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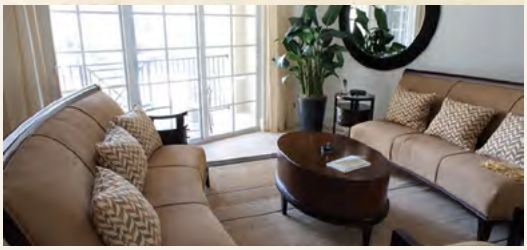

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(954) 360-0909 • (800) 851-9100
Fax: (954) 360-0034
E-mail: editor@counselormagazine.com
Website: www.counselormagazine.com

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New Generations and Cycles

Recently, celebrity overdoses once again made headlines. Heroin use is again on the rise, especially among younger adults. The marijuana debate begins anew with at least two states legalizing its use and others close behind. Didn't we address these issues once before or maybe even twice before? If you have been in the addiction and behavioral science field as long as I have, you start to wonder if you are repeating old information. Are we? I don't think so; it is never old for the audience that is hearing it for the first time. It is never old when we continue to update information and introduce new ideas and techniques for treatment and recovery.

At times we need to remember that addiction is often a family cycle. At other times we need to remember that each generation over the past one hundred years and more has been challenged to overcome substance abuse problems and often the unwanted accompanying behavioral health problems as well. The topics in this issue of *Counselor* reflect the need to provide current and cutting-edge information. At the same time, it is built on the knowledge, research, and life experiences of those who walked here before. It is an ever-growing community.

I am especially pleased to welcome a new contributor to *Counselor* and this ever-growing community. Dr. Dennis C. Daley, who is a professor of psychiatry and social work at the University of Pittsburgh, is a prolific author of more than ten books on substance abuse, countless workbooks for treatment centers, and numerous journal articles. He has extensive research experience with clinical trials evaluating the effectiveness of psychosocial, mediation, and combined treatments for substance abuse disorders. Dr. Daley joins *Counselor* as the author of a new column titled "Topics in Behavioral Health Care."

In this edition of the magazine we have the second parts of two previously published articles. The article "Relating Clinical Assessment Consideration to EHR Meaningful Use, Part II" is the last of LaVerne Hanes-Stevens' series on electronic health records. In addition, an article by Jerrold Pollak on cannabis use disorders and mental health is the second part in our "Cannabis Concerns" series, which began in the April issue of *Counselor*.

This issue also features the second article this year from the *Journal of Substance Abuse Treatment*, which focuses on the research and data of Twelve Step involvement. Also, the DSM-5 has certainly contributed to many discussions and debates. Gerald Shulman's article on the DSM-5 helps to clarify many changes as they relate to substance abuse disorders.

Finally, we are introduced to two new subjects for the addiction field. One is substance abuse in the elderly population—a growing concern in many treatment centers—and the other is an insightful comparison of cancer treatment to addiction treatment, authored by William White.

All of these articles indicate the diversity of related behavioral health issues to addiction. At the same time, they remind us that we are still talking about addiction, not by looking back in history, but by focusing on understanding what is coming and what we still need to learn.

Sincerely,

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

Editor's Note: On page eighty-two of the previous issue (April 2014), Dr. David E. Smith's biography stated that he is the chair of addiction medicine at Newport Academy. This is incorrect. Dr. Smith is the chair of addiction medicine at Muir Wood Adolescent and Family Services.

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Access to Recovery: No Addict Left Behind

Bob Tyler, BA, LAADC, CADC II, ICADC*

There is a huge problem in this country, given that drug and alcohol addiction is a multibillion dollar per year health care issue and that most people who need help are unable to get it. There is hope that health care reform will have a positive impact on this issue, but no one really knows what the effect will be. Yet, we do have free help in the form of various Twelve Step programs—Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA), to name a few—in nearly every community and often at multiple times a day. Call me crazy, but shouldn't we be showing people how to use these free resources so they can get started in recovery?

According to the National Intelligence Center (2010), drug and alcohol addiction costs our country $600 billion a year (see table 1). This total takes into account crime, loss of production at work, and health care. Even if the number one killer, tobacco, is taken out, it still costs us over $400 billion annually. (See table below)

Additionally, according to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health (2009), 23.5 million people needed treatment for an illicit drug or alcohol abuse problem in 2009 and 9.3 percent of those people were persons aged twelve or older. Of that population, only 2.6 million (11.2 percent) of those who needed treatment received it at a specialty facility.

Substance	Health Care	Overall
Tobacco	96 Billion	193 Billion
Alcohol	30 Billion	235 Billion
Illicit Drugs	11 Billion	193 Billion

National Drug Intelligence Center (2010). National Threat Assessment: The Economic Impact of Illicit Drug Use on American Society. Washington, DC: United States Department of Justice.

What is especially troubling about these numbers is that we know as treatment professionals that many folks who seek help are actually turned away due to lack of ability to pay. Therefore, it becomes apparent that we need to examine all possible resources to give the addicted person every chance to get sober.

Until a couple of months ago, when I decided to dedicate my career to helping people who can't afford rehab, I

worked at a private, for-profit agency. When someone finally got enough courage to call us, and if they didn't have insurance or the ability to pay for treatment, we needed to refer them to county-funded programs. Most of these programs, especially in California and in many parts of the country, have a minimum of a one-month-long waiting list. I knew in my heart that few, if any, of those people we referred were getting into these programs because the cunning part of this disease would tell them, "Well, at least you tried," and they would return to using. So, after years of substance use and contemplation, someone finally makes perhaps the most important call of their lives, and the best we can do is to send them into recovery "limbo" somewhere? Given that I take great pride in helping people turn their lives around, this horrifies me. I don't believe it is that much of a reach to view this practice of our profession as discriminatory against people who lack resources. Ironically, many of us have been fighting such discrimination against addicts for years.

For those of us receiving such phone calls, what we can do is to provide referrals to sources of community self-help, such as Twelve Step programs. On the surface, this appears to be a great idea because it is a place to rub elbows with those who are successfully dealing with the same problem and it is very accessible. Such meetings are available in most areas of the country, however, I suspect this type of referral is about as empty as providing referrals to county-funded programs which lack availability. Let me briefly share with you my first experience attending such a meeting.

