I don't know if you remember, but in our day kids used to sit in the lap of their parent while they were driving the car! You were also sent out the back door to play, and you would come back in at supper time. Your parents might be mad if you were late, but it wasn't about "where have you been?" I think we're such a global village now that we hear so much more about dangers in the rest of the world and the rest of the country, so it elevates our sense of danger. There are really two types of parents: the more protective, insecure parent, or the dominant, aggressive, "it's my way or the highway" parent, and either one of those can instill in the child an external locus of control. They then learn that it's more important to follow mom's rules to stay safe, or that they need to watch out for dad because if he's been drinking and he hits mom, then he might hit them too—either parenting style can lead to that external locus of control, and that causes kids to be more apprehensive.

Dr. Ackerman: I see, so both kinds of parents have the ability to inadvertently instill anxiety in their kids. You make a comment in your book about how some of the anxiety in children can actually come from the parent wanting to do too much for the child. Can you expand on that?

Lynn: Parents can definitely contribute. I actually have this line that I use when I'm speaking to a room full of parents, I say "We all just have to recognize that if it's 'nature,' it's you, and if it's 'nurture,' it's you." Our job as parents is to make our kids feel safe and cared for, but when we don't allow them to feel uncomfortable, when we overprotect, when we don't allow them to explore things . . . that's where it becomes dangerous in terms of creating an anxious child. All the reassuring doesn't give a child the opportunity to feel nervous or worried and move forward anyway. It's a bad thing when a parent comes in and says to their child "The world is a dangerous place, you can't handle it, let me step in and do it for you."

Dr. Wilson: Well, almost everything parents do for an anxious kid is understandable, makes sense, and is wrong!

Dr. Ackerman: Oh really!

Dr. Wilson: Yes! This is because our instinct is about trying to calm our kids down—I mean, my kids are in their twenties and I hate to find out that they have been crying, or that they are upset. Parents want to soothe and reassure children. They want to take away hurdles for them and that's just bad form! You can't take away a hurdle for a child, you have to help them learn to step over it; that's where we're going wrong. Plus, the anxiety disorders will run families because parents don't know what to do. It gets to the point where backing up, avoiding, and reassuring are the only things that might get

a child to go to sleep at night. Two things get parents to start showing up for treatment, sleep and school performance.

Dr. Ackerman: What has to happen within those two areas to get parents in treatment?

Dr. Wilson: With sleep it's usually when the parents start sleeping in the bed with the child, or allowing the child to sleep with them, or when the child is having tantrums so that no one can sleep at night. That usually brings families in. In regards to school, it's more about if the child doesn't want to get out of bed in the morning, is avoiding school, or doing poorly in school.

Lynn: Most of the questions I get asked at workshops are about sleep. That's the thing that gets parents' attention the most. Anxiety just wreaks havoc at bedtime and it exhausts families. Parents have a hard time dealing with nighttime anxiety because a lot of times, as Reid mentioned, that's when kids are the most demanding.

As Reid briefly mentioned, the other huge question that parents often ask is related to learning and anxiety. A lot of kids are diagnosed first with attention and focus problems and it presents all kinds of problems with homework and stepping into more challenging areas of school. The questions are usually "How do we deal with anxiety and its effect on learning?" It's a big issue because kids with an anxious brain have a really difficult time learning. The brain just becomes so hypervigilant and protective that it can't absorb new information really well.

Dr. Ackerman: When you're talking about parents inadvertently bolstering anxiety in their kids, you're talking about well-intentioned parents, correct? The parents whose hearts are in the right place, but who don't even realize that they are helping to produce an outcome they don't want?

Dr. Wilson: That's right. As we wrote in *Anxious Kids, Anxious Parents*, all parents of anxious kids are going to be anxious themselves because they don't know what to do. In addition, the other breed of parent is the kind who already has a predisposition to anxiety. A lot of what we try to do with the book is saying "This is not just about Janey or Johnny, this is about how to clean up your act so that you don't reinforce the worries."

Dr. Ackerman: Early in the book, you go from addressing anxiety to addressing worry. What is the relationship between the two and why is worry emphasized much more?

Dr. Wilson: Worry is what drives anxiety. Obviously you can have anxiety that comes from trauma or something like that, but for a child who maintains a sense of avoidance, they must have thoughts inside their minds that interpret circumstances or their ability to cope with those circumstances. Those thoughts are what we define as "worry." Anxiety relates more to the physical sensations that occur. They go hand-in-hand, but very quickly worry is what dominates the process. It's a cognitive approach.

Lynn: I don't think you can be anxious without worry! Worry is a natural thing that we do, it's what comes up and says "Hey! Pay attention!" It's what we do with that natural worry that determines whether we have anxiety. The worry is the process in your brain that is saying "what if this happens?" or "what if that happens?" to induce problem-solving. When an anxious person can't go from worrying to problem-solving, that's where it becomes an issue.

Dr. Ackerman: Definitely, and there were a lot of places in your book that speak to that. I've been screaming back and forth about the dangers of "micromanager" parents and your book reinforces that idea. These people are stuck at the "worry wall," where they can't get to the problem-solving that should follow worry or anxiety. Sometimes I wonder if the best help that parents can give their kids is really just no help at all, to let them learn. What do you think are the common mistakes that parents make when they're trying to help their child?

Lynn: General reassurance—you know, saying "There's nothing to worry about" or "It'll be fine" and things like that—and especially the reassurance about scheduling. Worry wants certainty and comfort, so when a child knows exactly what's going to happen and a parent enables the idea that there aren't supposed to be any glitches or bumps in the daily routine, that is a perfect environment for worry to grow. For example, a family will come in to see me and maybe they've already seen other therapists before. I'll ask the mother, "So in all of your sessions and your reading, what have you learned?" and the mother will reply "Oh, well I know that the most

important thing is to make sure my daughter knows exactly what's going to be happening throughout the day. We give her the schedule and as long as she knows how everything is going to play out, everything goes well." That is the exact opposite of what a child needs to learn how to do. Children need to learn to handle the unexpected, such as when there's a substitute teacher at school, or the car breaks down, or a tree falls through a window during a storm, or even minor things like trying out for the basketball team and not making it. Anxious families have such strict schedules that it makes children feel like the world is just one big booby-trap.

Dr. Wilson: Our method is about leading with cognitive and developmental approaches so parents can help their children and so families can get better. That's where we want to start, with generic principles like learning to be okay with worry.

Dr. Ackerman: How does that make *Anxious Kids, Anxious Parents* different from other approaches to this issue?

Dr. Wilson: By keeping the information generic, *Anxious Kids* allows parents and schools to deal with the problem of anxiety as a whole, and teach it to their kids in that way. For example, when we were getting ready to publish *Anxious Kids,* HCI Books asked us if we wanted an index. We said we didn't. We didn't want parents looking up "dog phobia" or "fear of sleep." It just gets too specific. When you keep things general, it helps people understand how to be part of the solution and not part of the problem.

Dr. Ackerman: Right, that makes sense. One of the things I noticed about *Anxious Kids, Anxious Parents* was that every chapter builds on the previous one. It isn't meant to be read, like you said, as a reference that parents can skim through to find the specific issue they're dealing with.

Dr. Wilson: Right. We did that on purpose and we framed it as seven puzzle pieces so that we can match the parenting book to the children's book. It's built as a logical system. You have to start working with "expecting to worry" and gradually move towards "talking to worry," and so forth. There are some strange, unorthodox approaches in the book, so we needed to get them grounded first before just leaping into them.

Dr. Ackerman: You indicate in your work that a certain level of worry and anxiety is normal and that about 20 percent of children are diagnosed with an anxiety disorder. Do you think that, in some cases, what's happening now might be because people are losing sight of what a normal level is?

Dr. Wilson: Absolutely. I think that's a confusing thing for everyone. We definitely want to normalize it because part of what's happening is that parents want to say "Don't be scared," and that's not the message you want to give your kids. You don't want to have dad look under the bed and say "Look, there's no monster. Go to sleep, don't be scared." That's going to just double-down on those kids who already have low self-esteem and who are insecure. What we want to be saying is "You're right to be scared, given how you're framing up this problem and your ability to face it."

Dr. Ackerman: So what kinds of worries are normal?

Lynn: Well, worry and anxiety in general are normal. Whenever you're stepping into a new situation, or facing something challenging, or taking part in something that is meaningful for you and you want to perform well, anxiety and worry are going to be present at those moments—and that's what's supposed to happen. For example, I was at a conference once with one of my mentors, a very important mentor for me, and he said "I'm going to come and listen to you when you present." Then he said it again later and I said "You know, that makes me feel really nervous," and he said "Yeah, it should!" It was important for me to do well in front of him; he was my teacher and such a valuable mentor, of course I was going to feel nervous.

Dr. Ackerman: So I have a question for you now, Lynn. For moms and dads, are there differences in gender when it comes to what people worry about?

Lynn: There are some gender differences, but one of the things we mention in the book is that the content of worry doesn't matter as much. Most of the differences are somewhat stereotypical things, such as mothers worrying about what other parents think of them. I have two boys of my own and it was a little funny when I was writing this book because I was seeing these families come in and their sons were dressed so perfectly. I remember one of my boys wore a superhero costume every day for nineteen months! I would just think to myself "Gosh, how do these moms do it?" Then it dawned on me that these were anxious mothers who were so concerned about looking perfect to others. Dads tend to worry about harm coming to their children, being good dads, making mistakes, achievement, success, and things of that nature.

Dr. Ackerman: I think something that occurs with fathers especially is looking for indicators that their son or daughter will be able to take care of themselves. Our middle child was quiet and shy, so I worried about him a little bit. He was out playing Little League baseball one day and he got a hit and ran to first base. Then the next kid hit, my son Bobby ran to the next base, and a kid from the other team was standing on the bag at third base. When it was time for him to run, Bobby almost knocked him over to get to the base and said "You can't stand on the bag!" That was the moment when I realized that perhaps I didn't have to worry about him so much. The same kind of thing happened with my daughter as well. So, in relation to gender differences and kids, are there things that perhaps girls worry about more than boys? Or, does it blend together when they're adolescents?

Lynn: It blends together, I think, but Reid and I really emphasize in our work that content doesn't matter. A lot of times parents get sucked into the content of what their kids are worrying about. People are going to worry about what's developmentally appropriate for them. For example, a kid will come to see me when he's six and he's worried about clowns and monsters. I would then have the same kid, who I hadn't seen in some time, come back into my office because he had his first girlfriend. It really is a developmental issue. We know that when kids are very young they're mostly scared about bad things getting them, and when kids grow into adolescents it

becomes more about performance issues and the social stuff. Both male and female teenagers worry about those things.

Dr. Ackerman: So it becomes a face-saving behavior.

Lynn: Yes, absolutely.

Dr. Ackerman: The reason I mention that is because it seems as though there's a lot more focus now on female adolescents and relational aggression. You addressed that in your last comment, but I think it's still very hard for them out there.

Lynn: Of course, and I was just about to say that the hard part about anxiety in teens—especially if you have an anxious parent or the whole family is anxious—is that anxiety is all about avoidance, as Reid mentioned earlier. The teenage stage of life is really about developing autonomy, so you end up with these two opposing forces; the need to develop independence and autonomy while you're in a family that is afraid of taking any risks and moving forward. That causes a lot of conflict.

Dr. Ackerman: Now Reid, I know you recently spoke in Canada to educators; can you tell me how that went?

Dr. Wilson: It's interesting because not only did we see an overwhelming turnout of teachers to those workshops, but about 80 percent of the teachers were also dealing with an anxious child at home.

Dr. Ackerman: Oh, so they were coming as professionals and leaving as consumers!

Dr. Wilson: Well, I think they were actually coming as consumers and getting paid as professionals. The teachers were definitely getting their CEUs and addressing problems in the classroom, but they were also realizing that everything they were doing at home with their own children was wrong. They were lining up to talk about their personal experiences. Anxiety is a widespread problem.

Dr. Ackerman: That sounds like a great indicator of how well your message has been received.

Dr. Wilson: There really is a need. People are being dominated by the disorder and they've got to do something.

Dr. Ackerman: There's a particular section in your book that deals with guidelines, perhaps we can go over one of them. This one is about how worrying can control a child and in turn negatively affect the whole family.

Dr. Wilson: The primary message of worrying that gets to the kid is "you can't handle it." You can fill in any topic, any specific area, and the main message that they take away is still the same. When a child feels as though they can't handle something, they are going to enlist family members to manage the issue. The parents then come in and have to pacify the child's needs or the child will keep them up until three in the morning. At that point, the parent feels the same "I can't handle this" that came from the child. Everyone ends up having to worship at the altar of worry because if they don't they will be punished. What the family needs to learn is how to step forward instead of backing away.

Lynn: As Reid mentioned, when a child is worrying, they are commanding the adults around them to create an environment where worry is eliminated. The way I describe it is that anxiety is like a cult leader; it's calling the shots, it's dictating the way things need to be. It determines what has to happen in order for the family to continue functioning, for mom and dad to get to work on time, for everyone to get sleep. The accommodations that families make to satisfy the needs of anxiety and worry are still surprising to me sometimes. Anxiety has a really good way of getting people's attention.

Dr. Ackerman: Let's move on to the chapter about facilitating courage. Can you talk a little bit about the importance of courage in dealing with worry?

Lynn: Sure. One of the big areas where parents and even therapists make mistakes is that they think the only way to move forward is to have mastered something or to feel calm and comfortable. The real focus of our book is to learn how to be uncomfortable, be nervous on purpose, and be able to step into something new even when you have that anxiety. That's where the courage comes from. In our book, courage is about moving forward even though you feel unsure. For example, there are a lot of programs in schools now for anxious kids that allow them to leave a classroom when they feel anxious and go to a guidance counselor or the library. They're told that when they "feel comfortable enough," they can go back to class. That's not going to help children become courageous in the face of their worries.

Dr. Wilson: The issue of courage partially has to do with what I mentioned earlier about helping children over their hurdles, not removing the hurdles from their path. We're not trying to get rid of anxiety; like what Lynn said about 'stepping into something new' despite the worry, we're trying to learn how to *perform with anxiety*. We know this with children who are athletic and who get nervous at the starting line. They think that's wrong. We have to teach them that it's fine to have that kind of arousal. It's all about being scared and doing it anyway. The problem happens when these kids, or any other kinds of kids, decide that the fear outweighs the enjoyment of the activity. When they start saying "I don't care about that anymore," that's when it becomes a real problem.

Dr. Ackerman: What you're saying about the "I don't care about that anymore" response to worry could be similar to the face-saving behavior of adolescents that we spoke about earlier.

Dr. Wilson: Definitely. Sometimes that's why adolescents come into our practices. For example, if you're seven years old at school and you have a teacher come get you before the fire drill goes off so that you won't be scared, what happens when you still need that teacher and that treatment when you're twelve? That kid is going to lose face with the other kids. A lot of times it's a motivating factor for them to start examining these worry issues.

Dr. Ackerman: I want to go back to what you said about the classroom, Lynn. So if I was a child who had anxiety in the

classroom, you would be telling me that my anxiety is fairly normal, is that correct?

Lynn: Absolutely. Even when it gets to the range where it's not normal, we still have to give you the experience of retraining your brain, of feeling the anxiety and getting through it. Normally what anxious people do is they feel the anxiety, they retreat, they feel better, so they think "Oh, that must be the solution." They end up learning that the "solution" is to get away from a situation that causes anxiety in order to feel better. The real goal is to provoke the anxiety and give kids the skills to handle it.

Dr. Ackerman: I was reading your book and thinking that there were so many people that I was trying to help who were just like that. The ones with the most problems were the ones who were constantly trying to alter the environment or the situation.

Lynn: Yes, they are just so focused on changing the external environment to meet their internal needs. It really has to be the other way around.

Dr. Ackerman: That's an excellent way to put it. So am I correct in thinking that parents are going about this in entirely the wrong way? You seem to be saying that handling this isn't about an absence of anxiety, it's about being able to handle the anxiety when it surfaces.

Dr. Wilson: Yes, it's the same thing as worry. We want to put it outside of them. I think it's a very useful thing to do because when a child starts to worry, they start to pose all those questions to the parents. It's very difficult for a parent to answer questions about what might happen, but when they externalize it and say "Oh, that sounds like your Worry talking. How do you want to respond to it?" it's a way of deflecting the question so the child learns to deal with and face the worry and anxiety.

Dr. Ackerman: That really seems to feed into what you said many times in the book about your "Take Action" message to the parents. Can you comment on that?

Dr. Wilson: Of course. Everything is based around the cognitive principle of "Take Action." If you don't take action, you won't ever do anything! As you know, *Anxious Kids* is the parenting book and we also have an accompanying book for children. We start slow so parents can warm their kids up to this frame of reference for getting better, and once they do start improving it's important to begin taking risks related to the specific topic they are struggling with. So everything is related to getting that action going.

Dr. Ackerman: So when you talk about kids in your book, you specifically mention kids from ages eight to eighteen. I'm curious as to why you selected that specific age group.

Dr. Wilson: Because the publisher thought that was a cute way to do it! "Eight to eighteen" just sounded good.

Dr. Ackerman: Oh, is that so! In many of your examples, I think you refer to children younger than eight.

Dr. Wilson: We do; sometimes we work with children as young as three years old with this kind of stuff. Obviously they won't be reading the children's book that goes along with *Anxious Kids*, but their parents will start working with them on the principles. We actually have a very nice clip that we play in our workshops of a six-year-old girl who has learned these skills in about eight sessions of working with Lynn. You can see that she's totally got it—she's not regurgitating anything, she's pretty clear about the principles. Technically adults can use and understand the book too; the concepts don't just stop at eighteen years old.

Dr. Ackerman: Yes, and I realized that a lot of the time when kids grow up and reach that age, the worry doesn't stop. They're just adults now and for us parents, there's a certain level of concern that happens as a result.

Lynn: Definitely, and we have to pay attention to kids with anxiety that isn't being treated. A huge problem that we often see is that a child whose anxiety hasn't been treated ends up becoming an adult who has anxiety and depression.

Dr. Wilson: Of course, and additionally the reason that we stop at eighteen is because they are still under the influence of these parents who can be inadvertently helping along the worry and the anxiety. When 65 percent of children who have an anxiety disorder have a parent at home who is diagnosable . . . that's the reason we're writing a book for the parents and having a kind of "trickle-down" effect to the kids. We wrote the book for the

children too so that they could be independent and work on these issues on their own as well. We wanted to focus on children particularly because if we don't help these kids now, we're going to be paying for it for a long time. Lynn already mentioned that anxiety disorders in children lead to depression, but it can also lead to potential drug abuse and difficulty applying and going to college—there are just so many things that will continue to cause havoc in a child's life as they grow into adolescents and young adults.

Dr. Ackerman: As we're winding this interview down, I'm sure you know that there are many clinicians who are going to be reading this interview. What do you think they should be looking for in their clients in order to effectively combat the growing problem of anxiety?

Dr. Wilson: Well if a family is seeking treatment because of anxiety-related issues, it's going to be fairly obvious. The family will be restricted and the world of the child is going to be made very small in order for him or her to feel comfortable. I think what's most important for the clinician is the question of "Now what do I do?" Counselors need to be thinking about how they can collaborate with the family and, by the end of the session, create a homework assignment that helps the child and the family become somewhat doubtful about the theme of the worrisome issue at hand. They need to come up with ways that the child can tolerate not knowing, tolerate the physical sensations of anxiety, and still step forward. They can take as small of a step as they want, but there has to be a step. That's where we think counselors should focus their attention.