In 1986, two years before I got sober, I went to my first CA meeting and left thinking, "This is all well and good, but this couldn't possibly help me. I need much more that this." Had someone taken me aside and told me to get a meeting directory at that first meeting, to go to meetings every day in the beginning, to get a sponsor and explained to me what that means, along with some of the other intricacies of the program, I might have had a chance. Unfortunately, I had to do two more years of painful research before my life got bad enough to get desperate about recovery.

I was fortunate enough to have insurance and, since this was prior to insurance managed care, I was able to go into an inpatient program for thirty days. I received a lot of great education, I got a head start in recovery, and I learned a lot about myself. However, the most valuable information I received was how to treat the chronic nature of my disease utilizing the free Twelve Step community resources!

The Two-Minute Drill and Sobriety Checklist

The "Two-Minute Drill" is a football term describing the undertaking of the team with the ball attempting to win the game in the final two minutes. What happens in the final two minutes is crucial to the outcome of the game. Now, the urgency and importance of what we do with a call for help from someone with this life-threatening disease transcends that of any football game. The following is an example of how the treatment-related Two-Minute Drill works.

After providing the usual referrals to county-funded programs, the following specific instructions provided to callers will take only a couple of minutes. This small investment of time can literally save a life! Instruct the caller to grab a pen and piece of paper so they can write down some additional instructions, ask if they are willing to go to a meeting tonight or tomorrow, and provide them with a referral to a particular meeting. All personnel who answer the phones should have a Twelve Step meeting directory handy. The following are additional instructions for the caller to write down:

- Go to the meeting.
- Get a meeting directory at the meeting.
- Use the directory to plan the next meetings you will attend. Plan to go to meetings every day or to at least four to five meetings weekly.
- Make at least one phone call daily. You can get a phone list at the first meeting and also the phone numbers of people you meet at the meetings.
- Purchase a *Big Book*, the basic text of the meeting you attend. Read a little every night.
- Get a "welcome chip" at the meeting when it is offered.
- Share at a meeting as soon as possible; introduce yourself to the meeting by stating you are new and need help staying sober.

Be sure to provide the caller with a detox warning: "If you have decided to get sober and are planning on discontinuing your use of alcohol and/or other drugs, the first thing that must be considered is whether or not you need a medically supervised detoxification from whatever you're abusing. If you are addicted to alcohol, barbiturates, sedatives such as benzodiazapines, GHB, and some of the newer designer drugs, withdrawal from these can be life-threatening. Be sure to contact a physician if you have any questions regarding the level of risk involved in discontinuing your drug of choice."

This is the end of the Two-Minute Drill. A one-page version of the drill can be obtained at www.bobtyler.net; it can be easily copied and distributed to all staff members at your agency who take inquiry calls.

If the call receiver wants to go a little over the top in this effort, they could invite the caller to call the next day after they have gone to the meeting to share their experience. Who knows, maybe a rapport develops that results in the caller actually figuring out how to pay for treatment they might have otherwise resisted considering.

Another resource that can be used for those who cannot afford treatment is the "Sobriety Checklist." The one I put together is easy to follow and allows the newly recovering person to check a box every time they complete even the simplest activities. For example, a person can

check the following off the list:

- Called AA, NA or CA to identify first meeting to attend
- Went to first meeting
- Got welcome chip
- Got phone list
- Got meeting directory
- Planned weekly meeting schedule using the directory
- Got basic text (e.g. the *Big Book*) of program
- Made first phone call
- Went to second meeting
- Shared at meeting
- Started looking for a sponsor

Part of what makes this Sobriety Checklist so simple is the information included on the reverse side of this one-page document of how to complete each task. I have included much of that information in this article as I believe this is what needs to be taught to new people in recovery regarding how to work a Twelve Step program.

For Clients: Getting Started

For now, you need to get started with meeting attendance as soon as possible. Meetings can be found by calling the central office of the program of your choice and asking where and when local meetings are held. The local telephone numbers for AA and NA can typically be found in the telephone book. You can also get the phone numbers by calling your local alcohol and drug treatment center, which can also be found in the telephone book. You should schedule and attend a meeting as soon as possible. At the meetings, you will hear what others have done to achieve successful recovery. This is also where you will begin to develop your sober support system.

At the first meeting, pick up a meeting directory so you can plan which meetings you will attend next. The most common suggestion regarding the number of meetings a newcomer should attend is ninety meetings in your first ninety days. If you have recently made the decision to begin a recovery program, such a commitment might seem overwhelming to you. At this point, it was helpful for me to apply the commonly used phrase in AA, "One Day at a Time." Using "One Day at a Time," instead of "Ninety in Ninety," can remove the overwhelming aspect by thinking about it as just one meeting a day. So all you have to do to keep this commitment is to go to a meeting today! Worry about tomorrow's meeting tomorrow. If you really think about it, an hour and a half out of your day for something so important should not be asking too much of yourself.

Developing a Twelve Step sober support system of peers is very important in recovery, and attending the same meetings every week will enable you to do that. One of the essential components of my early sobriety was meeting and hanging out with people in the program with whom I could relate.

A sponsor is a mentor or guide in the program who will help you along in your sobriety. A sponsor makes suggestions regarding how to work a good program based on his or her own experience. He or she will also provide support during difficult times in sobriety, take you through the basic text of your Twelve Step program of choice, and help to guide you through the Twelve Steps. I recommend getting a sponsor within your first thirty days of recovery. You want to find a sponsor whose brand of sobriety looks good to you, who has at least two years sober, who has worked the steps, and who is of the same sex.

Phone calls to your sponsor and other members of your sober support system are vitally important. You *must* have others involved in your sobriety to succeed. The more phone calls you make, the better your chances are at continued sobriety. You especially need to call someone when you are feeling as if you want to use, or are feeling particularly stressed or bothered about something. Phone calls that aid in sobriety must be made to other recovering people. People who are not, or never have been in recovery cannot fully understand what you go through as a recovering addict.

Sharing at meetings is another very important suggestion because it is a good way for people to get to know you so you can build a sober support system. Don't worry if you feel you don't have anything to share. A very acceptable share is as follows: "Hi. My name is Judy and I'm an alcoholic. I have five days of sobriety. I don't really have anything to share, but someone suggested that I share at meetings so that's what I'm doing. Thank you for letting me share." You will be amazed at the results of such a simple share. People will introduce themselves to you after the meeting and likely provide support and maybe even their phone number.

Reading Twelve Step literature is another essential tool for recovery. Along with learning how to utilize Twelve Step programs to help you get and stay sober, such reading also keeps you in a recovery state of mind and steers you toward new recovery behavior. You can purchase the basic text of your program of choice which typically bears the title of the name of that program, such as *Alcoholics Anonymous or Narcotics Anonymous*. Many groups simply use *Alcoholics Anonymous*, the text of the original Twelve Step program, commonly referred to as the *Big Book*. In the first 164 pages, you will find the entire AA program. Another valued book in the fellowship is *Twelve Steps and Twelve Traditions* (1981). In this book, the Twelve Steps are broken down to give a better understanding of how they work and how to work them.

Many people in recovery start their days by reading a morning meditation book like *24 Hours a Day, A Day at a Time*, or *Daily Reflections*. For each day of the year, these books provide a brief passage about a given aspect of recovery, a meditation topic, and a prayer. This is a great way to start your day on a spiritual and positive note. It reminds you that your most important task for that particular day is to stay sober.

Working the Twelve Steps will result in the peace and serenity necessary for long-term recovery. It will allow you to become comfortable in your own skin. The Twelve

Steps are a systematic way of developing a spiritual program and a manner of living that holds up to any problem you may be confronted with. The promises in the *Big Book* found on pages eighty-three and eighty-four will be fulfilled through working these steps (Alcoholics Anonymous, 2001). Specific instructions about how to work the steps can be found in the *Big Book*, but they have been done in various ways. I recommend following your sponsor's direction in working them so you can attain the same gifts that attracted you to your sponsor.

Journal writing is a valuable tool in recovery because it allows you to process your feelings on paper. When in the grip of your addiction, chemicals are used to repress your feelings. When getting sober, you are flooded by those repressed feelings and it can be very overwhelming. Without appropriate outlets for such feelings, you will eventually become so consumed by them that returning to the use of chemicals will feel like your only alternative. So, along with sharing your feelings with your sponsor, sober peers, and at meetings, you can also process them on paper.

Exercise is also a valuable tool for recovery. When doing cardiovascular exercise, your brain releases natural opiate-like substances called endorphins that give you a natural sense of well-being. You also tend to feel better psychologically when you feel good physically. When you feel good physically and psychologically, there is a tendency to feel less stress; the less stress you have, the less likely it is that you will relapse. Along with other tools of recovery, it is also helpful to exercise when a craving hits. Be sure to consult a physician regarding any physical limitations you might have that would limit your ability to safely engage in an exercise program.

Professional counseling is a very good adjunct to working a Twelve Step program and I highly recommend it if you can afford it. It is preferable that you select a counselor that has experience in working with alcoholics and addicts and one who will be supportive of your Twelve Step program. For most of the first year of my sobriety, it really helped to receive some direct feedback from a knowledgeable counselor.

Having fun is an often overlooked, but crucial element of recovery. If you don't take the time to have fun in sobriety, your addicted mind will tell you, "Heck, at least when I was using I had a little fun." This leads to resentment about your recovery and eventually to relapse. Asking people with time in sobriety what they do for fun will be helpful.

In addition to the checklist items I have already mentioned, additional checklists to track ninety meetings attended, twenty phone numbers attained, ninety phone calls made, sobriety chips earned, Step work completed with sponsor, and recovery readings are also included. I am now successfully utilizing the Sobriety Checklist with clients in a private practice setting. Free copies of the checklist are available at www.bobtyler.net to print out and use with your clients.

In closing, I hope you will join me in my passion of helping those addicted to drugs and alcohol who cannot afford formal rehab. If we embrace all those who are addicted, and provide meaningful resources, they will at least have a fighting chance to get sober if they want it bad enough. The Two-Minute Drill and the Sobriety Checklist are my modest attempts at contributing to such an inclusive mentality for our profession and, again, I am making them available for anyone who thinks they might be helpful. It is an absolute honor to walk alongside you in our wonderful profession!

Bob Tyler, BA, LAADC, CADC II, ICADC, *has been working in recovery since 1990. He is currently owner of Bob Tyler Recovery Services (counseling, consulting, writing), was past president of the California Association of Alcoholism and Drug Abuse Counselors (CAADAC), authored the book* Enough Already! A Guide to Recovery from Alcohol and Drug Addiction, *and teaches at Loyola Marymount University Extension. His website is www.bobtyler.net.*

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Credentialed Lived Experience—An Oxymoron?

Kristie R. Schmiege, MPH, ICADC, ICCS, CPC-M

"Lived Experience" has become the favored way of expressing that an individual has learned from some experiences in his or her life, especially from a mental illness, addiction or the combination thereof. The intent is to communicate in a single brief phrase that such an individual has gained something of great value that can and should be shared with others. The words denote intrinsic value gained through the proverbial school of hard knocks as opposed to in a classroom. Is it thus an oxymoron to couple "credentialed" with "lived experience"?

The concept of others gaining usable knowledge from one with practical wisdom is nothing new. The Old English idiom that focuses on "walking a mile in another man's shoes" goes back centuries. For at least fifty years, the World Health Organization (WHO) has promoted using indigenous community health workers (CHWs) alongside traditional health care providers to facilitate improved public health status of communities all over the world. This recognition of the value of local individuals being able to share lived experience with others in their own communities has saved countless lives and is experiencing great renewed interest from public health officials across the globe. CHWs advocate for and mentor peers in their communities by educating, lending support, and facilitating changes in health beliefs leading to improved health practices and reduction of disease and death.

In the behavioral health field, the incorporation of those with lived experience is also experiencing resurgence. The Substance Abuse and Mental Health Services Administration (SAMHSA) is increasingly emphasizing the inclusion of and roles for indigenous peers with practical experience alongside degreed clinicians in traditional addiction and mental health settings. These peer support services are performed by peer-recovery coaches, support specialists, and mentors, or by other names that advocate, mentor, educate, and navigate systems and all of the functions described above

in reference to CHWs. The outcomes include decreases in morbidity and mortality related to addiction and mental illness through empowerment of service recipients. Though sharing recovery experience is a newer concept in the mental health field, the addiction field is deeply rooted in the importance of common lived experience.

It is indeed well established that the sharing of one's lived experience can be of great value to one's peers. So, is it enough to simply have and share of one's own experience? Certainly; an argument can be made for this and it is effectively done all over the world on a daily basis. However, there is also increasing evidence from the WHO and jurisdictional public health authorities—as well as national US behavioral health entities—that there is value in identifying, defining, structuring, training, and certifying peers in the basic tenets of what makes the sharing of lived experience so valuable. Additionally, there is a growing awareness of the importance of assuring ethical and practice standards are defined and promulgated, as well as focus on the challenges of adding peers to traditional professional settings related to the lack of explicit role delineation. Credentialing is an effective tool to address these considerations.