Dr. Ackerman: What are the things that you hope parents will take away from your book and really learn to do with their children?

Lynn: The first thing is this; giving children the tools to help them tolerate uncertainty, to problem-solve, to be able to move forward despite worry and anxiety, that's what we need to do as parents. If we as parents have anxiety about letting our children be uncomfortable, we're not giving them long-term life skills. Kids who aren't good problem-solvers don't move forward very well.

Additionally, if parents have anxiety themselves, they need to really take a look at how they are talking to their children. There's a really good chance they might be catastrophizing situations and projecting their own low risk tolerance onto their child. Anxious parents have a tendency to talk about the world as a dangerous place. Expressing fears in front of the children really teaches them that the world is dangerous and that they need to be careful. That really hampers their growth.

Dr. Ackerman: Throughout this interview, Reid, you've mentioned the children's book quite often. What's the exact title?

Dr. Wilson: The title is *Playing with Anxiety: Casey's Guide for Teens and Kids*. It's actually a pretty substantial book, probably about forty-five thousand words. It's written through the voice of Casey, a fourteen-year-old girl who has had anxiety since kindergarten. The book is narrated by Casey and she tells kids what her life was like, what her brother went through, and provides analogies and examples to help. It matches up with *Anxious Kids, Anxious Parents*, which shows parents how to use the kid's book. It's available for the Nook and the Kindle, and there's a PDF of the book on our website, www.playingwithanxiety.com.

Dr. Ackerman: Any last thoughts before we conclude?

Lynn: Well, from a more optimistic viewpoint, even though anxiety is so common, it's very treatable. I get professionals who give me a hard time about using the word "curable" when I talk about anxiety, but it really is. What I mean by "curable" is that anxiety is going to show up—again, it's not about eliminating anxiety—and you're going to know how to handle it. Anxiety will never disappear, but you can understand it and have a reaction to it that allows you to keep moving, growing, and learning.

Dr. Ackerman: Thank you both so much for taking the time to sit down with me and provide this interview for the readers of *Counselor* magazine.

Reid Wilson, PhD, *is the director of the Anxiety Disorders Treatment Center and clinical associate professor of psychiatry at the University of North Carolina School of Medicine. Dr. Wilson has written two well-received publications in the field of anxiety, translated into nine languages and endorsed by the most highly esteemed professionals in the field. He designed and served as lead psychologist for American Airlines' first national program for the fearful flier and served on the Board of Directors of Anxiety and Depression Association of America (ADAA) for twelve years.*

Lynn Lyons, LICSW, *has been a psychotherapist for over twenty-three years, and specializes in the treatment of of anxiety disorders in adults and children, including generalized anxiety, phobias, social anxiety, obsessive compulsive disorder, and performance anxiety. She is a sought after speaker and consultant who presents nationally and internationally on the topics of the anxiety in the family, managing childhood anxiety in schools and medical settings, and pediatric hypnosis.*

OUT OF THE OFFICE & INTO THE WOODS:

Lessons from the Field of Wilderness Therapy

Brad Reedy, PhD

Nearly two decades ago when I was looking for a job, a mentor suggested I apply at a wilderness therapy program. I left several introductory phone calls with the clinical director to inquire about a potential job opening, but my attempts went unanswered. So I decided to make the three-hour drive to their office in Loa, Utah. I arrived with my resume in hand, a flannel-lined sleeping bag in my duffel, and the confidence that I was right for the position.

Lucky for me, the program was anxious to fill the job opening because the previous therapist had quit after his first attempt to find his group some forty-five miles into the desert. His trek ended with him frustrated and forty-five miles off course. After my impromptu introduction to the clinical director, I was invited to attend the staff meeting. When the director was asked, "Who will be the therapist for group three?" she gestured to me. Suffice it to say, I felt really good about my chances at the interview later that day. I was offered and

accepted a position to start immediately as a wilderness therapist. I had almost no idea what wilderness therapy was and I tried to learn about the milieu while waiting to head out to the field area, or wilderness area of operation. However, I received very little instruction before heading out with the staff to meet my clients, or "students," as they are called.

I drove along with the incoming shift of wilderness instructors to my group on one dusty road after another, through the picturesque landscape of Capital Reef National Park and Southern Utah. I took the opportunity the long drive afforded me to try to learn more about wilderness therapy. "What exactly is it?" "Why do we do therapy in the wilderness?" Clay, a nature enthusiastic, dread-headed, kind, and gentle instructor responded to my questions with the following imagery: "You see Brad, most people are living two miles off the planet. Out here, we are teaching kids to live on the ground. That is where you will meet your students." Later another instructor said it this way: "Nature has a healing power. It is magic and hard to explain, but there is a healing that occurs as these kids live outdoors, in the simple majesty of nature. The kids have a powerful spiritual experience, develop a strong sense of gratitude, and some even find God here."

While I appreciated their passion and agree with their answers, it wasn't good enough. I think it is incumbent on us as therapists to understand the "why" of wilderness therapy. Often when I ask people to describe the effectiveness of wilderness treatment, they will launch into a poetic answer about the healing effects of beauty, outdoors, and nature. I believe there is truth underlying their intuitive responses, and without taking the magic out of it, I still feel a responsibility to understand and explain how and why it works. So what are the mechanisms of this therapeutic delivery method? The answer to this question may offer our clients and families some insight into aspects of the intervention that can lead to greater generalizations posttreatment.

The Influencing Theory in Wilderness Therapy

My early observations of children and young adults participating in wilderness therapy led me to reflect on a course I took as an undergraduate titled Temporal Work and Relationships in the Home. The professor was Dr. Kathleen Bahr. It was a course on how many of the modern advances in our culture were taking families in a dangerous direction. The class began by viewing two documentaries. The first followed a day-in-the-life of "The Utah Mother of the Year." The second was about a primitive African tribe. The Utah mother was very impressive, with her planned, set schedule. One scene, which we later realized supported the thesis of the course, showed the mother interrupting some spontaneous rambunctiousness to follow the lesson plan and have the children do calisthenics. Her lesson plan was well-scheduled and she kept the house spotless, cleaning the morning mess while the children took their afternoon naps. The documentary of the primitive tribe showed family members engaged in the daily task of life and survival. There was a division of labor, with the mothers working and watching all the younger children around their simple homes, while the fathers took the young men into the woods to hunt and gather food. Throughout the day, and then highlighted during the evening around a fire circle, the parents shared stories and lessons with their children. The stories were both religious and practical, and wove life lessons into a mythical narrative. At night they sang songs and talked about how their God had blessed them and about how they were able to survive. The line between their religion and the struggle to survive was nonexistent. It was in the context of their struggle that they passed on their values and life lessons. What it meant to be a member of the tribe and to be a person was integrated into and inherent in their every day lives.

Parents in Western culture often contrive and stretch to create teaching moments like the Mother of the Year, while primitive cultures rely on oral tradition and modeling to pass on values. Their chores require the help of several family members

and create connection rather than the isolation that is sometimes created in more modern social structures. Lessons about life are woven together in their religion and in their daily traditions and rituals. One of the challenges, when all of the creature comforts are offered too readily to our children, is to create opportunities for teaching our children. In such instances, the lessons appear contrived—that is, the message seems to be about the parent and not about life. An example may be as simple as the old adage, "You reap what you sow." This saying is self-evident for the child who grows up on a farm. By contrast, a child raised by attorneys may have trouble seeing the value of high-school trigonometry and the impact it will have on her life.

While we appreciate technology and modern efficiency, it may distract or short-circuit natural routes for educating our children. Dr. Bahr challenged the common American ideal that the most basic task in life is to meet our visceral needs, as illustrated by Abraham Maslow's hierarchy of needs. This model posits that if we are struggling to survive, then we are prohibited from focusing on higher level needs. Yet, what is even more obvious today than back in the mid-1990s when I first started as a wilderness therapist, is that many of our modern conveniences are not necessarily advancing our humanity. In fact, it is often in the struggle to survive that we both learn for ourselves and pass on the most critical values to our children—through our rituals, our work, and our suffering. Life lessons are intrinsic in living. As the quote by Arnold H. Glasgow goes, "Telling a teenager the facts of life is like giving a fish a bath."

In a lecture, Dr. Bahr used ice cream as a simple illustration of how modern conveniences might be hurting the processes in family. She explained, "Years ago, ice cream might be made by the whole family. Each would have their turn at the hand crank, the ice maintenance and the salt. The ingredients were mixed and frozen and the activity might take hours. The family was engaged in the same goal and at the end they enjoyed the ice cream. Today, we buy a half-gallon of ice cream in order to save time. Time for what? Usually to watch TV or go our separate ways" (personal communication, 1992).

Consider the following observation from Harvard Anthropology Professor Dorothy Lee in 1959:

> *When my first child was two or three, I used to shell peas with her. Nowadays, I buy my peas already shelled and packaged. This saves time; and the peas are fresher . . . but was this all that happened when I shelled peas with my daughter? Did I merely get a dish of peas? It was a total process; and if I am going to see to it that the totality of the important aspects are retained, I shall have to find out what they were and then find the media through which they can continue to be expressed.*

If modern life was creating some obstacles for parents in the 1950s, and in the 1990s when I started in wilderness therapy, imagine the impact of our modern and technological wonders on today's family.

Many children of the current generation are suffering and baring the symptoms in an age where information is abundant and connection is stunted. Students are enrolled in a therapeutic wilderness program with a variety of presenting issues such as depression, anxiety, substance abuse and addiction disorders, behavioral problems, school problems, family conflict, learning disabilities with associated problems in functioning, and autism spectrum disorders. Wilderness therapy programs are a short term, primary care setting and offer families an interruption and stabilization in a crisis. Assessment, both formal and through natural observation, prepare individuals and families for follow-up care settings which may include outpatient therapy at home, residential programs or some form of transitional living. Therapeutic gains in wilderness therapy are often very dynamic and research has demonstrated very high levels of retention and generalization.

The Practice of Wilderness Therapy

The version of wilderness therapy I practice is a nomadic, primitive, small-group living model. That is a technical way of saying we hike around in the wilderness, in groups of eight to ten students, with three to four staff members and a therapist, setting up camp each day in a new area. Other versions of wilderness therapy incorporate adventure activities or utilize base camps (residential-living) during a significant portion of the clients' time in treatment. The curriculum in a primitive model is based on the tasks and chores associated with hiking and camping in small communal living. I prefer the way that simple primitive living creates a microcosm for clients—a small, manageable world that recreates the larger, infinitely complex universe outside the program. This microcosm recreates dynamics and reveals the issues without relying on self-report. Wilderness therapy also provides

space for incorporating new solutions to challenges that can generalize to life after treatment. Licensed therapists meet with the students each week in individual and group therapy and establish treatment plans with the wilderness instructors.

The treatment plans are based on traditional therapeutic models and include aspects of experiential therapy in the outdoor setting. Therapy with the wilderness staff occurs throughout the course of each day and may relate to the issues that brought the student to the program. Just as common, the topic of the therapy may focus on the here-and-now of group living, with the student being asked to make a connection between his current circumstances and the issues that he was struggling with at home before entering the program.

Weekly sessions with the therapist reference both daily living and the historical difficulties the student experienced prior to entering the program. The fabric of the therapy is both "here and now" and "then and there." A colleague explained it like this, "Wilderness therapy is the delivery method, but the therapies utilized are empirically based and found in many offices." The therapist dispenses traditional therapies, such as DBT, CBT, Twelve Step groups, and Family Therapy all in the sublime backdrop of experiential, wilderness therapy. The sessions help students to see the connections with their daily challenges, the challenges they are having with staff and peers, and similarities to the challenges they experienced at home. The focus becomes truly about the student. For example, when some issue creeps up during a trust exercise while crossing a river on a hike in the woods, students are more likely to own it as their own rather than reject it as their "parents' issue."

Similar to the primitive fathers teaching their sons during the hunt, senior students in wilderness therapy mentor newer kids in campcraft or "hard" skills—cooking, fire-making, site selection, bear-proofing, gear maintenance—and group organization. Most valuably, the students learn, role-model, and eventually promote the "soft skills" of accountability, communication and conflict-resolution, and seeking emotional support.

This is not an adventure therapy program with rappelling, mountain biking or white-water rafting. While that might play well to parents who are saddled with guilt for sending their child to a therapeutic program, it comes with some disadvantages. In their book *NurtureShock*, Bronson and Merryman (2009) address the pitfall of an increasing trend where parents are replacing hard work with recreation. This trend, they suggest, works because everyone is happy. Parents feel less stress, guilt, or personal discomfort and with kids entertained and distracted, parents survive to fight another day. Any parent can relate to those motives.

In the primitive living milieu, or "camping therapy," inherent challenges of nature and group living foster community, problem solving, healthy communication, and resiliency. It is not punitive or deprivational, but rather it is natural. The therapeutic staff utilize the challenges nature intrinsically provides to create the treatment plan. Rain, wind, and the elements become the antagonist and in facing those challenges, the wilderness student thrives. This use of nature truly underscores the message that it is the "journey and not the destination" that matters.

What Works in Wilderness Therapy?

I have heard wilderness therapy living referred to as a metaphor for life, but I find this a strange concept. That is, how can living in the natural world be the "metaphor" and living in the modern world with virtual realities be the "real" world? Primitive living is actually less contrived than other forms of therapy and as Dr. William White (personal communication, 2009) quotes a pioneer in the therapeutic primitive living model, "'Whenever we adopted what we have come to call contrived experiences, the overall impact diminished for the participants.' I like to explain to the clients, neither that neither we, nor your parents, are playing the role of God. We are more like Isaac Newton. We didn't invent gravity, we are just showing you how it works." I know of no better way to show a child how the world works than to expose them to it through small group living in the wilderness.

Nothing can be taken for granted in the wilderness. Everything comes with work, sacrifice, and often requires compromise, problem solving, and healthy communication in order for an individual to experience success personally and in the group. Students increase their self-reliance and develop a healthy sense of interdependence. Not listening to the staff might lead to a faulty shelter technique,

which would lead to a very wet night—no lecture is needed on such an occasion. Students hike, camp, cook, set up shelter, sleep, eat, clean, and carry everything they need in their backpack. Fresh food and water are delivered as needed, but the daily task of living is without most of the modern conveniences and creature comforts that we enjoy in our culture. The intentionality in this environment allows therapeutic staff to amplify and underscore the important skills and principles the treatment plan lays out, using a comprehensive integrated experiential framework.

Over the years, our newer staff members have asked me, during the winter's short days, or the rainy season of early spring, "How can we do therapy when we are spending so much of the day helping keep the children safe and warm?" My response is, "That IS the therapy. What better way to teach children the importance of patience, responsibility, self-worth, listening, trust, gratification delay, and frustration tolerance than by nurturing, caring for them, and teaching them to care for themselves? It relates to everything their parents want them to learn, only you use camping to teach it. The genius of the model is that the lesson is coming in through the back door, in a way that students don't recognize their parents as 'parents,' so their urge to rebel is less likely to be triggered." Dealing with the elements pits the student against nature and removes the need to struggle for a separate identity by rejecting parental values—the struggle that so often occurs as children navigate the tasks of adolescence.

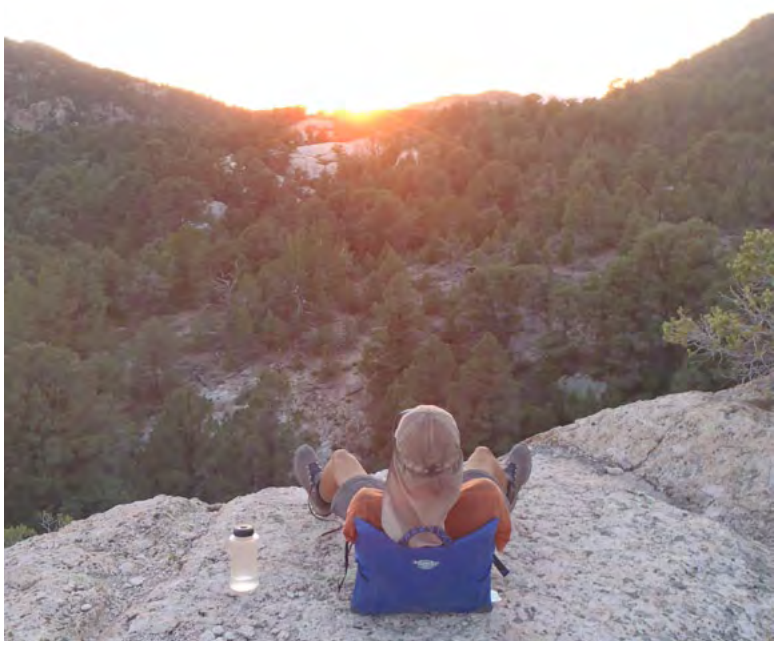
As this process unfolds for their children in the middle of the Utah Desert or in the Blue Ridge Mountains, parents learn principles such as healthy detachment. "Letting go of the outcome," and "trusting the process" are principles that are reinforced as the parent enrolls their child in a wilderness program. Rather than lectures, parents learn the value of teaching with healthy boundaries and experience. A parent explained to me, "The most important lesson I have learned by our participation in wilderness therapy is that children often change from the outside in, not the inside out. I have been engaged in lecturing and verbally teaching my son, and I realize that I have not reached him. He isn't struggling with something rational, and your program has taught me to shut up and understand that he is a child and needs to learn from his experiences." This doesn't relegate the parent to a bystander, but rather encourages them to create experiences and limits that do the teaching in the way that children learn. They are often not insight-oriented creatures, with their developing frontal lobes, but rather irrational and driven by unconscious needs and social influences.

Participants in wilderness therapy become the "hero" in their own journey through their experiences associated with hikes, making it though a storm, braving cold temperatures, participating in communal living, and cooking a tasty meal over an open flame. All these experiences create a sense of accomplishment and efficacy. These successes give birth to a greater sense of confidence. The students feel positive about themselves, not because they receive praise, but because of their accomplishments and increased sense of self-efficacy. Group therapy sessions occur throughout the day, highlighted by a group around a fire circle at night—the same fire where their dinner was cooked. The fire was created by a student using the meticulous bow-drill technique of rubbing sticks together. The fire circle is a perfect example of the integration of living and learning.

The first thing I learned about children, while working in wilderness therapy, is that they are much more resilient than they or their parents believed they were. Wilderness therapy is hard, challenging, and safe. It is a good place to practice living in relationship to others and to the self. The children develop such an affinity that they regularly promise to come back to work in a wilderness program. While all of them don't follow through on this promise, our ratios show that about 25 percent of our front-line staff are former clients.

Wilderness living is free of the usual distractions or hiding places that home offered. Without these distractions, the student learns how to feel, how to assertively express their feelings, and how to practice healthy coping strategies. The experiential aspect of wilderness therapy also speaks the language of children's developing brain. Rather than verbal therapy, the student is engaged through the context of daily activities related to living. Our brain stores our memories in cell assemblies; these are groups of associated cells that code information. Accessing our issues through the medium of verbal or oral therapy alone may limit our ability to deal with and correct the challenges we face in mental health and addiction treatment. Our pain or trauma may be stored in the parts of the brain where language doesn't exist or was stored in the brain before we had language to name it. As a result, experiential therapies may be most effective at accessing trauma and creating a reparative experience for the participant in a way that talk therapy cannot touch.

The use of story, metaphor, and experience commonly utilized by the wilderness staff also do well to bypass resistance. The change of context students experience as they move out of the city and into the woods creates a certain rawness or vulnerability. Students suddenly become exposed to themselves and to others. Since the lessons don't often walk through the front door and announce themselves like in a therapist office or the home, the student's resistance is less likely to be engaged. Practical living, rituals, ceremonies, and rites of passage become the mediums of the expression and healing in wilderness therapy.



One of the most common changes in wilderness therapy living for the student is the shift from an external to an internal locus of control. This transformation refers to a change from "Happiness and success are determined by the things that happen to me," to "I am the one that determines my happiness and success." Happiness doesn't come when we take our kids to Disneyland—any parent who has made the journey to the Magic Kingdom can attest to that—but rather it comes when we connect to ourselves, work through something, and find nurturing in our relationships. What better place to find and spend time with ourselves than nature?

It is important to note that play and fun occur in primitive living models also. A certain innocence is restored as students learn to create their fun through simple camp games. Participants learn that happiness and fun do not come externally through material things or from substances; they learn to create their own fun. Fun and play are an essential aspect of a child or young persons' development. In the book *Child-Centered Play Therapy*, the authors explain the therapist's "aim is to provide developmentally relevant treatment in a child's own 'language,' that of play" (VanFleet, Sywulak, & Caparosa Sniscak, 2010). As Plato reportedly observed, "You can discover more about a person in an hour of play than in a year of conversation." The difference between a true wilderness therapy model and the adventure therapy model is that life includes play in our model, and the adventure therapy model puts fun and play and excitement as the center of the treatment model (VanFleet, Sywulak, & Caparosa Sniscak, 2010).

Wilderness as An Intervention for the Entire Family

The earlier versions of wilderness therapy did not address or support the family. In fact, I was told as a new wilderness therapist to ignore the parents and the family dynamics. "They were beyond help," I was told. I was encouraged to avoid family coaching and parent education, and to refer the family to a therapist in their home community. This lack of parent support was one of the principal changes that ultimately led to me leaving my first wilderness program and creating a family-therapy-based wilderness program. Trained in family therapy and systems theory, I was able to see that addressing family dynamics didn't necessarily imply that the parents were the cause of the problem, but that by changing some of the dynamics we could improve outcomes and retain the change in our clients substantially.

With a family-therapy-based wilderness program, families are offered a plethora of services for support. Weekly parent coaching via telephone, family workshops, and parent groups are all a part of the experience. Family visits to the field during the middle and at the end of the course are encouraged. Cell and satellite phone therapy sessions are provided as student and parents begin to utilize new skills and insights developed in the weekly letter-writing process. The goal of wilderness therapy, like other therapies, is to treat the identified patients and all those effected by and embedded in their struggles. The primary tool in this model is the weekly phone call between the wilderness therapist and the parents. Updates, assessment, prognosis, and recommendations are offered each week during the family call.

Therapists review the written letters each week that are exchanged between the parents and their child. This letter-writing tool is a powerful version of family therapy and generates tremendous insight for families and the student. The deliberate form of family therapy, letter-writing therapy has also offered me a unique vantage point to treat the relationships between parents and their children. Coaching, communication skills training, and the restructuring of the relationship through letter-writing therapy is particularly clear because they occur in letter format. Because of the distance created by this unique intervention, the author of a letter has to wait days for a response, refocusing the individual on self, rather than focusing on the reaction of the other. The natural distance this process creates reduces reactivity, manipulation and codependency. This structure, inherent in wilderness therapy, is a fantastic rule encouraging healthy differentiation.

Concluding Thoughts

Wilderness therapy is safe, both physically and emotionally. One student said to me in tears, after hearing from his mother he had to complete the objectives on his treatment plan, "You have taken away all of my freedom," then he paused and continued, "except my choices." Another child told his parents after hearing he was going home, "I have never felt so safe and free in my life as I have felt here." This was coming from a young man who initially threatened to hurt himself unless his parents let him come home after one week.

Wilderness therapy is a sophisticated and compassionate version of therapy for adolescents and young adults. The practice of wilderness therapy has grown considerably in the twenty years I have been practicing, with outcome research replicating our early findings of efficacy (Hoag, Burlingame, Reedy, Parsons, & Hallows, 1999) and the development of standards and definitions about this unique treatment approach, which has come to be identified as "outdoor behavioral health care." Additionally, researchers have identified some of the factors that promote healing and health in wilderness therapy; small group living, promotion of self-efficacy through task accomplishment, and nature's facilitative influence on mindfulness are identified as key factors in promoting therapeutic change (Hoag, Massey, Roberts, Logan, & Poppleton, 2011; Russell, 2007). There is a powerful bond and quality created as therapeutic staff care for and work closely with students in this challenging and raw environment. It is emotionally rehabilitating. It is a rich, dynamic, spiritual, and even magical intervention. Perhaps the best way I can explain it is by using the language I used to explain it to my own children when they were young, "I work in the mountains to help the sad boys and girls feel better." That is basically what we do. We put backpacks on their backs, hike, live, teach them how to feel, and how to feel better. Going back to nature may be more important than ever in our digitally-drenched world. Like many of our students and their parents suggest after participation in wilderness therapy, "Everyone should have to do this!" C

Brad Reedy, PhD, *co-owner of Second Nature Wilderness Programs, has helped to establish Second Nature as a leader in Wilderness Therapy from his positions as primary therapist, executive director, and director of clinical services. Dr. Reedy has served on the boards of the Utah Department of Child and Family Services and the National Association of Therapeutic Schools and Programs. He has developed an accessible and liberating approach to treating addiction and codependency by utilizing a primitive living model. Currently, Dr. Reedy broadcasts live webinars twice weekly on the subjects of addiction, parenting the adolescent and young adult, and mental health issues.*

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SPIRITUALITY IN TEENS:

PROMOTING SOBRIETY & IMPROVING MENTAL HEALTH

MATTHEW T. LEE, PHD, & MARIA E. PAGANO, PHD

As theologians, philosophers, and countless other scholars and commentators have observed, one of the most destructive existential realities of modern culture is the temptation to cynical despair, meaninglessness, and materialism. We see this malaise in the lives of the young and the old, who are engaged in such self-destructive behaviors as crime and violence, alcohol and drug abuse, and suicide. Counselors are not unaware of the spiritual emptiness that afflicts many lives in our modern society and the relationship of this condition to mental health problems. In fact, some claim that spirituality is not simply an adjunct to therapy. Rather, "spirituality is the therapy, it is the treatment, it is recovery" (Booth, 2012). This is an important part of the approach of Alcoholics Anonymous (AA). Carl Jung (1933, p. 229) framed the issue in similar terms:

> *Among all my patients in the second half of life—that is to say, over thirty-five—there has not been one whose problem in the last resort was not that of finding a religious outlook on life . . . none of them has been really healed who did not regain his religious outlook. This of course has nothing whatever to do with a particular creed or membership of a church.*

Although Jung's experiences with his patients suggested that the spiritual side of life was especially important for adults seeking a solution to mental health difficulties, recent research shows that it is also highly relevant for adolescents as well, particularly those who are alcohol or drug (AOD) dependent (Lee, Pagano, Veta, & Johnson, in press). This would not surprise Jung. AA's cofounder Bill W. (1961) told Jung that a conversation Jung had with one of his patients, Rowland H., "was to become the first link in the chain of events that led to the founding of Alcoholics Anonymous." What was the nature of this conversation? As Bill W. (1961) tells it, and Jung later confirmed it:

> *First of all, you frankly told [Rowland H.] of his hopelessness, so far as any further medical or psychiatric treatment might be concerned. This candid and humble statement of yours was beyond doubt the first foundation stone upon which [AA] has since been built. Coming from you, one he so trusted and admired, the impact upon him was immense. When he then asked you if there was any other hope, you told him that there might be, provided he could become the subject of a spiritual or religious experience—in short, a genuine conversion. You pointed out how such an experience, if brought about, might remotivate him when nothing else could.*

Rowland did have such an experience, as did a mutual friend of Rowland and Bill W.'s named Ebby, and thanks to Ebby, eventually Bill W. had one as well (Alcoholics Anonymous, 1957/1994). Thus AA was born.

Because Jung discounts dogma or membership in a particular religious group, his reference to a "religious outlook" in the first quote above is more akin to the modern conception of spirituality, defined in the treatment literature as the "way in which an individual finds their freedom and meaning in life" (Stevens & Townsend, 2013, p. 3), instead of "religiousness," which includes "alignment with faith-based institutions and shared beliefs . . . an expression of spirituality, not its opposite" (Stevens & Townsend, 2013, p. 3).

"A psychoneurosis must be understood as the suffering of a human being who has not discovered what life means for him . . . And it is only the meaningful that sets us free."
—Carl Jung
(1933, p. 225)

For Jung, people are able to connect not just with the contents of their own unconscious, but also with a set of images and symbols shared by humanity as a whole, which he called the collective unconscious. Jung explained that his own experience with the collective unconscious had "come gradually and quite against his will" (Kelsey 1973, p. 289) and that psychological and physical health depended on "contact with the unconscious and its symbolic and mythological life" (p. 295). As Kelsey (1973, p. 289) notes:

> *Jung opened the door to the possibility of contact through the unconscious with an objective reality superior to human consciousness, which is able to order and vitalize human life when ego-consciousness is unable to do so. If the human psyche can thus act as a bridge between the physical body and the power of a transcendental reality, then religion and religious experience, particularly healing experiences, become a real and most significant possibility.*

Jung ultimately broke with Freud partly because of their differing viewpoints on religion (Palmer, 1997). For Freud, religion was essentially a "delusive attempt to return to the womb" (Kelsey, 1973, p. 287) and mental health improvements were the result of purely secular methods rather than divine intervention. Jung on the other hand—like William James before him—was convinced that there was much more to religious experience than implied by Freud's reductionist outlook. Jung's convictions were born, in part, from evidence of religious healings that he witnessed in his own clinical work. Whereas Freud viewed the unconscious in largely negative terms, as a repository of repressed thoughts and impulses, Jung saw something more: the unconscious could be a well-spring for creativity in addition to a source of neuroses.

Psychologists and counselors, among many other groups, remain divided to this day on questions related to the proper role of spirituality and religion in therapy, how to define these terms, and how to interact with clients in culturally sensitive ways when the religious and spiritual beliefs and experiences of the counselor and client are widely divergent (Booth, 2012; Stevens & Townsend, 2013). Some continue to side with Freud and see little value in incorporating spirituality into therapy. This is not surprising, since mental health professionals report lower levels of religiousness than their clients (Stevens & Townsend, 2013). However, spirituality and religion need not conflict with secular therapeutic goals and practices, as illustrated by Viktor Frankl's logotherapy. Frankl, in his influential book *The Doctor and The Soul*, argued that there are three dimensions to human life: "the somatic, the mental, and the spiritual" and that "the spiritual dimension cannot be ignored, for it is what makes us human" (1955/1965, p. x). The ultimate goal of "psychotherapy is to heal the soul" while the goal of religion is to "save the soul" and "provide a spiritual anchor" and "a feeling of security" which can be found "nowhere else" (p. xv). Frankl argued in favor of a "medical ministry" (p. 270), but he had "no wish to vie with the clergy" (p. 274). Like Jung, he did not use "spiritual" in a narrow, religious sense but rather sought to help patients clarify their ultimate values and become more "conscious and responsible," stating, "A man's soul is healthy so long as he remains what he intrinsically is: namely, a being conscious of his responsibility—in fact, the very vessel of consciousness and responsibility" (p. 275).

In order to achieve this goal, Frankl's approach is to incorporate the patient's particularistic religious/spiritual beliefs and practices into the therapy session,

rather than excluding them or attempting to convince the patient that they are illusory. For the nonreligious, logotherapy seeks to help the patient find their "task" in life; for the religious, this task is better understood as a "mission," the source of which is "God" (p. xv).

What is Spirituality?

Despite the work of the many counselors who are open to spirituality but who also have "no wish to vie with the clergy," spirituality remains a "neglected tool in therapy" (Booth, 2012). It is important to clearly define exactly what we mean by the term "spirituality." Booth's (2012) attempt to present spirituality in "a nonreligious way" to those in counseling resonates with the definition of spirituality provided by Stevens and Townsend (2013): the way in which an individual finds their freedom and meaning in life. As Booth puts it, "spirituality exists wherever we struggle with the issue of how our lives fit into the greater cosmic scheme of things," and it "is a journey intimately linked with the pursuit of personal growth or development" (2012). One need not be a Jungian or a practitioner of logotherapy to appreciate why such issues might be meaningful in a therapeutic context. Indeed, groups like AA construct spirituality in similar terms; not from within the framework of a particular religious tradition, but instead in the context of a "higher power." This transcendent force could include the God of a specific group, such as Christians or Muslims, or it could be a nontheistic entity such as a caring group of people who attend a local AA meeting in order to support the recovery of other alcoholics. The point is to find meaning and support in a power that is outside, and greater, than oneself.

Although I am not going to claim in this article that there is one correct definition of spirituality, or religiousness for that matter, scientific methods can be brought to bear on the extent to which a particular conception of spirituality might be associated with positive therapeutic outcomes, such as improved sobriety, enhanced mental health, and increased prosocial behavior. In this case, I will discuss findings derived from a conception of spirituality that is quite consistent with AA. However, before proceeding it is important to offer this caveat: it is dangerous to define spirituality *a priori*. As clinicians have attempted to adapt evidence-based practices to different cultural groups, they have become aware of the value of adopting a "Teach Me" posture; in other words, allowing clients to define what spirituality means to them (Stevens and Townsend, 2013). Many clients will not accept AA's definition, nor will all clients necessarily appreciate a nonreligious presentation of spirituality. For some, spirituality is inseparable from their specific religious tradition; the broader notion of spirituality defined in terms of "finding meaning" may seem like a secular attempt to co-opt religion. After all, there are some understandings of spirituality that minimize the supernatural in focusing on a "life well lived." Other forms of spirituality may stress a "special revelation" involving important perceived supernatural experiences.

Unlike the clinician who must understand religion and spirituality from the perspective of each individual client—or risk offending and alienating them, thereby compromising the therapeutic process—the social scientist is able to pick a particular definition of spirituality, operationalize it, and study its effects on outcomes of interest. In the study that produced the findings that I report in this article, my colleagues and I utilized the Daily Spiritual Experience Scale (DSES), which is a sixteen-item self-report of perceived awareness of the transcendent in daily life (Underwood & Teresi, 2002; Underwood, 2006). The DSES does not focus on religious beliefs or practices; the latter we measured with the Religious Beliefs and Behaviors Scale. Instead, the DSES assesses spiritual experiences, such as feeling God's presence, experiencing a connection to all of life, connecting

with God in a way that produces joy, feeling God's love, feeling spiritually touched by all of creation, feeling a selfless caring for others, being guided by God in daily activities, and other related items.

The DSES overlaps significantly with how AA discusses spirituality and the relationship with a "God of one's own understanding." AA's Twelve Step model is not a one-time solution to a short-term problem. It is instead a spiritual way of life that replaces the shallow materialism of the addict. Spirituality, finding freedom and meaning in life, or seeing how one fits into the greater cosmic scheme of things depends on constantly working the Steps. Without the spiritual development that comes from working the Steps, the grip of addiction cannot be broken. A higher power is needed to replace the selfishness at the root of addiction with a spirituality grounded in other-regard. The AA *Big Book* declares self-centeredness to be "the root of our troubles . . . Above everything, we alcoholics must be rid of this selfishness. We must, or it kills us" (Alcoholics Anonymous, 2001, p. 62). The phrase "King Baby" sums up the alcoholic's antispiritual worldview.

The solution to addiction, according to AA, is to recognize that one has lost control of one's life, turn to a higher power for help, root out the selfishness that is at the heart of the problem, work on spiritual development, and engage in prosocial (as opposed to egocentric) behaviors such as making amends, admitting wrongs, sponsoring other alcoholics, and leading an altruistic lifestyle. AA addresses the egocentrism that lies at the core of addiction and many other personal and social problems by getting the addict into deep relationships of mutual accountability and mutual beneficence with a God of their own understanding and a supportive network of recovered and recovering addicts.

The spirituality inherent in the Twelve Steps helps the alcoholic find that which is meaningful in life, which ultimately "sets us free" from addiction—to borrow Jung's words from the epigraph. But does it work? Preliminary findings from a recent study are encouraging.

Study Results

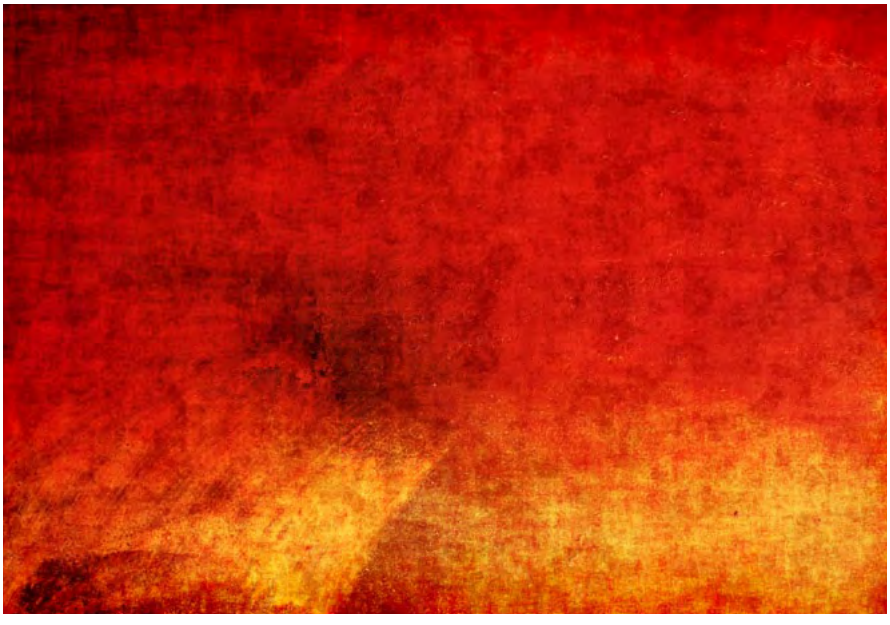
The study—part of Case Western Reserve University's Project SOS—involved a longitudinal investigation of the course of adolescent addiction recovery. Participants were 195 juvenile offenders, court-referred for residential treatment at New Directions (ND), the largest adolescent residential treatment facility in Northeast Ohio (Lee et al., in press). ND provides a range of evidence-based therapies, including cognitive behavioral therapy, motivational enhancement therapy, group therapies, and relapse prevention and aftercare. During their residential stay at ND, clients attended Twelve Step meetings as adjunct treatment.

We measured daily spiritual experiences using the DSES and also independently assessed religious beliefs and behaviors. We found that the adolescents reported a range of belief orientations at intake, including atheist, agnostic, unsure, nondenominational spiritual or denominational religious. Most of them, regardless of their religious background or denomination, reported having more daily spiritual experiences by the end of the two-month treatment period. Approximately one-third of the teens self-identified as agnostic or atheist at intake, and after two months of residential treatment, approximately half (40 percent) of agnostic/atheist teens endorsed being spiritual or identifying with a religious denomination.