Peer-based recovery support services have become an important component in any recovery-oriented system of care, and it is clear that peer recovery specialists, coaches, and mentors are increasingly considered an extremely valuable part of the recovery workforce. Responding to this need, IC&RC's most exciting initiative is the development of a credential for peers. The challenge is striking a balance. According to Mary Jo Mather (2012), the executive director of IC&RC, a 2008 report from SAMHSA's Center for Substance Abuse Treatment stated:

> *Recovery support services are nonclinical services. Many recovery community organizations have established recovery community centers where educational, advocacy, and sober social activities are organized. Peer recovery support services are also offered in churches and other faith-based institutions, recovery homes/sober housing. Maintaining the peer-ness of peer recovery support services and resisting the pressure to professionalize these services is a key challenge.*

Though it is important to remain intensely cognizant of maintaining this delicate balance and not overprofessionalizing peers, it is equally important to facilitate public protection as with clinical staff by assuring ethical and practice standards for peers are identified, learned, supervised, and followed. It is also key to assure peers understand the distinctions between their roles and that of clinicians, and vice versa, which credentialing facilitates by analyzing job-specific tasks, required knowledge, and skills.

Therefore, from IC&RC's perspective, "credentialed lived experience" is not an oxymoron. It is indeed possible to respect and enhance the integrity of an individual's lived experience within the structure of a professional credential. IC&RC is nearing completion of the process of developing a credential for peers. Credential development is a rigorous, psychometric process involving executing a full Job Task Analysis (JTA) with IC&RC's international testing company. Peers used as subject matter experts (SMEs) developed domains, tasks, knowledge, and skill areas. A broader solicitation of peers from across IC&RC boards reviewed the findings of the initial group of peer SMEs through a survey process. A group of peer SMEs then reviewed the survey data. Additional groups of peers were recruited and utilized for test development purposes.

Through this process, IC&RC fulfills its mission of protecting the public, while assuring that individuals most familiar with the job tasks have a voice throughout the strictly controlled, legally defensible, multistage effort. The Peer Credential is designed to be applicable and available to individuals with personal, lived experience in their own recovery from addiction, mental illness or co-occurring substance and mental disorders.

Kristie Schmiege, MPH, ICADC, ICCS, CPC-M, *is the director of Prevention and Health Promotion and Genesee Health System, as well as chair of Credentialing Services at IC&RC, which promotes public protection by setting standards and developing examinations for credentialing prevention, substance use treatment, and recovery professionals.*

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Editor's Note: This article originally appeared in *Addiction Today, May/June 2013, Vol. 24, No. 142* and appears here with minor edits by the author.

The Celebrity of Evil

Maxim W. Furek, MA, CADC, ICADC

The cover of the August 2013 issue of *Rolling Stone* featured typical music fare—including articles on Willie Nelson, Jay-Z, Robin Thicke, and Gary Clark Jr.—and an investigative piece on climate change and the "Arctic Ice Melt." However, what immediately stood out was a mesmerizing photo of a doe-eyed male, with tousled black hair and soft curls. Looking like a young Bob Dylan or Jim Morrison, the individual could have easily been a member of an alternative Austin City or Seattle band.

He was none of those.

The subject on the cover was nineteen-year-old Dzhokhar Tsarnaev, believed to have carried out the April 15, 2013, terrorist bombings near the finish line of the Boston Marathon. Three people were killed and almost three hundred others were injured in the twin blasts of two pressure-cooker bombs.

Tsarnaev's close-up image appeared to have been retouched, bathed in a soft sepia wash. There was immediate reaction and condemnation over the grainy cover. Numerous retailers refused to carry the issue, including those with strong New England ties such as CVS, Tedeschi Food Stores, and the grocery chain Roche Brothers. Walgreens and Stop and Shop soon followed.

Critics charged that the magazine, in projecting an appealing and vulnerable image, was offering up the first Islamic terrorist "rock star" and raising him to celebrity status. *Rolling Stone*, some felt, was making a martyr out of a monster. Edwin Hoffman, who had competed in the famed Boston race for fifteen consecutive years, was at the site of the bombing. Hoffman felt that the *Rolling Stone* cover was insulting. He said, "I do believe in freedom of the press, however I do take offense to the fact they photoshopped this terrorist and murderer to make him appeal to the rock culture and maybe sell more copies. I can only wonder what (John) Lennon's thoughts on this would be" (E. Hoffman, personal communication, December 12, 2013). The cover text said it all: "THE BOMBER: How a Popular, Promising Student Was Failed by His Family, Fell Into Radical Islam, and Became a Monster."

The controversy seemed to be merely about the cover photo and not about *Rolling Stone* writer Janet Reitman's well-researched and well-written article. The article, through interviews with numerous individuals close to Tsarnaev, described the teen as "the boy next door" with other glowing, respectful accolades. These are not the words that many of us wanted to hear, especially the victims of the horrific bombings. In addition, Tsarnaev did not have the appearance of what society views as a "terrorist." Exploring that theme, Roxane Gay observed:

> *The tone of Janet Reitman's reportage and the ongoing conversation about Tsarnaev as a 'normal American teenager,' are an interesting and troubling contrast to the way we talk about, say, Trevvon Martin, who was also a 'normal American teenager'*

and not a criminal or terrorist. George Zimmerman killed Martin because Martin fit our cultural idea of what danger looks like. Zimmerman was acquitted for the very same reason (2013).

Like other similar literary and artistic themes, the cover triggered raw emotions and outrage. Kathleen Hall Jamieson, a communications professor and the director of the Annenberg Public Policy Center at the University of Pennsylvania, viewed the provocative cover as an event we have not experienced before. She said, "I can't think of another instance in which one has glamorized the image of an alleged terrorist. This is the image of a rock star. This is the image of someone who is admired, of someone who has a fan base, of someone we are critiquing as art" (Italie, 2013).

Prior to the inflammatory cover, a shaken Tsarnaev, with a swollen face and arm in a cast, pleaded "not guilty" to the bombing charges. The evidence appeared to indicate otherwise.

CBS News senior correspondent John Miller, a former FBI assistant director, revealed that Tsarnaev left behind a note claiming responsibility for the attack. He was hiding in a boat as police pursued, bleeding from gunshot wounds sustained in an earlier shootout between police and his older brother, Tamerlan. Scrawled on the interior wall of the boat's cabin were words calling the bombings retribution for US military action in Afghanistan and Iraq. Tsarnaev wrote, "The US Government is killing our innocent civilians . . . when you attack one Muslim, you attack all Muslims . . . we Muslims are one body . . . you hurt one you hurt all of us" (CBS News, 2013).

Straddled between terrorist retribution and grief-stricken victims, *Rolling Stone* was entrenched inside a no-man's land. Offering condolences to the bombing survivors and their families, *Rolling Stone*, in a prepared statement, said: "The fact that Dzhokhar Tsarnaev is young, and in the same age group as many of our readers, makes it all the more important for us to examine the complexities of this issue and gain a more complete understanding of how a tragedy like this happens" (Reitman, 2013).

In our rush to understand the reasons behind the Boston Marathon attack, elements of censorship and free speech collided in heated debate. For some it was painful to read accounts of young women defending the actions of Dzhokhar Tsarnaev and raising him to the status of martyr. *Rolling Stone*, the magazine that raised awareness of Tsarnaev, was now scrutinized by a shocked nation. Others demonstrated a knee-jerk response, predicated upon fear and ignorance. Some glanced at the photograph, but did not read the text that offered an unflattering portrait of the making of a monster.

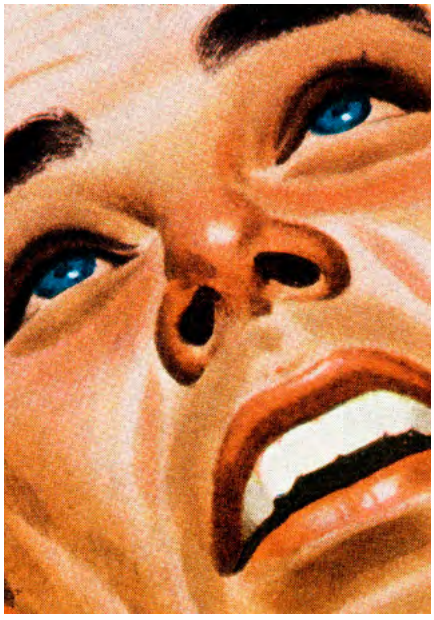
Charles Manson

Even before the magazine hit the newsstands, there were blog sites defending the innocence of Tsarnaev, and young girls idolizing him as their latest dark celebrity. This conjoining of dark forces—an amalgamation of curiosity, voyeurism, and celebration—has been a frequent visitor in times past. Depraved individuals including Charles Manson, Richard Ramirez, and Adolph Hitler all possessed a similar allure. Manson and Ramirez received letters from smitten females, gravitating to them like moths to a flame.

Charles Manson was called "the stuff of a nation's nightmares" by journalist Geraldo Rivera (Hedegaard, 2013). Because of sensationalized media analysis and the book *Helter Skelter*, Manson was transformed from a petty career criminal to a monster whose slimy tentacles menacingly threatened us with harm. Manson became the personification of evil and, as Theologian David R. Williams observed:

Manson became a living metaphor of Abaddon, the God of the bottomless pit. We, as a collective culture, looked into Manson's eyes and saw in those dark caves what we most feared within ourselves, the paranoia of what might happen if you go too far. He was the monster in the wilderness, the shadow in the night forest, the beast said to lurk in the Terra Incognita beyond the edges of the map" (2008).

Charles Manson and other members of his so-called family were convicted of killing actress Sharon Tate and six other people during a bloody rampage in the Los Angeles area during two August nights in 1969. He is housed at Corcoran State Prison in a special unit for inmates felt to be endangered by other inmates, separate from the general prison population (Blankstein, 2012). The maximum security Corcoran is where he will live out his final days. Manson, who has spent much of his life caged like a mongrel, accepts this reality, stating that "Too much freedom is detrimental to the soul." "I should not have been out there. It was too fast for me" he remarked (Hedegaard, 2013). The seventy-nine-year-old Manson still exudes a bizarre magnetism and spends every weekend with a twenty-six-year-old woman named Star. She received her name from Manson. Star operates a website called "Release Charles Manson Now" and admitted that that she started writing to Manson when she was nineteen. In 2007, she moved to Corcoran, California, to be closer to her idol and claims they will be married (Hanson, 2013).



Serial killer Richard Ramirez, christened the "Night Stalker" by the media, was convicted of thirteen murders. The self-proclaimed devil worshipper found his victims in quiet neighborhoods and,

dressed in black, silently entered their homes. Sometimes he ritualistically removed the eyes of his victims. He drew pentagrams on the walls in lipstick. Ramirez was incarcerated in California's San Quentin State Prison. From there he welcomed a coterie of admirers, paying homage through intimate letters and visitations. Freelance magazine editor Doreen Lioy developed an intense and compulsive attachment toward the killer. Beginning in 1985, she wrote him nearly seventy-five letters and sat through every day of his trial (Ramsland, 2014). In 1988, Ramirez proposed to her. They were married in California's San Quentin State Prison on October 3, 1996. When Ramirez was sentenced to death in 1989, Lioy vowed to commit suicide if he was executed. Doreen Lioy and Richard Ramirez eventually separated, and at the time of his death he was engaged to a twenty-three year old writer—an unfitting ending to Lioy's obsessive fantasy with a psychopath.

The Dark Side

Like Doreen Lioy, many of us have a fascination for the dark side, that forbidden world of shadows and amorphous shapes. Jung addressed the often negative and unconscious shadow, writing: "Everyone carries a shadow, and the less it is embodied in the individual's conscious life, the blacker and denser it is. It may be (in part) one's link to more primitive animal instincts, which are superseded during early childhood by the conscious mind" (Jung, 1970). Robert Lewis Stevenson explored that link in *Dr. Jekyll and Mr. Hyde*, based on Scottish city councilor Deacon Brodie, who harbored a secret life as a burglar. We are intrigued by the dark side and seek to know more. Like a classic Lucille Fletcher radio drama, we enter into the sick mind of the murderer and experience what it might be like to think and act like them. This mechanism serves as a gauge for society; we watch rather than participate in the actual slaughter. That fascination has spilled over into popular culture. Note the current popularity of *CSI*, *Criminal Minds*, *The Following*, *The Mentalist*, and similar television programs offering detailed examinations of serial killers and psychopaths.