What difference did increased spirituality, as measured by the DSES, make in terms of our outcome variables? Controlling for other factors—gender, age, minority status, ethnicity, grade (years in school), number of arrests in prior twenty-four months, parental education, single parent household, and addiction severity—and independent of intake belief orientation, increased DSES scores were associated with reduced likelihood of testing positive for AOD use based on toxicology screens. These scores also predicted reduced narcissism, as measured by the Narcissistic Personality Inventory, and increased prosocial behavior including helping other alcoholics, donating money, or holding a service position in a Twelve Step program.

It would seem that spirituality is indeed important in fostering positive therapeutic outcomes. We should note that our study cannot prove that AA, or any other single aspect of the treatment process, was the "cause" of the increased DSES scores. However, what we can say is that spirituality did increase from intake to discharge in a treatment program that includes Twelve Step meetings and this increase was associated with better outcomes. Spirituality is not static; it changes with more time sober. Given the association between greater improvements and increased spirituality, facilitation of spiritual growth by clinicians may further promote youth progress.

The capacity of the adolescents in our study to become more spiritual and overcome self-centeredness provides evidence of the malleability of personality and belief orientation. Contrary to conventional wisdom, personality is not relatively fixed by late adolescence, and Axis II disorders such as narcissistic personality disorder can improve. Just because an adolescent is not spiritual prior to participating in the treatment project, does not mean that they are incapable of becoming spiritual. Our results demonstrate that if they do become spiritual, they will tend to have much better outcomes. Changes in spirituality during treatment may serve as the 'switch' that moves youth off of the track of substance dependency and onto the track of recovery and enhanced wellbeing, thereby countering harmful social trends like youth unemployment and decreased volunteering that have worked against addiction recovery.



Conclusion

For AA, spirituality is central to therapy and the spiritual life itself—other-regarding, meaningful, transcendent—is the goal. Sobriety is really a side-benefit of becoming more spiritual. As the *Big Book* states, "We are not cured of alcoholism. What we really have is a daily reprieve contingent on the maintenance of our spiritual condition . . . To some extent we have become God-conscious" (AA, 2001, p. 85).

I have attempted to situate recent findings from a study on adolescents with AOD dependency who participated in a treatment program that utilized AA's Twelve Step approach within the context of a broader discussion of spirituality that stretches back to influential therapists like Frankl and Jung. If these pioneers are correct, AA's effectiveness is partly related to the extent to which its Twelve Step program fosters spiritual progress, which we might understand to mean the degree of growth towards finding "freedom and meaning in life" (Stevens & Townsend, 2013). Some clinicians remain skeptical of this claim and much confusion continues to surround the related, but distinct, concepts of spirituality and religion. More research is needed to help us understand which aspects of spirituality are beneficial in a therapeutic setting. The DSES might be a useful tool in this regard and counselors may wish to employ it in their clinical practice. Alternatively, Stevens and Townsend (2013) suggest using the Spiritual Social Support Index with clients. Regardless of the measure, the evidence is mounting that substance use disorders are "biopsychosocial-spiritual" diseases and that clients would be better served if we more fully understood the relatively neglected spiritual dimension (Stevens & Townsend, 2013, p. 6; Booth, 2012).

This is not to suggest that spirituality alone is enough to solve the problems associated with addiction. Bill W. (1961) noted this in his letter to Carl Jung about the case of Rowland H.; he recounted that during the events that led to the founding of AA Jung had explained to Rowland that although a transformative spiritual experience might save him, just as they "had sometimes brought recovery to alcoholics," this was a "comparatively rare" outcome. Rowland did have this atypical result, as did a mutual friend of his and Bill's named Ebby, and ultimately Bill himself. Empowered by his own unexpected spiritual awakening, Bill W. immediately "sought to fix up all the drunks in the world," with predictable effects: "This posture didn't pan out well at all. At the end of six months nobody had sobered up. And, believe me, I had tried them by the score. They would clear up for a little while and then flop dismally" (AA, 1957/1994, pp. 64-65).

Bill W. discovered, in dialog with AA's other cofounder, Dr. Bob, that the "mutual give-and-take" that is at the "very heart" of AA's Twelfth Step was an important component that worked with spirituality and the rest of the Twelve Steps to enhance recovery and sustain it over the long term (AA, 1957/1994, p. 70). Bill W. referred to the mutuality involved in helping other alcoholics that he discovered in his very first conversation with Dr. Bob as the "missing link" for which he had been searching (p. 70).

The spiritual life enhances this mutuality by bringing people into what Martin Buber (1958/2000) would refer to as "I-Thou" relationships involving an authentic communion between two fully realized human beings. This is perhaps the hallmark of the successful sponsor/addict relationship in AA and it contrasts markedly with the "I-It" relationship where another person is merely an object to be used. Addicts may treat others, and even themselves, as objects, inflicting great harm on the important people in their lives, in ways that are ultimately self-destructive. Spiritually-infused therapeutic approaches like

AA suggest that we cannot ultimately find freedom and meaning in life without genuinely appreciating others, as well as ourselves, as sacred subjects instead of profane objects. This is the spiritual path to healing and sobriety. Contemporary research is just beginning to illuminate this perennial wisdom.

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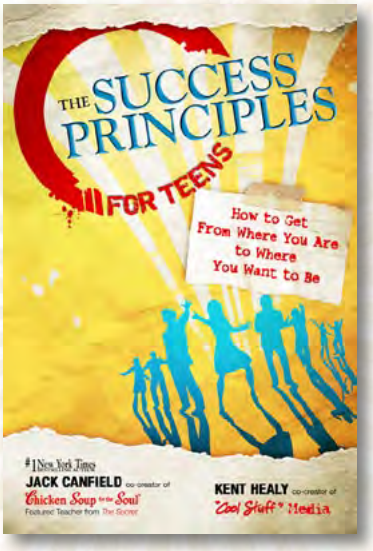

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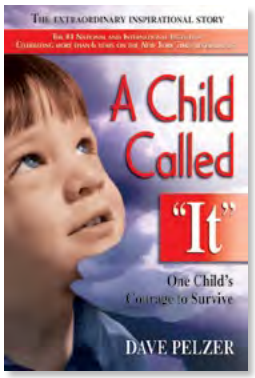

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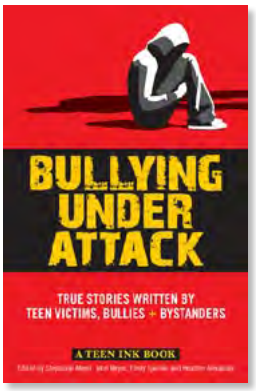

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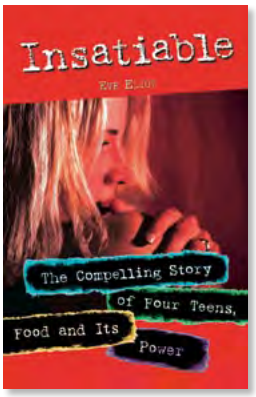

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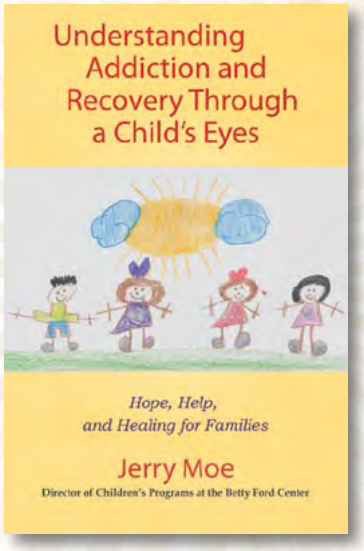

I have spent my adult life in the company of children who have been my teachers. We got to know each other because someone in each child's life was addicted to alcohol or other drugs. ... these youngest victims of addicted families [are] children who live with a legacy that can break hearts and destroy souls—one they certainly did not choose. They arrive carrying secrets, confusion, and pain. But almost all find their voice. These children can and do heal.

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In *Understanding Addiction and Recovery Through a Child's Eyes,* esteemed children's counselor Jerry Moe shares the poignant and profound healing journeys of children who have found their voice and reclaimed their sense of self-worth. He also reveals how the healing process transcends the children and has a dramatic impact on the entire family system, giving them a new, deeper commitment to break the multigenerational legacy of addiction.

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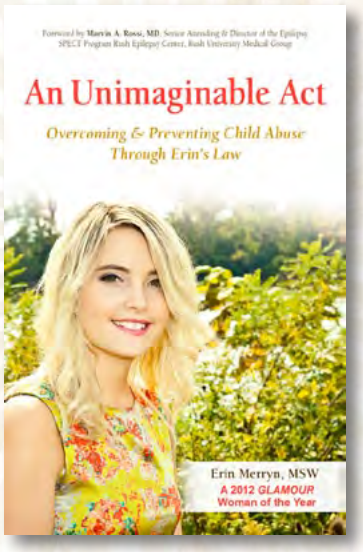
A GLAMOUR MAGAZINE WOMAN OF THE YEAR PROVES THAT ONE PERSON CAN MAKE A VERY BIG DIFFERENCE



Erin takes readers on a remarkable journey of resilience, faith, courage, and forgiveness. She shares how she turned tragedy into triumph, which has led her on an unstoppable crusade to give children the voice she never had as a child. . .

—Julianna Margulies, Actress and star of *The Good Wife*

[Merryn] has taken her personal crusade and turned it into a public one. So many children will be protected because of her.

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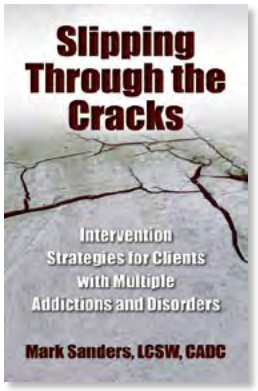

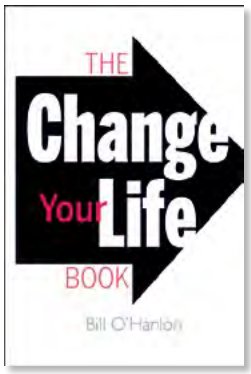

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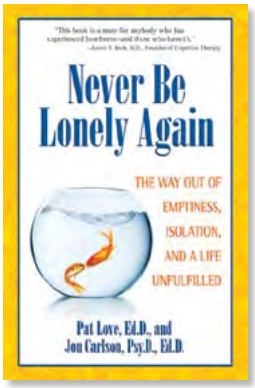

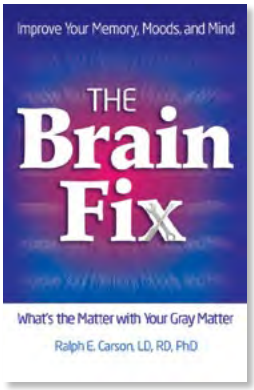

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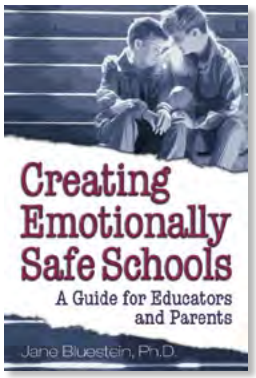

How did a sanctuary for kids become a source of fear and intimidation?

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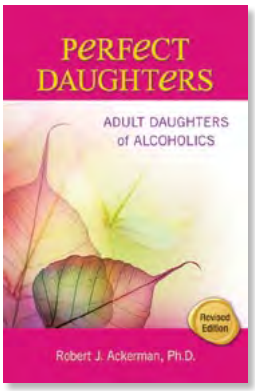
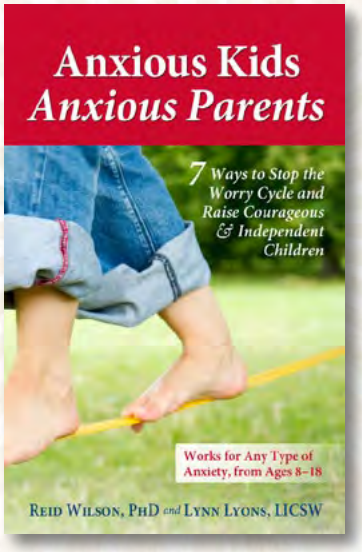


ONE IN EVERY FIVE KIDS SUFFERS FROM A DIAGNOSABLE ANXIETY DISORDER



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This book is a great tool for parents and professionals.

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YOUNG PEOPLE in the new RECOVERY ADVOCACY MOVEMENT

William L. White, MA

"A small body of determined spirits filled by an unquenchable faith in their mission can alter the course of history."—Mahatma Gandhi

In the late 1990s, new grassroots recovery community organizations (RCOs) began to dot the American landscape. These RCOs and the recovery community centers they spawned defied categorization as either recovery mutual aid organizations or addiction treatment organizations. In 2001, recovery advocates representing RCOs from across the country came together in St. Paul, Minnesota, to officially launch a new recovery advocacy movement. This article describes the growing role of young people in the new recovery advocacy movement and introduces Justin Luke Riley, one of the young leaders of a new organization—Young People in Recovery—that is bringing great energy and vision to that movement.



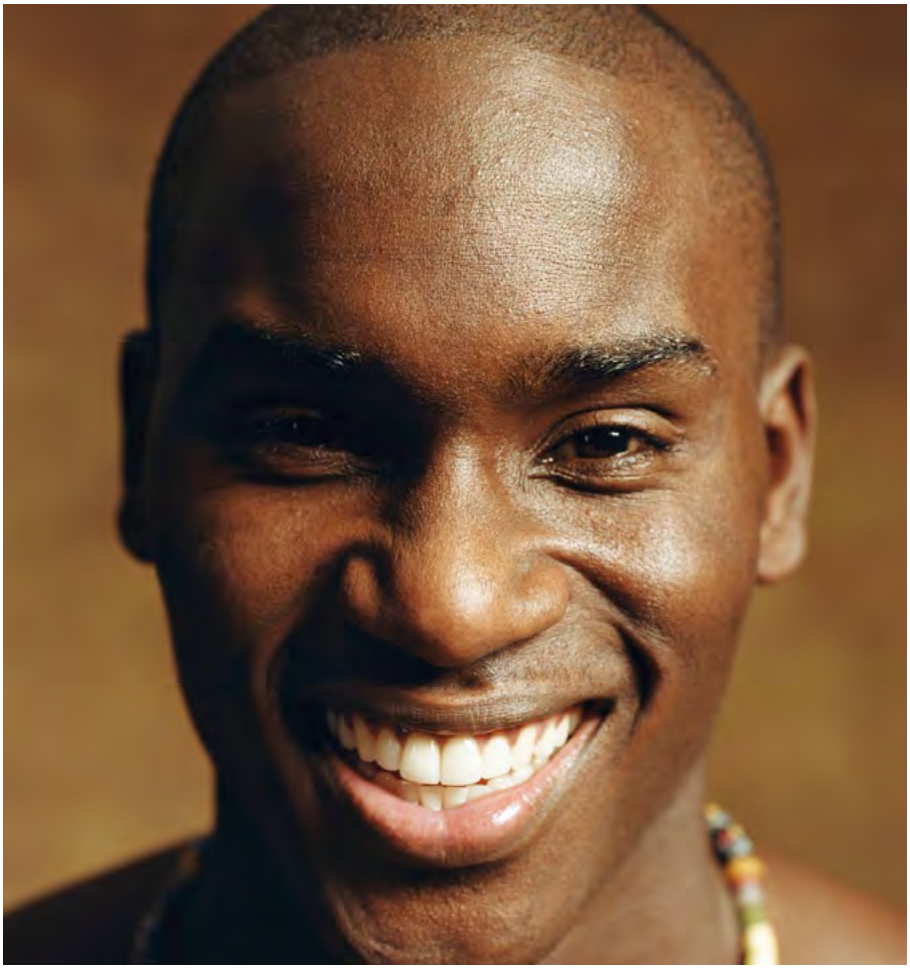

The New Recovery Advocacy Movement

Organizationally, the new recovery advocacy movement brought together resources from multiple national organizations, including the Johnson Institute, the National Council on Alcoholism and Drug Dependence, the Legal Action Center, and the newly formed Faces and Voices of Recovery, but its strength remained within its grassroots RCOs and their growing memberships. Five kinetic ideas formed the heart of this movement: addiction recovery is a living reality for individuals, families, and communities; there are many—religious, spiritual, secular—pathways to recovery, and all are cause for celebration; recovery flourishes in supportive communities; recovery is a voluntary process; and recovering and recovered people are part of the solution—recovery gives back what addiction has taken from individuals, families, and communities.

In its early years, the national movement and its local RCOs focused on eight core strategies:

1. Building strong, grassroots RCOs and linking these RCOs into a national movement
2. Advocating for meaningful, authentic, and diverse recovery representation at local, state, and federal policy levels
3. Assessing local recovery support needs
4. Educating the public, policymakers, and service providers about the prevalence and pathways of long-term addiction recovery
5. Expanding philanthropic and public support for addiction treatment, recovery support services, and recovery advocacy and cultivating volunteerism within local communities of recovery
6. Creating recovery community centers as a focal point for the delivery of nonclinical, peer-based recovery support services
7. Celebrating recovery from addiction through major public events
8. Supporting recovery-focused research

The thirteen years since the historic St. Paul Recovery Summit have witnessed the growing vibrancy and diversification of this recovery advocacy movement. Recovery has emerged as a major organizing paradigm within the addictions field; programs across the country seek to extend addiction treatment from a model of acute biopsychosocial stabilization to models of sustained recovery management nested within larger recovery-oriented systems of care. People in recovery have been culturally and politically mobilized at an unprecedented level. This past September, more than 100,000 people in recovery and their families and allies participated in public recovery celebration events across the country—something that would have been unimaginable only a few years ago.



Two emerging trends portend even greater power and influence of the new recovery advocacy movement. The first is the growing mobilization of family members affected by addiction, particularly parents who have lost a child to addiction. This is evident in new mutual aid structures (e.g., Grief After Substance Passing), grieving parents finding creative ways to share their stories through books (e.g., David Scheff's *Beautiful Boy*) and films (e.g., Jim Contopulos' *More than an Addict*), and parents such as Stacie Mathewson (Transforming Youth Recovery) and Gary Mendell (We Are Shatterproof) who are turning their grief into powerful advocacy voices and are forging new long-term recovery support systems for young people.

The second trend is the growing involvement of young people and the influence they are exerting on that movement. An example of this

influence is the film *The Anonymous People* developed by the young, brilliant filmmaker Greg Williams, which has been viewed by more than thirty thousand people since its 2013 release. Nothing has been more effective in revitalizing and expanding involvement in the advocacy movement than the local screenings of this film. Also of note are the increasing roles young people are playing in organizations like Faces and Voices of Recovery and the Association of Recovery Schools as well as within local RCOs.

Nothing better illustrates the growing presence and leadership of youth in recovery than the early history of the newly formed organization, Young People in Recovery (YPR). I recently interviewed Justin Luke Riley about the history and future of YPR. I hope you will find this conversation as engaging and inspiring as I did.

Early History of Young People in Recovery

Bill White: Justin, could you share the story of how you came to be involved in recovery advocacy and with Young People in Recovery (YPR)?