A more clinical means of examination comes from the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). The paring down from ten to six personality disorders was strongly considered for the DSM-5, but removed at the last minute because of pressure and politics. Still, the DSM-5 proposed a hybrid model that retained six personality disorder types. They included avoidant personality disorder, borderline personality disorder, obsessive-compulsive personality disorder, schizotypal personality disorder, narcissistic personality disorder, and antisocial personality disorder (ASPD).

Symptoms of ASPD begin in early childhood or adolescence and continue throughout the person's life. These individuals demonstrate a disregard for social norms and laws and tend to be more belligerent and more prone to getting into fights and being arrested, especially at an early age. ASPD types tend to lie, steal, and act with impetuosity, without thought for their own safety or those around them (Hanna, 2012).

The most dangerous are the psychopaths, characterized by an absence of empathy, poor impulse control, and a total lack of conscience. About 1 percent of the total population can be defined as psychopaths, and they tend to be egocentric, callous, manipulative, deceptive, superficial, irresponsible, parasitic, and even predatory. The majority of psychopaths are not violent and many do very well in jobs where their personality traits are advantageous and their social tendencies tolerated. However, some have a predisposition to calculated, "instrumental" violence—violence that is cold-blooded, planned, and goal-directed. Psychopaths are vastly overrepresented among criminals; it is estimated they make up about 20 percent of the inmates of most prisons. They commit over half of all violent crimes and are three to four times more likely to reoffend. They are almost entirely refractory to rehabilitation (Craig et al., 2009).

The American Psychiatric Association estimates that 3 percent of the male population, which equals four million in the United States alone, is comprised of people who suffer from psychopathic personality disorder. Ted Bundy, Charles Manson, and Dennis Rader (the BTK killer) have been identified as the nation's most infamous psychopaths. Despite these few extreme examples and the loveable serial killer in the television show *Dexter*, murder is not on the mind of every psychopath.

Psychopathy was not recognized by the DSM-IV as a mental disorder, but as a form of personality disorder. Moreover, even among professionals, there are misconceptions about the illness. According to Marc Pickren,

> *Although popular opinion paints the psychopathic personality as one who has no emotion, the truth is that emotion, especially anger, plays an integral part in such behavior. A psychopath is typically impulsive, paranoid, and aggressive. What makes the psychopathic personality frightening is the lack of remorse for wrongdoing and the blatant disregard for the rights of others; others are always to blame for bad conduct* (2010).

Providing additional clarification to the nature vs. nurture debate, Pickren deduces that

> *Scientists have yet to find a substantial link between biological factors and psychopathy. Rather, the disorder seems to manifest as a result of environmental factors, primarily abuse or neglect. Psychopaths exist in diverse cultures across the globe, but they are more prevalent in the United States, which suggests a social connection to the development of the disorder* (2010).

As observed by J. R. Meloy, a combination of chronic psychotic disturbances and personality disorders are most often seen in mass murderers:

> *Personality disorders also abound in this group of dangerous individuals. We have found that personality disorders in mass murderers are often a mixture of antisocial, paranoid, narcissistic, and schizoid traits—someone who habitually engages in criminal behavior, is suspicious of others' actions, is self-centered and grandiose with little empathy for others, and is chronically indifferent toward others and detached from his emotional life. It takes little imagination to see how such an individual, in the right circumstances, could intentionally kill others* (2014).

Furthermore, Meloy explained that individuals who are clinically depressed, or have a psychotic disorder, pose little risk of violence. He also noted that schizophrenia is quite treatable with medication and other psychotherapeutic support, and few people with schizophrenia are violent.

Craig N. Piso, PhD, author of *Healthy Power*, believes that

> *The very most dangerous psychopaths are those with the nightmarish combination of sociopathy (deficient in conscience, empathy for others, and regard for norms/rules/laws) and sadistic yearnings, often deriving pleasure through torture, even murder. Of course, the most heinous of such criminals are the sexually sadistic pedophiles who rape, torture, and often murder children to feed their addiction* (personal communication, February 12, 2014).

Citing the Bobo Doll experiment by psychologist Albert Bandura, Piso cautions that men who watch pornographic films depicting sexual violence against women are at risk. Piso says, "My great concern here is that both children and adults are malleable, particularly at early ages, thus they are prone to imitate the violent/antisocial behavior they observe, especially when they associate it with social norms, expectations, and rewards, such as becoming popular or receiving attention" (2014).

Adolph Hitler

Adolph Hitler received that attention. Recognized for an ability to deliver nationalistic speeches, he roused Germany to follow his warped Aryan ideology. For some, Hitler's charisma was irresistible. Hans Frank, ex-governor general of Poland, while awaiting trial, confessed to a prison psychologist his attraction to Hitler (Persico, 1995):

> *I can hardly understand it myself. There must be some basic evil in me. In all men. Mass hypnosis? Hitler cultivated this evil in man. When I saw him in that movie in court, I was swept along again for a moment, in spite of myself. Funny, one sits in court feeling guilt and shame. Then Hitler appears on the screen and you want to stretch out your hand to him . . . It's not with horns on his head or with a forked tail that the devil comes to us, you know. He comes with a captivating smile, spouting idealistic sentiments, winning one's loyalty. We cannot say that Adolf Hitler violated the German people. He seduced us.*

But Hitler went beyond that queer platitude. Hitler was an angry, obsessive, and paranoid tyrant, intent upon eliminating any who did not fit into his white supremacist mythology. He warned, "We must be ruthless . . . there must be no weakness or tenderness" (Kahler, 1989, p. 63).

Charles Manson. Richard Ramirez. Dzhokhar Tsarnaev. Their names have been penned in blood, their behaviors more like unleashed animals than human beings. Undoubtedly, we struggle to determine a fitting diagnosis for such individuals. Manson and Ramirez were clearly psychopaths, demonstrating many of the frightening variables described at length in this article. Hitler and Tsarnaev, however, challenge our collective expertise.

In his 1998 book titled *Hitler: Diagnosis of a Destructive Prophet*, Dr. Fritz Redlich, a neurologist and psychiatrist, concluded that though Hitler exhibited many psychiatric symptoms, including extreme paranoia and defenses that "could fill a psychiatry textbook," he most likely was not truly mentally ill (Goode, 1998). Redlich wrote that Hitler's paranoid delusions "could be viewed as a symptom of mental disorder, but most of the personality functioned more than adequately." Redlich offers a list of psychiatric symptoms evident in Hitler—paranoia, narcissism, anxiety, depression, and hypochondria, to name a few—and finds some evidence for every one, but an analysis of Hitler concludes that madness or illness was not at the root of his evil acts (Goode, 1998).

Identifying a formal psychiatric diagnosis for Dzhokhar Tsarnaev is more difficult. Anything that involves extreme religiosity is typically met with extreme political correctness. Many conclude that Tsarnaev had been radicalized as an explanation for his violent actions. Psychologist John Horgan, PhD, who directs the Pennsylvania State University's International Center for the Study of Terrorism, states that people who are more open to terrorist recruitment and radicalization tend to feel angry, alienated or disenfranchised;

believe that their current political involvement does not give them the power to effect real change; identify with perceived victims of the social injustice they are fighting; feel the need to take action rather than just talking about the problem; believe that engaging in violence against the state is not immoral; have friends or family sympathetic to the cause; and believe that joining a movement offers social and psychological rewards such as adventure, camaraderie, and a heightened sense of identity (DeAngelis, 2009).

Still, religiosity intertwined with violence is more commonplace then we realize. In many cultures a spiritual connection incorporates both pain and sacrifice. Mutilation and body modification rituals are thought to be pleasing to the gods and believed to foster the achievement of special states of holiness, ecstasy, and insight. Consider Christian religious zealots who are crucified on Good Friday, or Hindus during the Thaipusam Festival, who pierce their skin with sharpened steel rods before climbing the 272 steps of the Batu Caves. Consider the Tibetan monk who self-immolates in an ultimate act of protest against Chinese rule. These are individual acts of self-inflicted violence.

There are other quasi-religious groups that are equally violent. Former Pennsylvania State Police Officer Sgt. Phillip Harchack notes the actions of the modern terrorist:

> *Many enthusiastic citizens are led to violent behavior by what they believe to be a worthwhile cause, such as protection of the earth or animal cruelty. Environmental terrorists have caused damage to forestry facilities in Northwestern Pennsylvania and housing developments and car dealerships in California, as well as other states, tallying in the millions of dollars. Environmental groups such as People for the Ethical Treatment of Animals (PETA), Earth Liberation Front (ELF), and Animal Liberation Front (ALF) have become frustrated and angry. They feel that by setting fire to construction sites or releasing captive animals, they can rectify social injustice. They find their personal glory in news media coverage and postings to their websites* (personal communication, February 15, 2014).

Nonetheless, the Islamic terrorist who commits suicide on a crowded Tel-Aviv bus is different. He or she views the slaughter of innocent individuals as an honorable cleansing, a self-sacrifice, and act of retribution. Evil is in the eye of the beholder. There may not be an immediate DSM-5 diagnosis for Tsarnaev, but perhaps a diagnosis of "evil" would be the most appropriate.

On January 30, 2014, federal prosecutors announced they would seek the death penalty against Tsarnaev, accusing him of betraying his adopted country by ruthlessly carrying out a terrorist attack. US Attorney General Eric Holder said in a statement,

> *The nature of the conduct at issue and the resultant harm compel this decision. Dzhokhar Tsarnaev received asylum from the United States, obtained citizenship and enjoyed the freedoms of a United States citizen, and then betrayed his allegiance to the United States by killing and maiming people in the United States (*Serrano, 2014). C

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

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"Visions": The Gift

Bob L.

The auto parts whirled down the conveyor chute. Like every other day at the plant, I would catch them and place them in the cages for transport. However, today was a special day. This hourly auto worker began to write what it was like to have an alcohol and drug addiction, how it affected his family, job, and society, and the changes that came with it. "I will write what happened as a play," I said to myself.

The first few pages came easily and then silence. *Another failure*, I thought to myself. *You never completed anything!* The parts kept coming down the chutes. I lowered my head in surrender and went inside the cage where the parts were to be sorted. The cage reminded me of the disease. In the cage I prayed, amidst the noise of the large sorting machine nearly a city block long. "God help me," I said, like I did when I hit bottom over two years earlier. Suddenly, something happened. I was inspired! Soon I was able to complete the play. I called the play "Visions" and considered it, like my recovery, a great gift. Every evening after I finished work, I would sneak into the traffic department and peck at the typewriter until the once-penciled manuscript was finished.

With script in hand I went to several community theatres and colleges, hoping they would present it. All of them turned me down saying "Not our cup of tea," "Too harsh," or "Too real." Dejected, I wondered why there was no interest. *It was inspired*, I thought, and the gift continued. Soon the script would find its way into the hands of a friend, who passed it on to a Hospital and Institution (H&I) convention committee. The committee reached out and asked me to perform it at their upcoming convention a few months down the road. I was overjoyed, but I wondered where I would get the actors. How would I direct? Where would we rehearse?

I turned to the rooms of recovery where my new friends met and asked them to join me. Twenty wonderful souls said they would come. Five churches would donate space and I began the rehearsals. We began rehearsing a few times here and there, eventually bringing everything together like beads on a string.

I had decided, from the day I sought the "Visions" troupe, that we would remain anonymous; no last names and no pay. "Visions," the play on addiction, was a gift to me and the

greatest of all gifts is the one that gives without ever asking in return. Our egos would be put aside.

The day before the H&I convention, we brought the play to a long-term rehabilitation center called Integrity House in Secaucus, New Jersey. After the short performance, the clients were weeping in gratitude and hugging us. That reaction would continue the next day at the H&I convention.

The years have passed—twenty-two of them since that September evening in 1991. My hair has thinned and I have grown older, but my "Visions" play still remains the great gift, healing and bringing hope to more than four thousand people in the hearts of treatment centers, shelters, prisons, and communities. It would be a healing experience for me, and for the more than five hundred anonymous members who would join to carry a message of recovery to their peers. The "Visions" troupe would eventually receive a Presidential Points of Light Award from Washington, DC, for their community service and volunteerism.

The play would make its way, slowly and surely, to eight states and as far west as Texas. Over a dozen separate troupes would be formed, several started from treatment centers and even prisons—addicts carrying the message to other addicts. "Visions" would receive educational accreditation in the addiction field and be used as a training medium at a medical university. Those who participated—social workers, counselors, psychologists, and nurses—would receive graduate credits in behavioral medicine and counseling. It would be performed in the House of Representatives in Washington, DC, for National Recovery Month. We would rock them at the World Convention. We became a nonprofit organization with the assistance of the Volunteer Lawyers for the Arts. The play would go Off Broadway, where 50 percent of all tickets were donated to area treatment centers and shelters. All of these great opportunities and more were done with no funding. The gift continues.