Justin Luke Riley: Absolutely. First, let me introduce myself to our readers. My name is Justin Luke Riley, and I'm a young person in recovery. For me, that means that I've learned to be a much better son and an asset to my community, and I'm still learning how to be a husband—I've only been married for two-and-a-half years. It also means to me that I've been alcohol- and other drug-free since November of 2007. In November of 2007, I heard a message that was very simple and clear—and that was my need to help others in whatever way I could. So at age nineteen I began to carry the recovery message, and to let other young people know that it is okay and even exciting to be in recovery.

I was then asked to participate in something that changed my life. It was a government-funded conference in December 2010, and I was asked to share that I was in recovery and how that had happened. I talked about my friends, how people around me were helping me, and how I was going back to school. At this meeting, there were other young people who kept saying, "We're part of CRC at Rutgers." I finally interrupted and said, "I don't know what you mean when you keep saying you're part of CRC. Is that a treatment center? Is that a new AA thing?" They said, "No, it's a collegiate recovery community. There's a house on Rutgers University that supports us and our journey to recovery. Some of us go to Twelve Step meetings. Some of us just learned a different way to live without abusing substances." I was flabbergasted, Bill. I'd never heard of this. I asked them, "So basically, it's just like Hogwarts for kids like us who need an alternative environment?" I said, "Your campus not only knows your history, but they're supporting you in your recovery? That's amazing to me."

Those present included Devin Fox, Daniel Turino, Benjamin Shand, Sarah Nerad, Aaron Hoffman, Mike Deagros, and others who would later play important roles in YPR. Young People in Recovery was really birthed out of the sharing that began at that conference and at a follow-up conference held in July 2011.

Bill White: What is your recollection of the early vision or hopes of what YPR could achieve?

Justin Luke Riley: We had this vision of empowering young people, of carrying a message of hope, not proposing we have the best way to recover, not endorsing a certain kind of recovery, but just lifting up all these great things that we'd experienced and heard about. After those first two meetings, there were frequent conference calls until 11 pm at night because so many of us were either working or going to school. Those first calls were, "Hey, what's happening in your part of the country?" type of exchanges. We finally came up with a vision and a mission statement, and we met again in Bethesda with some outside help to do some strategic planning to formalize ourselves as an organization. So many people believed in us: Faces and Voices of Recovery, the National Recovery Foundation, SAMHSA, and the Stacie Mathewson Foundation.

Our really big vision is a world where all young people in or seeking recovery can achieve their potential in life. We wanted to be as inclusive as possible—embracing people in traditional Twelve Step programs to harm reduction programs and everything in between, from SMART Recovery to the All Recovery Meetings that are becoming more popular among young people. We wanted to be supportive of any way a young person could find recovery.

Structure and Financing of YPR

Bill White: How is YPR currently structured?

Justin Luke Riley: Young People in Recovery is incorporated in good standing in the state of Colorado. It is governed by an advisory board made of people from coast to coast—some in the addiction recovery field and some who are representatives from foundations or other nonprofit organizations. The advisory board meets by conference call each month, at which time the finances and budget are reviewed and plans made for the continuing future of YPR. Our 501(c)3 status is pending with officers, including a chair and vice chair of the board of directors and a secretary and treasurer. Like other organizations, we have bylaws and committees.

YPR has three staff members, two of which have come on in a more full-time capacity in January 2014. These positions include the vice president of communication filled by A. J. Senerchia who's been with YPR a little over a year now, and Douglas Rudolph, who's our chief public policy officer. They're both wonderful leaders who have volunteered thousands of hours to the cause of Young People in Recovery. A. J. makes sure that all chapters know how to recruit volunteers, host a YPR chapter meeting, and manage themselves financially. Doug helps us continue to be aware of all of the rules and the very strict guidelines that distinguish education and advocacy from lobbying. Doug has a meeting with the Office of National Drug Control Policy (ONDCP) at the White House coming up in the next few weeks. We have worked very closely with ONDCP over the last few years. I'm the president and CEO of Young People in Recovery and was

the chair of the National Leadership Council before we were fully organized as a nonprofit organization. My job is to develop a business model for YPR to assure its sustainability and to meet with the YPR chapters and support them in any way I can.

Another person I would like to mention is Devin Fox. He was the trailblazer who carried YPR on his shoulders in our early days. I can confidently say that without Devin Fox, YPR wouldn't be where it is today and might not even still be here. Devin kept us all together in those early days and solidified our relationships with key organizations. Mike DeAgro, our current board chair, also deserves acknowledgement for bringing YPR to its present level of development.

Bill White: How has YPR been financially supported?

Justin Luke Riley: The way we've been funded so far is from key partners. SAMHSA paid for us to get together for our early strategic planning and, through Abt Associates, provided the consultants that guided our early organizational efforts. The National Youth Recovery Foundation and Faces and Voices of Recovery both housed us within their umbrella before we became an independent organization. Two foundations—the Bridge Foundation and the Stacie Mathewson Foundation—have supported us. The Stacie Mathewson Foundation is by far the largest financial supporter we have had to date.

YPR Chapters

Bill White: You have referenced state and local chapters of YPR. Could you describe the current state of chapter development?

Justin Luke Riley: We now have more than ten chapters. It's a bit tough pinning this number down because there is no ironclad rule of what it takes to be a chapter. We don't say, "Hey, if you want to have a chapter, it has to have these five ingredients and if it doesn't, then you can't be a chapter." What we have are suggested guidelines of how different chapters have organized themselves and what types of activities they have pursued. Some of our chapters, like the one here in Denver, Colorado, where I live, are promoting collegiate recovery programs and promoting the development of recovery community centers. The Colorado YPR chapter has a facility where chapter meetings, Twelve Step meetings, and All Recovery meetings are held. They provide some peer-based recovery support services through the Access to Recovery program. The major recovery advocacy organization in Colorado, Advocates for Recovery, is also housed at the YPR facility.

In contrast, we have a YPR chapter in Ohio that focuses on sponsoring sober events such as bowling or going to athletic games to help people have a social life in recovery that is not centered around alcohol and drugs. Other chapters have more of a public policy focus. Many of our YPR chapters, such as those in Reno and Los Angeles, focus their efforts on supporting their collegiate recovery programs. At the end of the day, the mission of each chapter is to identify, prioritize, and respond to the recovery support needs of young people in their community. What that looks like is helping people getting back to college, helping them get jobs, helping them navigate the pre- or posttreatment world, helping them socially integrate and thrive and contribute as a recovering person within the community.

What we've done is turned it all upside down. Rather than having a set program we want everyone to replicate around the country, we are asking local chapters to define what their community needs and then we are supporting them in their efforts to meet those needs. One of the ways we're going to offer that support is to host national leadership conferences every year and develop young leaders in recovery from across the country and give them opportunities to learn from

each other. We're going to have young people from diverse cultural settings have the opportunity to be nominated to participate in these conferences. We don't want any financial barriers to keep anyone from creating a YPR chapter and participating in these conferences. Instead of our staff flying around everywhere telling everyone what to do, we are going to bring everyone together to share what is working within local communities in terms of recovery support for young people. We will have some of our key partners, such as Faces and Voices of Recovery, also represented at these meetings. In addition, we are putting money in our national budget to help local YPR chapters seed some of their key activities.

Bill White: Justin, what can Young People in Recovery as an organization and young people in recovery bring to shape the future of the larger recovery advocacy movement in the United States?

Justin Luke Riley: I think we're going to be able to change the way people in our country view addiction and recovery. I know that's a big statement and that this will require a huge culture shift, but I do believe that Young People in Recovery, and not only as an organization but just what we are doing to mobilize young people as an advocacy force, will have this effect. I see the changes in people's faces when I say, "I used to be homeless but today I'm in recovery and I'm married and productive." Through their stories, young people are going to be able to change the public perception of addiction recovery and mental health recovery.

Personal Reflections

Bill White: What has your involvement in YPR meant to you personally?

Justin Luke Riley: I'm twenty-five years old and I got involved when I was twenty-one. I've lost about twenty of my closest friends due to addiction. Today, I have the sense that part of my destiny is to give people hope and help. My mentor once told me, "One day, you're going to be able to help a lot of people. God made you specifically for that. You're not perfect and you never will be, but you're going to be able to influence others and you're going to be able to let people know that there is hope, that there is a solution and you're going to be able to carry that message forward." He also told me very clearly that this isn't about ego. It was about a larger purpose in my life. There's a higher power I choose to call God, and me and God are working together to try to help people. This is not just a social thing or a rite of passage for me. It's about this larger need in the community and a larger purpose in my life related to that need. I know that I have a Batman complex sometimes, but I know that recovery is possible. I mean, my dad was the best man at my wedding and there was a time when my family did not speak to me because of the things that I had done and the destruction I was wreaking in my life. My dad is in recovery himself now! He lets me tell people. He didn't used to, but then he saw clips from [the film] *Anonymous People* and he called me and he said, "I finally get it." He said, "If you ever need help telling people that there's a solution, let me know." So, for me, it doesn't get more personal than that. Recovery saved my life, my father's life, my family's life, and it's given me a new life. I saw a lot of lives lost along the way and I know YPR is now saving and changing lives.

Getting Involved

Bill White: Justin, let me ask a final question. How can young people in recovery get involved in YPR or addiction professionals get more information about YPR?

Justin Luke Riley: They can e-mail me directly at jl.riley21@gmail.com, they can e-mail the vice president of communication, whose contact information is on our website (www.youngpeopleinrecovery.org), or they can go to our Facebook page (www.facebook.com/youngpeopleinrecovery) and message us. If anyone sends us a message, A. J. or myself will call to follow up. We love doing Google Hangouts because we can see each other. So contact us and we'll set up a Google Hangout, Facetime, or Skype. We'd love to support development of a YPR chapter near you.

Bill White: Justin, thank you for taking this time to speak with us and thank you for all you are doing for young people and their families.

Justin is just one of a legion of advocates among the largest generation of young people in recovery in history. The future of addiction recovery in America may well rest in their hands. C

Acknowledgements: *Support for this interview was provided by the Great Lakes Addiction Technology Transfer Center (ATTC) through a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the views of the author and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.*

William 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*

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From the *Journal of Substance Abuse Treatment*

OUTPATIENT TREATMENT OPTIONS FOR ADOLESCENT SUBSTANCE ABUSE:

A Systematic Research Review & Meta-Analysis

Emily E. Tanner-Smith, PhD, Sandra J. Wilson, PhD, & Mark W. Lipsey, PhD

RECENT NATIONAL ESTIMATES INDICATE THAT APPROXIMATELY 14 percent of the 1.96 million substance abuse treatment admissions in the United States in 2010 were for adolescents under age twenty, the majority of whom presented with marijuana or inhalants as their primary substance of abuse (SAMHSA, 2013). With so many adolescents enrolled in substance abuse treatment programs, it is important to know whether such treatments are effective and, if they are not all equally effective, which are most effective. Adolescents with substance use disorders often have different treatment needs than adults (Brown, Tapert, Granholm, & Delis, 2000; Tapert, Caldwell, & Burke, 2004/2005; Winters, 1999). Therefore, when assessing the current research evidence for substance abuse treatment effectiveness for adolescents, it is crucial to consider research conducted with adolescent samples rather than generalizing findings from studies on adults. Fortunately, there have been numerous high-quality studies over the last two decades focusing on the comparative effectiveness of different types of substance abuse treatment options specifically for adolescents (e.g., Dennis et al., 2004; Waldron & Turner, 2008; Williams & Chang, 2000).

One useful approach for summarizing the current best evidence in a research literature is a systematic review and/or meta-analysis. Systematic reviews refer to literature reviews that identify, collate, and summarize all empirical evidence on a specific research topic using explicit, systematic, and transparent methods designed to minimize bias in the review process. Meta-analysis refers broadly to a range of statistical techniques used to collect data from studies identified in a literature review, and to synthesize findings from multiple studies included in the review. Meta-analyses based on systematic literature reviews can provide a comprehensive picture of the entire research literature on a topic, permitting broader scope, depth, and generality than discussion of any single study by itself. Indeed, this is why systematic reviews and meta-analyses are often considered important sources of information for promoting evidence-based practices.

Several narrative literature reviews have summarized the research literature on the effectiveness of treatment for adolescents with substance use disorders (e.g., Deas & Thomas, 2001; Ozechowski & Liddle, 2000; Waldron & Kaminer, 2004). In one of the most comprehensive systematic reviews to date, Waldron and Turner (2008) used meta-analysis to synthesize findings from forty-six different treatment conditions reported in seventeen different randomized clinical trials. Their results indicated that treatment effects were especially positive for multidimensional family therapy, functional family therapy, and cognitive behavioral therapy. However, that review did not summarize comparative effects for other treatment modalities, such as motivational enhancement therapy, and due to the small number of studies, was unable to further explore variability in treatment effects across different treatment settings or for different adolescent populations.

Given this gap in the research literature, we recently conducted a systematic review and meta-analysis of the existing research on the effectiveness of outpatient treatment options for adolescents with substance use disorders. Specifically, this systematic review examined the comparative effectiveness of different types of substance abuse treatment options for adolescents, the magnitude of change in adolescents' substance use after they entered treatment, and whether certain types of adolescents or treatment settings were associated with greater improvements. This article summarizes the findings from that systematic review and meta-analysis on the comparative effectiveness of different outpatient substance abuse treatment options for adolescents.

Methods

Studies included in our meta-analysis were those that met predefined inclusion criteria and were identified in an extensive search of the research literature. To be included in the meta-analysis, studies were required to focus on a substance abuse treatment program delivered on an outpatient

basis to adolescent participants twelve to twenty years old who met DSM criteria for substance abuse or dependence, or the equivalent. Eligible studies had to use random assignment to treatment conditions or a quasi-experimental nonrandomized design that employed matching or statistical controls on baseline substance use or risk variables. Studies also had to report results for at least ten participants per condition on at least one posttest measure of substance use, in a format that permitted estimation of an effect size. Finally, to be eligible, studies had to be reported in English in 1980 or after.

In 2008, we identified eligible research studies by conducting a comprehensive literature search, which included searching electronic bibliographic databases—Dissertation Abstracts International, PsycINFO, PubMed—hand-searches of conference proceedings, reviewing reference lists in other studies, and contacting researchers in the field. This search yielded a total of forty-five eligible published and unpublished studies reported from 1981 through 2008. All of the studies compared substance use outcomes for adolescents in a given treatment program, such as family therapy, with outcomes for adolescents in a comparison condition, most often an alternative treatment of some sort.

Standardized mean difference (Hedges' g) effect sizes for the substance use outcomes were used to represent the magnitude of the treatment effects. These are calculated as the difference between the posttest means for the treatment and comparison conditions divided by the pooled standard deviation (Lipsey & Wilson, 2001). Within each of the treatment and comparison conditions, we also estimated pre-post mean change effect sizes for substance use outcomes, calculated as the difference between the posttest and pretest means divided by the pooled standard deviations. All effect sizes were given algebraic signs such that positive values indicated better results, such as lower substance use, in the focal treatment group versus the comparison group, or better results at posttreatment than pretreatment. We synthesized effect sizes across studies using random effects inverse variance weighted meta-regression models that used robust standard errors (Hedges, Tipton, & Johnson, 2010). These methods allowed us to analyze all available effect sizes from all studies, such that multiple effect sizes from the same participant sample could be included in the same meta-analysis.

Results

Our comprehensive literature search yielded a total of forty-five eligible published and unpublished studies reported from 1981 through 2008. Because some studies compared multiple treatment conditions, we were able to extract posttreatment outcome data for seventy-three different treatment-comparison group contrasts. Most of the studies (84 percent) were reported in journal articles and virtually all (99 percent) used random assignment to conditions. Most of the participant samples were predominantly male (68 percent) and white (61 percent), and their average age was sixteen. Nearly half (47 percent) of these samples included adolescents with clinical levels of psychiatric comorbidity, such as oppositional defiant disorder or major depressive disorder. Treatment conditions represented in the research studies were provided in group settings, versus individual settings, in 32 percent of the studies and many included at least some level of family involvement. The average treatment duration was seventy-six days and, on average, treatment programs had contact with adolescents several times per week.

Comparative Treatment Effectiveness

Overall, the treatment types most prevalent in the research literature were family therapy, motivational enhancement therapy (MET)/motivational interviewing (MI), psychoeducational therapy (PET), behavioral therapy, and cognitive behavioral therapy (CBT). These different treatment modalities were often compared with each other or with other control conditions. However, every treatment type was not compared with every other treatment type—for example, behavioral therapy was never directly compared to MET—and thus we could not make direct comparisons between many treatment types. Nonetheless, we used meta-analytic methods to estimate the comparative effectiveness of different outpatient substance abuse treatment types from the direct comparisons that were available, while also statistically adjusting for the potentially confounding effects of differences across studies on methodological and sample characteristics.

Figure 1 displays the treatment types with arrows connecting those compared in the available research. Each arrow points to the treatment type with the better outcomes in that comparison. Treatment types are shown so that those favored in fewer comparisons are farther to the left while those favored in more comparisons are further to the right. The thickness of the arrows is proportionate to a composite indicator of the magnitude of the respective effect sizes and the number of studies on which they are based. The thickest arrows represent the relationships with the largest effect sizes and the most studies while the thinnest ones represent the relationships with the smallest effect sizes and the fewest studies.

Although some treatment types tended, on average, to show somewhat larger or smaller effects than the treatment conditions with which they were compared, most of those differences were not statistically significant. The notable exceptions to this were the family therapy and MET programs, which often produced better results relative to the other treatments to which they were compared; although on average, family therapy programs yielded better results relative to MET programs. In general, results from this analysis indicated that the outpatient treatment options for adolescents with substance use disorders could be roughly divided into the following four groups.

No-Treatment and Placebo Control Conditions

These control conditions were consistently less effective than any active

treatment conditions. Furthermore, results comparing no-treatment conditions with all other treatment types provided evidence that most outpatient treatment options yield better outcomes than no treatment.

PET, Group/Mixed Counseling, and Practice as Usual

These treatments fared worse than almost every other treatment with which they were compared. These treatment modalities may be more effective than no-treatment control conditions, but the evidence for that is limited.

CBT, MET/CBT, MET, Behavioral Therapy, and Pharmacological Treatment

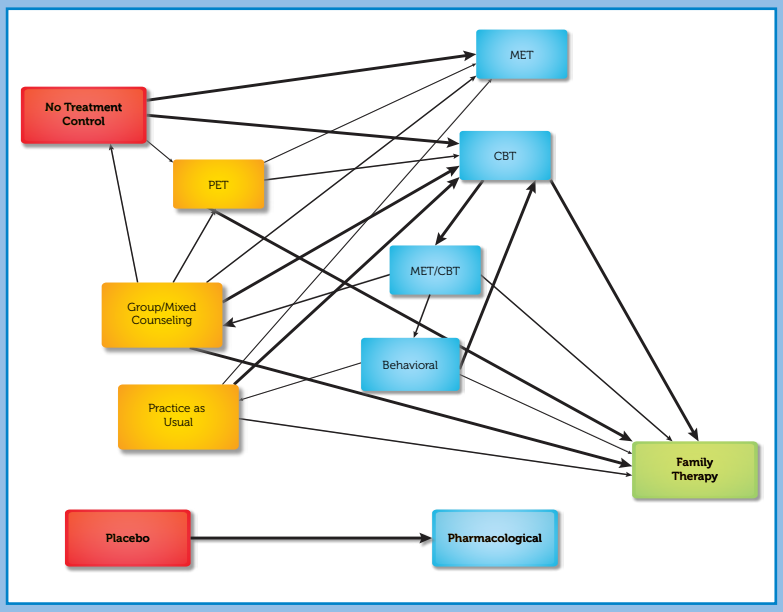
CBT showed better outcomes than any of the treatment types in groups one and two above with which it was compared. The pattern of results comparing findings across CBT, MET/CBT, and behavioral therapy were inconsistent in a way that did not allow them to be easily differentiated. MET was not directly compared with any of those three treatments, but showed favorable outcomes relative to the treatments in group two and no-treatment controls. Pharmacological treatment options—acamprosate, cyanamide, disulfiram, fluoxetine, naltrexone, pemoline, tianeptine—were only compared with placebo control conditions, so little can be said about their relative effectiveness in comparison to the other treatments in this group.

Family Therapy

Family therapy compared favorably with every other treatment with which it was compared, including the treatment types in group three above. The average effect of family therapy was equivalent to reducing the number of days adolescents used marijuana in the past month from ten days to six days. Although this is a modest substantive impact, it still equates to a 40 percent reduction in marijuana use.

These comparisons of outcomes between different types of treatments do not provide much insight into the extent to which substance use was reduced after adolescents participated in these treatment programs. To assess that, we examined pre-post change in substance use among adolescents enrolled in both the treatment and comparison conditions within each of these studies. We also conducted analyses to examine whether reductions in substance use varied for different types of adolescent participants, and across different treatment settings. The results of this analysis, which will be described next, provided an additional perspective on the comparative effectiveness of different types of outpatient treatment for adolescents.

FIGURE 1. COMPARISONS BETWEEN DIFFERENT TREATMENT TYPES



Notes: The arrows point to the treatment type with the more positive outcomes in each comparison. The thickness of each arrow indicates the magnitude of the mean effect size and the number of studies on which it is based, each equally weighted. The treatment types are arrayed from left to right with those to the right generally showing larger positive effects than those to the left with which they are compared. Adapted from original JSAT *article. See editor's note.*

Assessing Change over Time

To examine changes in substance use over time, we extracted information about the pre-post change in substance use among adolescents enrolled in either the treatment or comparison conditions in each of the studies included in the meta-analysis. It is important to note that pre-post change scores should not be used to make causal inferences about treatment effects, given that changes in substance use might occur naturally over time or could be due to other personal or environmental factors. Nonetheless, an examination of pre-post change scores can be informative, particularly when examined in parallel with the comparative treatment effectiveness results shown above. Pre-post change data were available for seventy-nine different treatment or comparison conditions from forty-four of the forty-five studies included in the first analysis.

On average, adolescents showed significant reductions in all types of substance use after entry into treatment. Those reductions were largest for marijuana and mixed substance use, and smallest for alcohol or other specific substances. These effects were equivalent to a pre-post reduction from two to 0.6 days of alcohol use in the past month, from thirteen to six days of marijuana use, from ten to five days of mixed substance use, and from 3.5 to 2.7 days of other substance use.

Overall, there was no evidence that the aggregate gender, race/ethnicity, age, clinical comorbidity, delinquency, or baseline substance use severity of the

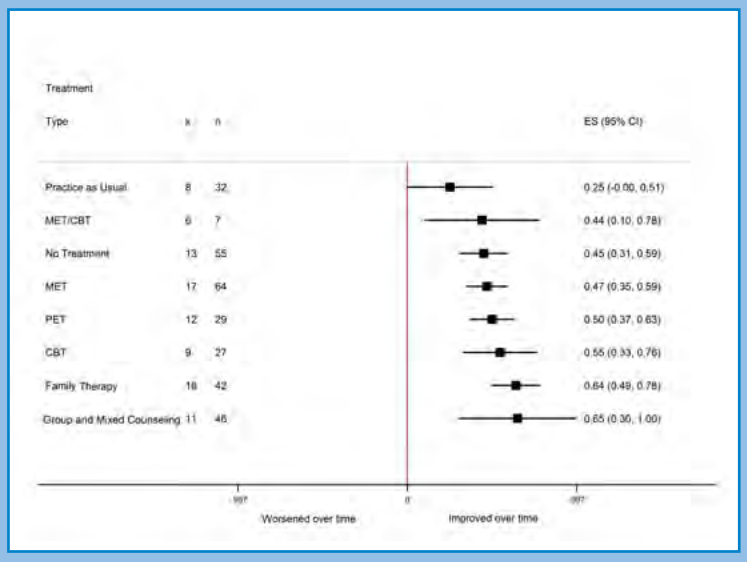
treatment samples was related to larger or smaller reductions in substance use over time. However, adolescents in longer treatment programs generally showed less improvement over time. For instance, after controlling for other background and study characteristics, the predicted pre-post mean effect size for one-day treatment programs, or brief interventions, was 0.68, versus 0.61 for thirty-day programs, 0.45 for ninety-day programs, 0.37 for 120-day programs, and 0.14 for 210-day programs. Thus, participants in all types of programs showed reductions in substance use over time, but participants in longer-duration programs reported somewhat less improvement over time.

Finally, to provide an additional perspective on the comparative effectiveness of different outpatient treatment options for adolescents, we examined whether different treatment modalities were associated with larger or smaller reductions in substance use over time. Results from that analysis are shown in Figure 2, which presents the random effects means and 95 percent confidence intervals for the adjusted pre-post change effect sizes for each of the treatment types represented in at least four independent samples. The vertical line at zero represents no improvement from pretest to posttest and mean effect sizes to the right of that line indicate that, on average, there were improvements over time.

As shown in Figure 2, the results indicated that, with few exceptions, adolescents in all treatment types exhibited significant and positive improvements in substance use over time. The group/mixed counseling treatments and family therapy programs showed the largest adjusted mean pre-post effect sizes, although there was substantial overlap among the confidence intervals for most of the treatment types, indicating that their differences were not statistically significant.

Thus, findings from the pre-post change analysis were similar to those reported above for the comparative treatment effects, with a few notable exceptions. Relative to the other treatments, group/mixed counseling and PET showed stronger effects in the pre-post analysis and MET/CBT showed weaker effects. As in the earlier analysis, however, few of these differences were statistically significant. Moreover, because of the limited reporting of information in the studies, not all the treatment arms represented in the group comparisons could be included in the pre-post analysis, thus the two sets of results are not strictly comparable.

FIGURE 2. ADJUSTED MEAN PRETEST-POSTTEST EFFECT SIZES FOR EACH TREATMENT TYPET



Note: Means to the right of zero indicate reduced substance use over time (i.e., lower frequency, more abstinence) in the treatment type listed. Treatment types with k < 4 (behavioral, pharmacological, placebo) are omitted from the figure. Adapted from original JSAT *article. See editor's note.*

Discussion and Conclusions

Results from this systematic review and meta-analysis provide an encouraging pattern of findings that address several key questions about the treatment of adolescent substance use disorders. First, the results provide clear evidence of the efficacy of some outpatient substance abuse treatments for adolescents with substance use disorders. Although only four of the distinct treatment types identified in this meta-analysis were studied in controlled comparisons with no-treatment control conditions—group/mixed counseling, CBT, MET, and PET—results from the meta-analysis indicated that these treatment options were clearly superior. Furthermore, results from the pre-post analysis indicated an almost universal reduction in substance use between treatment entry and termination. Although this could be due to spontaneous remission on the part of the adolescents, it is entirely consistent with the expected effects of effective treatment.

Second, results from this study also provide important information regarding the comparative effectiveness of different outpatient substance abuse treatment options for adolescents. Indeed, the goal of conducting this research was to assess which, if any, treatment options work best, and for which adolescents. Ideally, for purposes of assessing this question, multiple studies would exist that compare each treatment type with every other treatment type. Although the research to date falls short of this ideal, we were still able to assess comparative effectiveness by examining each treatment type relative to the other conditions with which it was compared in the available research. Results

indicated that family therapy (e.g., Family Support Network, Functional Family Therapy, Multidimensional Family Therapy, Multisystemic Therapy) and MET programs (e.g., MET/CBT-5, MET/CBT-7), on average, were efficacious relative to the various treatment and control conditions with which they were compared. CBT, MET/CBT, and behavioral therapy were also favored in the comparisons in which they were involved. These patterns were largely replicated when the pre-post effect sizes for the individual treatment arms were compared. Family therapy, behavioral therapy, CBT, and MET were among the treatment types showing the largest substance use reductions while placebo and no treatment control conditions, as expected, were among those showing the smallest reductions. The most convincing and consistent comparative effectiveness finding was for family therapy, which showed relatively large positive effects relative to other treatments in both analyses.

Third, results from this study provided little evidence of differentiation in treatment effects for different adolescent participants. The analysis of pre-post reductions in substance use, for instance, found no differences related to gender, race/ethnicity, age, baseline substance use severity, comorbidity, or delinquency level. This somewhat surprising finding is perhaps encouraging in that different outpatient treatments appear to be relatively robust in their effects—that is, they produce similar outcomes for adolescents with different demographic and health profiles. This conclusion is premature, however, and will need to be addressed in future research studies that explicitly examine the comparative effectiveness of outpatient treatment options for different subgroups of adolescent participants.

Finally, findings from this meta-analysis indicated that among adolescents enrolled in outpatient substance abuse treatment programs, reductions in substance use were smaller for alcohol and other substances, like heroin and cocaine, than for marijuana. Marijuana use thus may be more responsive to outpatient treatment than alcohol or hard drug abuse, at least among adolescent participants.

Any practical implications of the findings from this study should of course be considered in tandem with issues of cost and feasibility of implementation of different outpatient treatment options, issues which were not addressed in this study. Although some types of treatment outperformed or underperformed other treatment types, in general, there is a range of treatments available for adolescents with substance use disorders that may be effective. Practitioners tasked with choosing a specific treatment program to implement should therefore consider the costs of implementation associated with different treatment types. For instance, cost effectiveness research from the Cannabis Youth Treatment Study suggests that the cost per day of abstinence produced is significantly higher for branded family therapy programs than for MET/CBT and ACRA programs (Dennis et al., 2004). More research will be needed to fully integrate information about the comparative effectiveness of different outpatient substance abuse treatment options with their cost and feasibility when used in routine practice. C

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CANNABIS CONCERNS, PART 1

CANNABIS DEPENDENCE & ADOLESCENT ADDICTION TREATMENT

DAVID E. SMITH, MD, FASAM, FAACT, MICHAEL WACHTER, MD, JENNIFER GOLICK, LMFT, & SCOTT SOWLE

MARIJUANA is by far the most widely used illicit drug by adolescents. In the past few years, marijuana use by teens has been increasing while perceived risk of marijuana use has shown steady declines. In 2013, at Muir Wood Adolescent and Family Services, a gender-specific residential treatment program for boys aged thirteen to seventeen in northern California, the majority of teens entering residential treatment were admitted with a diagnosis of cannabis dependence. Recent studies by Monitoring the Future (Johnston, O'Malley, Bachman, & Schulenberg 2013) have shown that adolescent males are more likely to use marijuana than females, that males had an earlier age of onset, and that males are more likely than females to become marijuana dependent.

Research into the effects of cannabis on the developing brain has increased exponentially over the past decade, largely as a result of discovering the importance of the naturally occurring cannabinoid system that regulates brain growth and development (Berghuis et al., 2007; Heng, Beverley, Steiner, & Tseng, 2011). This system has natural receptors for cannabis-like signal molecules produced in the body. These signals are used for development of healthy adolescent brain structures and function. The disruptive effects of external cannabis on the development of healthy adolescent brain function and structure are potentially very concerning and far-reaching (Keimpema, Mackie, & Harkany, 2011; Rochetti et al., 2013; Moore et al., 2007; Hall & Degenhardt, 2009).

Cannabis, or marijuana, is a complex plant containing a wide variety—at least eighty-five—of chemicals called cannabinoids. Cannabinoids exert their psychoactive properties by interacting with the brain's cannabinoid CB1 receptors, which are found in the brain in higher concentrations than any other receptor, and the endocannabinoid system, which is at least ten times the size of the endorphin system (Cermak, 2010), to repress the release of neurotransmitters.

Anandamide is the naturally occurring molecule that binds to the brain's natural cannabis receptor, modulating the receptor's function. The problem with externally consumed cannabis is its nonspecific flooding of the naturally regulated endogenous system, which emulates and alters the endogenous neurotransmitter system, the same way that external administration of thyroxin can shut down the naturally occurring internal production of thyroid hormone. This alteration in the hormonal neurofeedback loop is the basis for cannabis dependence and withdrawal.

The endocannabinoid system regulates such necessary physiological functions as appetite, memory, pain threshold, attention, fear/anxiety, and others (Cermak, 2010). This internal system is altered by ingesting cannabis, whose psychoactive cannabinoid THC produces euphoria and anxiety relief, increased appetite, higher pain threshold, and other symptoms in many; some, depending on their individual genetic and neurobiological makeup, will experience these effects differently.

Chronic use of cannabis, however, can suppress this naturally occurring cannabinoid system, leading to dependence, tolerance, and withdrawal when the drug is stopped, and progress to drug-seeking behavior, often with adverse consequences. Therefore, cannabis dependence qualifies as a psychoactive drug addiction and is so characterized both by the American Society of Addiction Medicine (ASAM) and by the American Psychiatric Association (APA) in the new DSM-5.

As with other substances, the diagnosis of dependence involves significant intrusion of the substance into a patient's life, with clinically significant impairment in function in multiple areas. In the adolescent population, that impairment may manifest itself in impairment in school, peer and family relationships, as well as basic emotional, cognitive, and psychological function. Accordingly, the diagnoses of cannabis dependence and cannabis withdrawal have recently been added to the accepted psychiatric and medical literature (Budney, Hughes, Moore, & Vandrey, 2004; Budney & Hughes, 2006; Ramesh, Schlosburg, Wiebelhaus, & Lichtman, 2011). The severity of the cycles of intoxication and withdrawal in cannabis dependence are now recognized internationally as quite significant (Danovitch & Gorelick, 2012).

As stated in the DSM-5 (2013), "Cannabis use disorder is a problematic pattern of cannabis use leading to clinically significant impairment or distress" which could manifest by at least two symptoms within a twelve-month period. Some of symptoms listed by the DSM-5 include cannabis "taken in larger amounts or over a longer period than was intended," "persistent desire or unsuccessful effort to cut down or control" use, "craving, or a strong desire or urge to use," and "continued cannabis use despite having persistent or recurrent social or interpersonal problems exacerbated by the effects of cannabis" (2013).

The growing problem of cannabis dependence in youth is posing an increasing challenge to adolescent addiction treatment programs. Part of this challenge is the prevailing belief in the youth drug culture that marijuana is a safe drug that has medical utility, which researchers are increasingly finding may be true. Similarly, prescription opiates are medically useful, but have potentially dire consequences when misused.

The CB1 receptors—which are broadly distributed throughout the brain, but selectively activated during adolescence for healthy brain structure development—show disruption in their function when flooded by internal cannabinoid exposure. The result can be altered structure and function of brain regions that control emotion, thought, memory, and social interaction (Van Laere et al., 2009). These changes can persist well into adulthood and increase risk for psychiatric illness as well as other drug addiction (Chadwick, Miller, & Hurd, 2013).

Cannabis is the most commonly used substance in the adolescent population between eighth and twelfth grade, recently surpassing even the use of cigarettes (Johnston et al., 2013; Chadwick et al., 2013). The prevalence of twelfth grade students who have used marijuana in the past month is roughly 25 percent, and those who have used it within the past year is roughly 35 percent (Johnston et al., 2013). Among first time cannabis users, 2 percent will develop addiction within a year, with that number increasing to 6 percent after a decade of continuous use (Lopez-Quintero et al., 2011). Each year 1.5 percent of Americans struggle with addiction to cannabis and 17 percent of admissions for treatment are for cannabis dependence (SAMHSA, 2012). However, over half of cannabis admissions are for those twenty-five years of age or younger, so clearly this is a problem that disproportionately affects youth, contributing to early-onset addiction. Parental referral may affect this statistic, since parents are more able to direct adolescents than their adult children.

As with alcoholism, one of the challenges facing the individual is that the drug of abuse is so widely used and accepted in society. Cannabis is the most widely used illicit substance in the United States. Results from the 2010 National Survey of Drug Use and Health indicate that 7 percent of the population uses marijuana compared to less than 1 percent for cocaine, heroin, and methamphetamine combined (SAMHSA, 2011). The risk of developing cannabis dependence in adulthood for users that begin smoking at age eighteen is approximately 9 percent (Budney, Roffman, Stephens, & Walker, 2007), however that risk is doubled in users that begin smoking in childhood or adolescence, and can be tripled, as high as 35 to 40 percent, for daily users under eighteen (Winters & Lee, 2008; Kandel & Davies, 1992).

The young person who is suffering negative health and behavioral consequences as a result of his or her chronic and compulsive cannabis use is a significant clinical and public health problem.

Despite the widespread use of cannabis in our society, the overall incidence of cannabis use remains constant with prescription drug abuse as more of a growing drug problem among young people. With the relatively constant incidence of cannabis use, why has dependence increased? It is clear that a major factor is a substantially higher potency of THC in current engineered marijuana being consumed. Since 1983, when THC concentrations averaged below 4 percent, many marijuana samples now reflect content in the 10 to 20 percent range, with some specialty products showing concentrations exceeding 30 percent (Meserve & Ahlers, 2009). Specialty products seen in adolescent treatment include "earwax" aka "dabs," which is hash oil extracted using alcohol heated with a butane flame. Dabs has a THC concentration of as much as 80 percent (Doan, 2013). This powerful product has been known to induce psychotic breaks, hallucinations, and phantom tactile sensations, to say nothing of the potential danger of fire and explosion in its hazardous production method (Doan, 2013).

Acute intoxication with potent forms of marijuana has long been described (Smith, 1969), with effects varying depending on the physical and psychological characteristics of the individual and the environment in which the drug taking occurs. The complexity of the interplay of these variables means that many patients seeking treatment present as patients with both cannabis dependence and comorbid psychiatric disorders. Twenty-three percent of patients with psychosis are current cannabis users (Green, Young, & Kavanagh, 2005). Although many patients coming into treatment may in effect be using marijuana to self-medicate, their underlying psychopathology and the medications they're on combine to create a synergistic effect that can be very destructive, particularly if they are misusing medications such as psychostimulants like Adderall, or combining marijuana with alcohol in a social setting. A study by Dennis and colleagues determined that thirty-six percent of teens seeking treatment for cannabis use disorder had internalizing disorders such as depression or anxiety, and 59 percent had externalizing problems such as conduct disorder and ADHD (2004). Cannabis can relieve anxiety in the short-term and be perceived as a benefit to the user, but can aggravate or precipitate comorbid psychopathology in the long-term, particularly in younger users when the adolescent brain is still maturing (Amen & Smith, 2010).

Adults entering treatment for cannabis use disorder typically have been using cannabis on a daily basis for ten years and report multiple serious attempts to stop. The consequences of their marijuana use include relationship problems, financial difficulties, low self-esteem, and impaired productivity associated with sleep and memory problems (Stephens, Babor, Kadden, & Miller, 2002). Most report that they experience withdrawal symptoms when they try to stop.

Initially, youth are not interested in recovery but are in fact seeking to moderate their use rather than quit using marijuana completely (Lozano, Stephens, & Roffman, 2006). However, little empirical evidence exists about such harm reduction approaches for cannabis dependence, where harm reduction does

not seek abstinence *per se* but rather focuses on reducing the harm associated with substance use. A state-of-the-art addiction treatment program, such as Muir Wood Adolescent & Family Services in Petaluma, CA, embraces a well-established abstinence- and recovery-based model which focuses on managing the medical and psychiatric consequences of cannabis abuse, detoxification from the drug, and participation in a psychosocial program embracing youth-oriented recovery support groups and education for both residents and parents.

Teens and young adults entering treatment do not as readily admit problems related to their cannabis dependence, although they are at increased risk for a myriad of problems including sexually transmitted diseases, unplanned pregnancies, low educational achievement, early dropout rates, delinquencies, and legal entanglements (Tims et al., 2002). Using an abstinence and recovery model, cannabis-dependent youth respond to the same types of psychosocial therapies used for opiate dependence and other substance use disorders, including motivational enhancement therapy, cognitive behavioral therapy, and contingency management; combining these three modalities yields the best results when abstinence is the goal (Peters, Nich, & Carroll, 2011).

Muir Wood has established specific protocols for the treatment of cannabis dependent youth and dual-diagnosis patients. It is crucial that a multidisciplinary team, including a psychiatrist, begin with an evaluation when the presenting problem is cannabis.

Assessment

We must keep in mind that even without substance use, adolescence is a period where the greatest number of psychiatric disorders first present. The twelve month prevalence of psychiatric illness is 40 percent in adolescents compared to 25 percent in adults, highlighting the vulnerability of the developing adolescent brain to substance exposure broadly, and, as discussed above, to cannabis exposure specifically (Chadwick et al., 2013; Heng et al., 2011).

Therefore, from a clinical psychiatric perspective, the correlation between adolescent cannabis use and psychiatric illness is an area of great concern and urgent clinical investigation (Chadwick et al., 2013). Areas of inquiry include: vulnerability to other substance addictions, depression and suicide, anxiety, cognition, memory, psychosis, and problems with personality and psychosocial development. Current research indicates

potentially significant correlation in all areas (Degenhardt et al., 2013; Fergusson, Horwood, & Swain-Campbell, 2002; Fergusson, Boden, & Horwood, 2006; Ferdinand et al., 2005; Moore et al., 2007; Winters, Stinchfield, Lee, & Latimer, 2008; Galéra et al., 2013). This increasing understanding lends special consideration to the diagnosis and treatment of cannabis use disorders in the adolescent population.

With that in mind, we can now consider the importance of a broad-based psychiatric assessment for the cannabis dependent client at Muir Wood, particularly given the prevalence of cannabis dependence in excess of 80 percent of admissions to date.

The psychiatric protocol begins by constructing a case formulation with biopsychosocial underpinnings (Winters, Hanson, & Stoyanova, 2007; Perry, Cooper, & Michels, 1987). In contrast to a typical review of systems and reduction toward diagnostic-driven treatment algorithms, the case formulation is structured to keep clinical attention open and flexible to unfolding information. The construct of the formulation is well developed, and has three essential components: evaluation of external, nonpsychological problems, early assessment of the individual psychology of the client, and early prediction of the client's response to treatment. Most importantly, the case formulation is designed to evolve throughout the course of treatment.

In the treatment of cannabis dependence, the hallmark example of an external problem in treatment at Muir Wood is cannabis withdrawal, which occurs acutely upon admission and lasts

up to several weeks. At the time of admission, Muir Wood staff members routinely see extremely high levels of blood THC, due to the exponentially increasing potency of available cannabis street products (Atakan, 2012; Cascini, 2012). This in turn leads to the management of cannabis withdrawal, which occurs over the first forty-five days of treatment.

Symptoms of cannabis withdrawal include anxiety, irritability, depressed mood, restlessness, disturbed sleep, decreased appetite, and gastrointestinal disturbances. Treatment for cannabis withdrawal does not yet have an evidence-based protocol (Budney et al., 2004; Budney & Hughes, 2006; Allson, Norberg, Copeland, Fu, & Budney, 2011). However, several medications classes are under investigation, with the strategy of influencing the brain circuits that mediate cannabis intoxication and withdrawal. Examples used in the adolescent population are trazadone and nefazadone for sleep disturbance, and clonidine for anxiety and agitation (Danovitch & Gorelick, 2012). These medications can be used safely and for short periods in the initial phases of cannabis withdrawal at Muir Wood.

As with all substance use disorders, cannabis dependence carries a wide range of additional external factors that demand clinical consideration. These range from comorbid psychiatric conditions such as unipolar or bipolar depression, anxiety, psychosis, attention and learning disorders, to acute academic and legal problems, emotional and psychological conflicts, social conditions, family dynamics, and the stressors inherent in adolescent development (Patton et al., 2002). Therefore, the case formulation includes medically-assisted treatment and close monitoring of external symptoms as the course of withdrawal progresses.

The internal aspects of the client take on equal significance in the case formulation. The psychiatrist must pursue an understanding of the client's internal emotional conflicts, resistances, wishes, and fears in an ongoing fashion to establish a therapeutic alliance (Horvath & Luborsky, 1993; McWilliams, 2011). A good therapeutic alliance is important for early retention and for ongoing collaboration, trust, disclosure, and more accurate assessment of each client's individual needs.

All psychiatric evaluation and case formulation should evolve collaboratively with the multidisciplinary treatment team, as well as with the client and family. From a psychiatric perspective, this mandates ongoing evaluation of affect, cognition, and overall psychological wellbeing, which the psychiatrist conducts at the individual and group therapy level in the treatment setting. Hence, the evaluation is dynamic, as the course of cannabis withdrawal evolves in conjunction with the broader emotional and cognitive changes that invariably occur over the course of a multidisciplinary family-based treatment. Specific medication considerations, as well as other psychiatric treatment considerations, including specific psychotherapies, require continuous reassessment of the client and dialogue with the family. Finally, the formulation must evolve with consideration of a useful interface with longer-term treatment settings at the time of discharge to other levels of care.

As demonstrated by the following case study, cannabis dependence may be the primary problem or it may be secondary with significant psychopathology being the main therapeutic issue.

A Case Study

By Jennifer Golick, LMFT

Robert was admitted to treatment for marijuana dependence. He began using marijuana at age fifteen, beginning with periodic use with friends and culminating with smoking alone several times daily. He was admitted to treatment after his parents found drug paraphernalia in his "clubhouse," a gardening shed that he had constructed to isolate himself and use in his back yard.

Robert is the son of two professionals, an attorney and a finance manager. He was adopted at birth through an out of state adoption agency. He has a younger sister who is also adopted. Both adoptions were closed and the adoptive parents were avoidant of discussing the details of the adoption with either child. His mother presents as highly anxious and father presents as analytic and somewhat overwhelmed by affective expressions of emotion. Neither parent has a family history of addiction.

Robert's marijuana use escalated in conjunction with several life stressors at approximately age sixteen. One primary stressor was the transfer of schools. Robert experienced bullying at his public school and initiated a transfer to a private academy in the hopes of forming healthier peer relationships. This goal was not met and he perceived experiencing the same disenfranchisement and social isolation that he'd experienced at his public school. The second stressor was being contacted by his biological mother via social media. Due to the nature of the closed adoption and the lack of familial context given to Robert about the details of his adoption, this created an internal conflict with regards to his identity and curiosity of his biological family of origin. His use of marijuana escalated to multiple times daily and he admitted to smoking up to a gram a day of medicinal-grade marijuana.

He became isolated from his family, spending hours and sometimes overnight in the garden shed in the backyard of his family home.

During the course of treatment, which included a combination of CBT, motivational interviewing, and weekly family therapy, the entire family participated in Muir Wood's Intensive Family Education Program, which included a combination of didactic instruction about topics germane to cannabis dependence and family dynamics, as well as a therapist-facilitated Multi Family Process group. In addition, they participated in weekly family therapy where the dynamics of the relationships within the family were explored in greater depth. During this process, Robert was able to address his mother's anxiety and emotional fragility as being problematic for him, as he felt responsible for her affective instability. By extension, the father was able to discuss his anger toward Robert and identified that he felt powerless when the mother became so emotionally overwrought, and as a result, directed that anger toward Robert as being the cause of her upset. It was discovered that throughout the family, they were reacting to one another based upon their assumptions of situations, often wrongly, which lead to further chaos and conflict within the house. During individual family therapy, parents received much coaching from the therapist on how to set limits and engage in more direct and healthy communication. Additionally, they were able to minimize pathologizing Robert's behavior and established a baseline for what was "normal" adolescent behavior versus perceived disordered behavior. Both parents participated in weekly Al-Anon meetings and learned about addiction and codependency from that perspective.

Upon discharge, the family was able to engage in difficult and historically conflict-inducing discussion with positive outcomes. This included a discussion of what to do with the "clubhouse," which was a point of great conflict historically. What was once viewed as the epicenter of his drug using behavior and isolation, the "clubhouse" was repurposed as a garden tool storage area that everyone had access to. Both parents were also able to detach from a pattern of micromanagement based out of fear and moved to a place of supporting Robert's recovery through his involvement in Twelve Step groups and work with a sponsor. Following discharge, the whole family remained in contact with the treatment program as a means of peripheral support while engaging the resources in their community.

In summary, the potential harm of cannabis use in adolescence is becoming increasingly clear, as is the need for effective treatment. The treatment of cannabis dependence and cannabis withdrawal is rapidly evolving, though it currently lacks standard evidence-based treatment protocols. Therefore, at present, we must do our best to construct treatment plans that correlate broad scientific considerations with the specific presentation of each adolescent and family.

Muir Wood's psychiatric strategy is to construct a formal, broad-based case formulation that takes into account external problems for the client and family, as well as the internal and interpersonal psychology of the client and family. The case formulation is fundamentally designed to evolve. This design is particularly important in the treatment of cannabis dependence, where clinical presentation evolves quite dynamically over the course of a residential treatment.

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Boulder, CO 80302

FOREST HEIGHTS LODGE
www.forestheightslodge.org
Phone: 303.674.6681
4761 Forest Hill Rd.,
Evergreen, CO 80437

INSIGHT INTENSIVE AT GOLD LAKE
www.insightintensive.com
Phone: 877.952.1444
3371 Gold Lake Rd.,
Ward, CO 80481

LIVING WELL TRANSITIONS
www.livingwelltransitions.com
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1320 Pearl St., Ste. 320,
Boulder, CO 80302

OPEN SKY WILDERNESS THERAPY
www.openskywilderness.com
Phone: 970.382.8181
PO Box 2201, Durango, CO 81302

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RUSHFORD*
www.rushford.org
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459 Wallingford Rd.,
Durham, CT 06422

TURNING POINT
www.tpextendedcare.com
Phone: 877.581.1793
139 Orange St., Ste. 300,
New Haven, CT 06510

WELLSPRING*
www.wellspring.org
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21 Arch Bridge Rd.,
Bethlehem, CT 06751

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1ST STEP BEHAVIORAL HEALTH
http://firststepbh.com
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Pompano Beach, FL 33064

BEHAVIORAL HEALTH OF THE PALM BEACHES*
www.bhpalmbeahc.com
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631 US Hwy. 1, Ste. 304, North
Palm Beach, FL 33408

CANOPY COVE
www.canopycove.com
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13305 Mahan Dr.,
Tallahassee, FL 32309

THE FLORIDA HOUSE EXPERIENCE
www.floridahousesunlight.com
Phone: 866.421.6242
505 S. Federal Hwy.,
Deerfield Beach, FL 33441

THE PALM BEACH INSTITUTE
www.pbinstitute.com
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314 10th St., West Palm
Beach, FL 33401

PALM PARTNERS
www.palmpartners.com
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705 Linton Blvd., Delray
Beach, FL 33444

PASADENA VILLA**
www.pasadenavilla.com
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625 Virginia Dr., Orlando, FL 32803

RECOVERY ASSOCIATES
http://recoveryassociates.com
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2801 N. Flagler Dr., West
Palm Beach, FL 33407

THE REFUGE*
www.therefuge-ahealingplace.com
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Ocklawaha, FL 32179
Additional Locations: Ocala, Florida.

WELLINGTON RETREAT
http://wellingtonretreat.com
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2200 N. Florida Mango Rd., Ste.
201, West Palm Beach, FL 33409

GA

BREAKTHROUGH RECOVERY OUTREACH
www.my-breakthrough.com
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3648 Chamblee Tucker Rd., Ste. F,
Atlanta, GA 30341

GRACEWAY RECOVERY RESIDENCE FOR WOMEN
www.gracewayrecovery.com
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412 W. Tift Ave., Albany, GA 31702

LAKEVIEW BEHAVIORAL HEALTH
www.lakeviewbehavioralhealth.com
Phone: 678.713.2600
1 Technology Pkwy. S.,
Norcross, GA 30092

RIDGEVIEW INSTITUTE
www.ridgeviewinstitute.com
Phone: 770.434.4567
3995 S. Cobb Dr.,
Smyrna, GA 30080

RIVERWOODS BEHAVIORAL HEALTH
www.riverwoodsbehavioral.com
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223 Medical Center Dr.,
Riverdale, GA 30274

SKYLAND TRAIL*
www.skylandtrail.org
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1961 N. Druid Hills Rd.
NE, Atlanta, GA 30329

WILLINGWAY
www.willingway.com
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311 Jones Mill Rd.,
Statesboro, GA 30458

ID

BOULDER CREEK ACADEMY
www.bouldercreekacademy.com
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378 Emerson Ln., Bonners Ferry, ID 83805

CHERRY GULCH
www.cherrygulch.org
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PO Box 678, Emmett, ID 83617

ECHO SPRINGS TRANSITION STUDY CENTER
http://echo-springs.com
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3210 Kootenai Trl. Rd., Bonners Ferry, ID 83805

ELK MOUNTAIN ACADEMY
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INNERCEPT
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INTEGRATED INTERVENTIONS
www.integrated-innovations.com
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Location: Hayden Lake, ID 83835

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www.thewalkercenter.org
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605 11th Ave. E., Gooding, ID 83330

IN

MIDWEST CENTER FOR YOUTH AND FAMILIES*
www.midwest-center.com
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1012 W. Indiana St., Kouts, IN 46347

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www.tcharris.com
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3700 Rome Dr., Lafayette, IN 47905

IL

CARE ADDICTION TREATMENT PROGRAM
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CHESTNUT HEALTH SYSTEMS*
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www.crossmont.com
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10522 S. Cicero Ave.,
Oak Lawn, IL 60453

EDGE LEARNING & WELLNESS COLLEGIATE COMMUNITY
www.edgelearningcommunity.com
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63 E. Lake St., Chicago, IL 60601

LAWRENCE HALL YOUTH SERVICES
www.lawrencehall.org
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4833 N. Francisco Ave.,
Chicago, IL 60625

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Rockford, IL 61107
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1365 E. 60th St., Chicago, IL 60637

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www.timberlineknolls.com
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40 Timberline Dr.,
Lemont, IL 60439

IA

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1523 S. Fairmount,
Davenport, IA 52802

JACKSON RECOVERY CENTERS*
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Parker, Colorado; Boonville and St.
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Nebraska; Cushing and Oklahoma
City, Oklahoma; Grapevine, Texas.

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PO Box 139, Saint
Martinville, LA 70582

WOODLAKE ADDICTION RECOVERY CENTER
www.woodlakecenter.com
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3015 Hwy. 956, Ethel, LA 70730

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67 Captain Cushman Rd.,
Morrill, ME 04952

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www.summitachievement.com
Phone: 207.697.2020
69 Deer Hill Rd., Stow, ME 04037

MD

CLEARVIEW COMMUNITIES
www.clearviewcommunities.org
Phone: 240.439.4900
617 W. Patrick St.,
Frederick, MD 21701

PATHWAYS ALCOHOL AND DRUG TREATMENT PROGRAM
www.pathwaysprogram.org
Phone: 800.322.5858
2620 Riva Rd., Annapolis, MD 21401

MA

ADCARE HOSPITAL
http://800alcohol.com
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107 Lincoln St.,
Worcester, MA 01605
Additional Locations: Boston, Dartmouth, Quincy, and West Springfield, Massachusetts; Warwick, Rhode Island.

CAMBRIDGE EATING DISORDER CENTER
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3 Bow St., Cambridge, MA 02138

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1 Pleasant St., PO Box 778,
Middleboro, MA 02346

EAGLETON SCHOOL
www.eagletonschool.com
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446 Monterey Rd.,
Great Barrington, MA 01230

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www.penikese.org
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565 Woods Hole Rd.,
Woods Hole, MA 02543

VALLEY VIEW SCHOOL
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North Brookfield, MA 01535

THE VAN DER KOLK CENTER
www.jri.org/vanderkolk
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160 Gould St., Ste. 300,
Needham, MA 02494

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Hattiesburg, MS 39402

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MCCALLUM PLACE
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BUILDING BRIDGES
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CHRYSALIS
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77 Trails End Rd., Eureka, MT 59917

EXPLORATIONS
www.explorationsMT.com
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119 S. Hill Rd., Box 1469,
Trout Creek, MT 59874

INTERMOUNTAIN
www.intermountainschool.org
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500 S. Lamborn St.,
Helena, MT 59601

MONARCH SCHOOL
www.monarchschool.com
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PO Box 410, Heron, MT 59844

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Marion, MT 59925

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Kalispell, MT 59901

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31733 S. Fork Rd., Troy, MT 59935

WILDERNESS TREATMENT CENTER
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200 Hubbart Dam Rd.,
Marion, MT 59925

YELLOWSTONE BOYS & GIRLS RANCH
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1732 S. 72nd St. W.,
Billings, MT 59106

NV

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2810 W. Charleston Blvd., Ste. 64, Las Vegas, NV 89102

CENTER FOR HOPE OF THE SIERRAS
http://centerforhopeofthesierras.crchealth.com
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3740 Lakeside Dr., Ste. 201,
Reno, NV 89509

CENTRAL RECOVERY TREATMENT
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3371 N. Buffalo Dr.,
Las Vegas, NV 89129

NH

LAKEVIEW**
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244 Highwatch Rd.,
Effingham, NH 03882

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www.mountainvalleytreatment.org
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2274 Mt. Moosilauke Hwy., Pike, NH 03780

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619 Governor's Rd.,
Milton, NH 03851

SOVEREIGN JOURNEY
www.sovereignjourney.com
Phone: 603.869.7318 x115
PO Box 216, Bethlehem, NH 03574

WEDIKO CHILDREN'S SERVICES
www.wediko.org
Phone: 603.478.5236
11 Bobcat Blvd.,
Windsor, NH 03244

NJ

ADVANCED HEALTH & EDUCATION
www.advhealth.com
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3 Corbett Way,
Eatontown, NJ 07724

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Phone: 888.955.8226
5034 Atlantic Ave.,
Mays Landing, NJ 08330

NM

SHADOW MOUNTAIN RECOVERY**
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250 Shadow Mountain Rd.,
Taos, NM 87571

NY

ARMS ACRES
www.armsacres.com
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75 Seminary Hill Rd.,
Carmel, NY 10512

CAMP HUNTINGTON
www.camphuntington.com
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56 Bruceville Rd., High Falls, NY 12440

NEW YORK CENTER FOR LIVING
www.centerforliving.org
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New York, NY 10022

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www.phoenixhouse.org
Phone: 888.286.5027
164 W. 74th St.,
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990 Glovers Grove Church Rd.,
Siler City, NC 27344

COOPERRIIS HEALING COMMUNITY*
www.cooperriis.org
Phone: 800.957.5155
101 Healing Farm Ln., Mill Spring, NC 28756

DILWORTH CENTER FOR CHEMICAL DEPENDENCY
www.dilworthcenter.org
Phone: 704.372.6969
2240 Park Rd., Charlotte, NC 28203

FOUR CIRCLES RECOVERY CENTER
www.fourcirclesrecovery.com
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156 Clear Crossing Ln.,
Horse Shoe, NC 28742

SUWS OF THE CAROLINAS
http://suwscarolinas.crchealth.com
Phone: 888.828.9770
363 Graphite Rd., Old
Fort, NC 28762

TRAILS CAROLINA
http://trailscarolina.com
Phone: 800.975.7303
500 Winding Gap Rd.,
Lake Toxaway, NC 28747

OH

NEIL KENNEDY RECOVERY CLINIC*
www.nkrc.org
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2151 Rush Blvd.,
Youngstown, OH 44507

OK

A CHANCE TO CHANGE FOUNDATION
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5228 Classen Cir.,
Oklahoma City, OK 73118

OR

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Phone: 800.910.0412
PO Box 5986, Bend, OR 97708

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www.bridgesboysacademy.com
Phone: 888.283.7362
67030 Gist Rd., Bend, OR 97701

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www.dragonflytransitions.com
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Klamath Falls, OR 97601

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PO Box 6454, Bend, OR 97708

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198 Cooper Rd.,
Westminster, SC 29693

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1010 E. 2nd St., Canton, SD 57013

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TX

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MERIDELL ACHIEVEMENT CENTER
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12550 W. Hwy. 29, Liberty Hill, TX 78642

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Lubbock, TX 79403

RIGHT STEP*
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UT

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1280 Whispering Horse Dr., Erda, UT 84074

ASHCREEK RANCH ACADEMY
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652 N. Toquerville Blvd.,
Toquerville, UT 84744

ASPEN INSTITUTE FOR BEHAVIORAL ASSESSMENT
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2732 W. 2700 S.,
Syracuse, UT 84075

ASPIRO WILDERNESS THERAPY
www.aspiroadventure.com
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63 E. 11400 S. #186,
Sandy, UT 84070

BIRDSEYE RTC
www.birdseyertc.com
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PO Box 117, Spanish Fork, UT 84660

CATALYST
www.catalystrtc.com
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970 S. 1025 W., Brigham City, UT 84302

CEDAR RIDGE ACADEMY
www.cedaridge.net
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4270 W. 5625 N.,
Roosevelt, UT 84066

CENTER FOR CHANGE
http://centerforchange.com
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Location: 1790 N. State
St., Orem, UT 84057

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www.diamondranchacademy.com
Phone: 877.372.5250
433 S. Diamond Ranch Pkwy.,
Hurricane, UT 84737

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www.discoveryacademy.com
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105 N. 500 W., Provo, UT 84601

DISCOVERY RANCH
www.discoveryranch.net
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1308 S. 1600 W.,
Mapleton, UT 84664

DISCOVERY CONNECTIONS
http://discoveryconnections.com
Phone: 801.800.8033
1834 S. Sandhill Rd.,
Orem, UT 84058

FALCON RIDGE RANCH
www.falconridgeranch.com
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633 E. Hwy. 9, Virgin, UT 84779

FORTE STRONG
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1071 E. 100 S., Ste. C1, St.
George, UT 84770

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11706 S. 700 E., Draper, UT 84020

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Syracuse, UT 84075

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1338 E. 600 S.,
New Harmony, UT 84757

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Enterprise, UT 84781

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Cedar City, UT 84721

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AD INDEX

Out of the Office and Into the Woods: Lessons from the Field of Wilderness Therapy

1. All of the following are true about wilderness programs, except:

Ⓐ They are short-term, primary care programs
Ⓑ Assessments prepare families for follow-up care settings
Ⓒ Treatment plans are based on nontraditional therapeutic models
Ⓓ None of the above, these are all true statements

2. True or False. Therapeutic wilderness programs help adolescents with issues such as depression, anxiety, substance abuse, addiction, school problems, family conflict, and autism spectrum disorders.

Ⓐ True Ⓑ False

3. Senior students in wilderness programs mentor newer students in campcraft, which involves all of the following, except:

Ⓐ Cooking and fire-making
Ⓑ Site selection and bear-proofing
Ⓒ Gear maintenance
Ⓓ None of the above, these are all elements of campcraft

4. True or False. The short days of winter and the rainy season of spring are both examples of times when wilderness programs take their students inside facilities to be treated.

Ⓐ True Ⓑ False

5. Which of the following is not a listed benefit of letter-writing therapy?

Ⓐ It reduces reactivity, manipulation, and codependency
Ⓑ It helps the writer/student refocus on the self instead of the reaction of others
Ⓒ It allows the writer/student to speak to his or her parents without going through a therapist
Ⓓ It provides insight on coaching, communication skills, and relationship restructuring

Spirituality in Teens: Promoting Sobriety and Improving Mental Health

1. True or False. Jung's propensity for advocating religion and involvement in particular religious groups led to his determination that spirituality is an important factor for improving mental health.

Ⓐ True Ⓑ False

2. Which of the following is not one of Frankl's dimensions of human life?

Ⓐ The somatic
Ⓑ The spiritual
Ⓒ The conscious
Ⓓ The mental

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3. All of the following are definitions of spiritual experiences as measured by the Daily Spiritual Experience Scale (DSES), except:

Ⓐ Connecting with God
Ⓑ Being guided by God daily
Ⓒ Feeling God's presence
Ⓓ None, all of the above are valid experiences

4. True or False. In the study, a third of the teens in treatment self-identified as agnostic or atheist and 40 percent claimed a religious or spiritual or religious identity at discharge.

Ⓐ True Ⓑ False

5. Which of the following was the definition of spirituality listed as being defined in treatment literature?

Ⓐ The "way in which an individual finds freedom and meaning in life"
Ⓑ "Alignment with faith-based institutions and shared beliefs"
Ⓒ A "religious outlook"
Ⓓ "A bridge between the physical body and the power of transcendental reality"

Young People in the New Recovery Advocacy Movement

1. Which of the following was not one of the eight core strategies of grassroots recovery community organizations?

Ⓐ Supporting recovery-focused research
Ⓑ Creating community centers for nonclinical, peer-based support
Ⓒ Educating the public about long-term addiction recovery
Ⓓ None of the above, these are all valid strategies

2. In which state was the new recovery advocacy movement officially launched in 2001?

Ⓐ California
Ⓑ Montana
Ⓒ Colorado
Ⓓ Minnesota

3. True or False. In September 2013, twenty-five thousand people participated in public recovery celebration events all over the United States.

Ⓐ True Ⓑ False

4. Which of the following is/are not true about the recovery community organization known as Young People in Recovery (YPR)?

Ⓐ YPR is incorporated in Ohio
Ⓑ YPR has been supported by SAMHSA
Ⓒ YPR has five staff members
Ⓓ Both A and C are untrue

5. True or False. According to CEO Justin Luke Riley, Young People in Recovery now has over ten chapters.

Ⓐ True Ⓑ False

LEARNING OBJECTIVES:

Out of the Office and Into the Woods: Lessons from the Field of Wilderness Therapy

- This article parallels the learning styles of children in modern and primitive families. While the "mother of the year" might be pushing her children to learn through calisthenics, schedules, and lesson plans, the primitive family teaches through the experiences of everyday life; stories are shared around a campfire after a day of hunting and daily chores which revolve around the need to survive. Wilderness therapy uses the latter principles to treat children with depression, anxiety, substance abuse, addiction, behavioral disorders, school problems, family conflict, learning disabilities, and autism spectrum disorders.
- Treatment plans are based on traditional therapeutic models, but also include experiential therapy. Therapy occurs throughout an entire day and while it might relate to an issue that brought a student into the program, it also focuses on day-to-day group living. Students participate in weekly sessions with a therapist, letter-writing therapy, and phone therapy sessions with family members.
- In wilderness therapy, students will learn self-reliance, develop interdependence, and enjoy the feeling of accomplishment when difficult tasks are completed out in nature. Students become their own "hero" in the wilderness as they hike, camp, cook, set up shelter, sleep, eat, clean, carry their tools, and mentor others.
- Wilderness therapy benefits parents almost as much as the child. Parents learn to let go and trust the treatment process, instead of lecturing, thinking they can "fix" their children, and attempting to battle the addiction alone. It also helps parents understand how to create different scenarios where their children can learn.

Spirituality in Teens: Promoting Sobriety and Improving Mental Health

- Carl Jung, despite his discounting of dogma and belonging to a particular religious group, believed that spirituality was indeed something that could help those suffering from mental health difficulties. Viktor Frankl agreed to some extent, by stating that the spiritual aspect of human life is essential and can't be ignored.
- There are several ways to define spirituality, but the simplest definition is that spirituality is a method for individuals to find "freedom and meaning" in their lives. This could be involvement in Alcoholics Anonymous or belief in the God of a particular group. Finding meaning and support in something greater than oneself is the key to finding a spirituality that can help an individual through addiction and other disorders.
- The study mentioned in the article included the use of the Daily Spiritual Experience Scale (DSES). The DSES does not measure religious beliefs, but rather "experiences," which could include anything from feeling God's presence to feeling a selfless caring for others. The idea of the DSES is very similar to that of Alcoholics Anonymous, which promotes a "God of one's own understanding."
- The study conducted by Dr. Lee and his colleagues studied 195 substance-dependent adolescents from the ages of fourteen to eighteen. After controlling for other factors, the study concluded that increased DSES scores were associated with a decrease in positive AOD tests based on toxicology screens. These results imply that spirituality does indeed have a positive effect on addiction and mental health treatment.

Young People in the New Recovery Advocacy Movement

- Grassroots recovery community organizations (RCOs) began all over the country in the 1990s, and the new recovery advocacy movement was officially launched in 2001. Young people are now taking a bigger role in RCOs through new organizations and collegiate recovery programs.
- In the beginning, RCOs focused on eight strategies: building strong RCOs and bringing them together in a national movement; advocating for representation at local, state, and federal levels; assessing what was needed in local recovery institutions; educating the public about long-term recovery; expanding philanthropic support for addiction treatment and cultivating volunteerism; creating centers for nonclinical, peer-based recovery services; celebrating recovery through public events; and supporting recovery-focused research.
- Young People in Recovery (YPR) is an RCO incorporated in Colorado. It is steadily growing by helping to build other chapters across the US. They have been supported by SAMHSA, Faces and Voices of Recovery, and the Stacie Mathewson Foundation, to name a few.
- The mission of YPR is to reach out to young people in recovery, whether it be through a YPR chapter that hosts events or can refer people to Twelve Step meetings, or through a chapter that works in tandem with a local collegiate recovery program.

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Never Again

An Excerpt from *Bullying Under Attack*

Elizabeth Ditty

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February 14th of my senior year I was bullied for the last time. That day, I hit my breaking point and felt that suicide was my only option. As I ran through the hallway my head swam in depression. My hands were shaking as they reached for my cell phone. I couldn't even remember how to speed-dial Mom.

I was the girl who got called fat every single day. The girl who camouflaged her pain by laughing really hard and talking too loud, drowning out the demeaning comments. The girl fighting an internal battle to get up, get ready, and go to school every morning. Yes, I was that fat girl waddling to school, getting honked at by the popular kids, and even getting snowballs thrown at her butt in the winter. I was the girl who ate lunch alone on the bench in front of the cafeteria doors. The girl who had one friend, but lost even her when her boyfriend called me names too.

I had a simple, deadly, desperate plan to escape the social torment I'd been facing since the fifth grade: leave school, lie in the street on my stomach, and wait until a speeding car came along. Then it would all be over.

Never before had I come so close to acting on this fatal fantasy, but that day I was feeling adrenaline I never even knew existed in my body. Then, as I passed the counselor's office, out of nowhere, a voice spoke to me. It said, "You need to change your life. You are going through this so you can help other bullied children." I dashed straight into the counselor's office, in desperate need of help.

The counselor was busy, but after taking one look at me a secretary sprinted to get him. I was soon inside his office, heaving, hiccupping, and hysterical. I have never cried like that in my life. Tears streamed down my face as I hugged the trashcan, afraid of vomiting out my feelings.

After my crisis, I refused to go to school. Wallowing in self-pity and depression at home wasn't helping, and I finally decided not to be a victim any longer. I forced myself to get out of bed and write a letter. A letter to my bully. Three pages in red ink.

Upon returning to school, I went to a prearranged meeting in the dean's office and read the letter to my bully; out loud, to his face. For the first time in my life I stood up to my tormentor.

Dear _____,

Think back to ninth grade. Every day in study hall you would call me "fat ass" and "beached whale." One day I wore shorts; you looked at your friends and said, "That shouldn't be allowed." Those words left your mouth in just one second, but they entered my consciousness and still refuse to leave.

After your comments, I wanted to die. Do you know that I go to bed and cry every night? I have thoughts of killing myself. Sometimes I don't know how I've made it this far. When I hit rock bottom though, I remind myself that if I ended my life, you would win. I'm not going to let you win. No matter what you do, I'll be here to prove a point. To show that you can't crush me.

Do you know that all the hell I've endured in school is my reason to go on living? I am going to go to college, become a counselor, and help other victims of bullies like you. I understand the pain they live with, and I want to help them survive it. When I want to die, I think about helping those in need, just as many kind souls have helped me to survive.

Do you know that I am okay with how I look? When I look in the mirror I see beauty. What I can't stand is my inner-self, and you're the one who trained me to feel this way. When I entered school, I instantly felt like a second-class person. I listened to your comments and didn't stand up for myself. I accepted all the pain you caused me, and never took action—until now.

Are you aware of how I feel just being near you? I feel like I am not worth anything because you can't look into my eyes, past my weight, and see a normal girl. Sitting in class near you makes me anxious every day.

I am your equal. I am no less than you, and I never will be! You have no right to point out my "faults" and try to cut me down every day. Sadly, I have learned to expect and passively accept your comments. I live with them and believe them. They are and always will be etched into my heart and mind. You should really think about what you say before you say it, because some people are not as strong as I am, and they really might end up killing themselves.

What you did on February 14th is NOT okay. What gives you the right to touch my personal belongings? Who gives you the power to state who sits at what table? When you threw my

purse and books onto the floor, it hurt me more than all of the demeaning comments over the years. It hurt me so much that I wanted to kill myself. Your actions told me just where I fit in here: that I am a piece of shit that belongs on the floor.

What's even worse is that I almost accepted what you did to me, just like I accepted the names you called me every day. I almost believed you were right, because you are a god in this school. Everyone respects you and looks up to you.

You have violated me with your words and actions, and you should know that what may seem to you like jokes are ruining my life and causing me to miss school.

I am through being your victim. I am done tolerating and accepting it. I am determined to enjoy the last few months of high school. From this day forward, you are going to treat me with the respect I deserve.

He cried. Seriously, my bully cried. Then he apologized sincerely. For the rest of high school, I, the former social reject, was never bullied again.

That was six months ago. Look at me now—I'm a new person. I've undergone a transformation. I am a college freshman—a psychology major with plans to become a school counselor. I gave my first public speech on school bullying and got a standing ovation, and I didn't even cry! Now I don't have to fake my smile. I stay up late, laughing and talking with my roommate, who is my new best friend. I walk into a crowded cafeteria and feel welcome at numerous tables. I'm not afraid to approach new faces. I'm the student who can't wait to get to class.

I'm finally happy not only on the outside but on the inside as well. I am new. I am the person who I want to be. Finally.

I treasure my life each and every day. I question why I once wanted to end my life. I realize just how lucky I am. So many people are being bullied every day and don't realize yet that they can make it through and have a happy life. They don't know the torture will end.

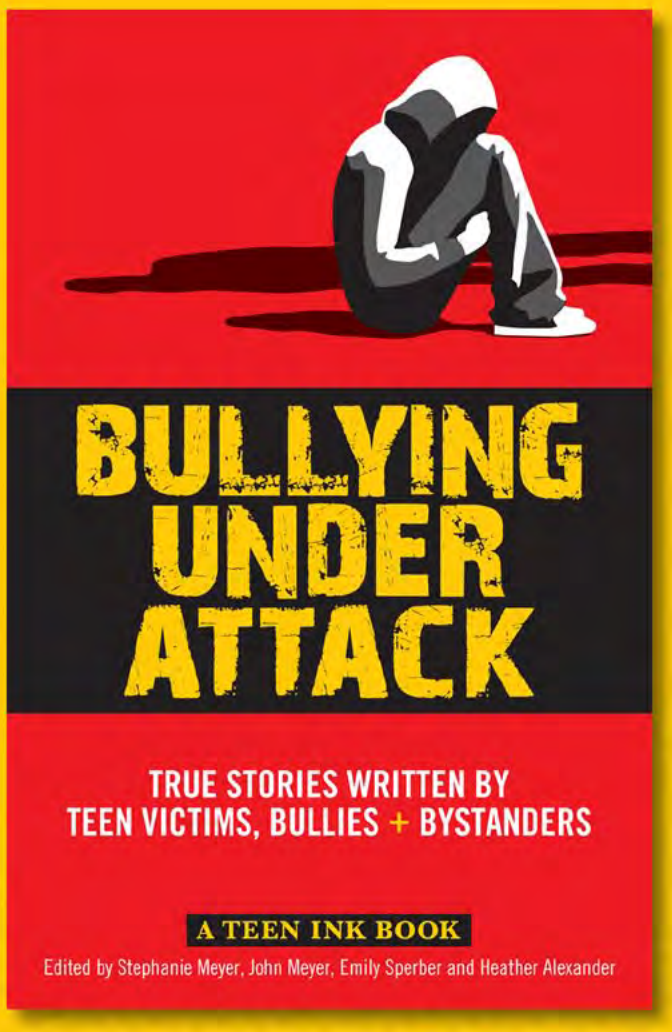
I am blessed beyond belief. I've found joy. I've found my meaning, my calling: to become a counselor and help kids struggling with bullying. I have a passion and a purpose, and it becomes clearer each day. I'm so grateful I gave myself a second chance to live and to help other bullied children survive and rise up.

I am finally who I want to be. C

Elizabeth Ditty *is a nineteen-year-old college sophomore, majoring in early childhood education with a concentration in English and a minor in psychology. She plans on going to graduate school for counselor education. For Elizabeth, writing is an outlet: a safe and healthy way to vent without being afraid of judgment, and to reflect on memories that can be uncomfortable to discuss. She dedicates her pieces, "Never Again" and "Kids, Meet the Real World," to her mother, sister, late father, stepfather, and Momma Taylor.*

MEET THE BULLY

THE BULLIED AND THE BYSTANDER



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Perhaps the most prominent new release along these lines is the latest work from Teen Ink, Bullying Under Attack

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