Through the years in my journey with "Visions," I have gained insight regarding the great gift that was so freely given to me years ago. If we, the cast and crew, did the best we could performing the play with selflessness and the spirit of love, we could serve as a medium of intervention with our audience. I'm not sure how it happens, but it does happen. Over the years the troupe and I have witnessed it time and time again. It is an intervention that brings hope and recovery, an intervention that breaks the denial of addiction to our brothers and sisters caught in the talons of addiction. How blessed we are to be a part of this. We are witnessing our audiences jump out of their seats to give us standing ovations, their hearts brimming with love and gratitude. Yet it is the cast who want to bow to them. By serving these special souls, we are serving our Higher Power. God is right there in the trenches with each and every one of them. He is carrying our audiences as he carried us in the beginning of recovery. It is only out of compassion that God lets us walk on our own feet, like parents watching their children take their first steps.

From November 26 to December 1, 2013, "Visions" performed Off Broadway at the Hudson Guild Theatre in New York City. Pulling no punches, "Visions" depicts powerful scenarios of alcoholics and addicts hitting rock bottom, and also deals with homelessness, domestic violence, HIV, and youth at risk. More importantly, "Visions" conveys the message of hope and recovery loud and clear. Fifty percent of all seating was donated to area treatment centers and shelters. The troupe brought in beloved audiences from rehab centers and shelters into the intimate, state-of-the-art theatre for this part of the "Visions" play Gratitude Tour.

Come witness the magic!

Bob Lo Bue, *known as Bob L., is the author and director of the "Visions" theatre play on addiction and recovery, which has reached more than forty thousand people. The "Visions" troupes are the recipients of a Presidential Points of Light Award from Washington, DC, and the State of New Jersey Governor's Volunteer Award in the Arts and the Humanities. Bob is the president of Visions Recovery, Inc., a not-for-profit arts organization dedicated to substance abuse prevention and recovery education., and the owner of Visions Lighting and Sound event company.*

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Miracle Uncovered

Rev. Leo Booth

We often hear people say "Expect a miracle" and it has become part of the spiritual novella. However, I don't think that it's true.

Let's take a step back and examine the idea of God for a moment. For centuries people believed that God, a separate entity from creation, was removed and beyond what He had created. God made things, occasionally intervened, wasn't beyond exacting formidable punishment, and for those with a religious or spiritual conscientiousness, could be sought after or pursued. Religions journey into God. Religions worshipped God. Religions spoke of a life beyond the grave where we would be at one with God, or not.

We get the drift—God was and is divinely separate.

With this in mind, miracles came to be seen as divine events that amazed any onlookers. Oceans parted so that the faithful could pass through, and then closed over the sinful pursuers. The elderly (I'm talking really old!) gave birth to healthy sons and daughters. The sick were miraculously healed.

The belief was established that the faithful should pray for a miracle, expect a miracle, hope desperately for a miracle and, just maybe, God would grant a miracle. God was beyond creation and miracles came from outside of creation.

For Christians, the vehicle for God working a miracle, the instrument that enabled miracles to happen, was grace. So mantras were established:

- I was saved by the grace of God.
- Only through God's grace am I sober today.
- My cancer was miraculously healed by the grace of God.

As I have written in *The Happy Heretic*, the consistent casualty caused by this philosophy and religious thinking is the lack of emphasis on the human being. The personal stories miss or completely gloss over the role, the thinking, and the actions that human beings create to achieve success.

Some sayings have become so popular and widespread that few challenge what is being said: "God is doing for us what we cannot do for ourselves." Really? I don't see this being true when I look around the world, or when I observe the lives of my friends and family. What I do see reflects an equally popular saying: "God helps those who help themselves."

I have come to the conclusion that not every popular saying is true! In *The Happy Heretic*, we consider our part in the following messages. Let's examine these examples:

If God wants you to have it, then it will happen.

I do not believe that you have a job, a wife, a car or a college degree just because God wants you to have them. I am convinced that we *did something* to get those things. We attended the interview with an excellent resume, we got to know and love the woman who is now our wife, we saved for the car that we now own, and yes, we studied hard for our exams.

There, for the grace of God, go I.

I liked this saying until I began to think about it. Do I really want to suggest that we are not in prison, or homeless or drunk because God's grace *stopped* these things from happening to us? Should we thank God because we're not like those we feel sorry for, or do we need to be proud about the circumstances, actions, or choices that prevented us from breaking the law, making our house payment, or seeking therapy to maintain our sobriety. Our *choices* create success in life and we are necessarily involved, even if we are not always conscious about it.

When your time is up, God will take you home.

This statement feels appropriate when we die at eighty, in a comfortable bed, with family around us. It

does not feel so acceptable when our teenage son or daughter is killed by a drunk driver or dies as a young soldier in war. Are we seriously suggesting that God directed that drunk driver or created the war? Maybe it is better to say that accidents happen and people die in circumstances that are truly tragic. Yes, we are grateful for the time we shared together, but it is not helpful to suggest that God had a hand in an untimely death.

> *These sayings conjure up a picture of God as a master puppeteer, pulling the strings of life and death.* – *The Happy Heretic*, pgs. 19–21.

Let's return to where I started, concerning miracles. What if the real miracle is within the human being? It's not so much that we should expect a miracle, but that we *are* the miracle.

In contrast to the religion of yesterday, many spiritual writers today are embracing the power of the human spirit. This spirit of God was given to us within creation, it's who we are; we don't have to seek or expect what we have already been given.

I see this reflected in a section of the *Big Book* of Alcoholics Anonymous (pg. 436) where it says:

> *I looked up an AA meeting and went there—alone.*
>
> *Here I found an ingredient that had been lacking in any other effort I had made to save myself. Here was—power!*
>
> *Here was power to live to the end of any given day,*
>
> *power to have the courage to face the next day,*
>
> *power to have friends, power to help people,*
>
> *power to be sane, power to stay sober.*
>
> *That was seven years ago—and many AA meetings ago—and I haven't had a drink during those seven years.*
>
> *Moreover, I am deeply convinced that so long as I*
>
> *continue to strive, in my bumbling way, toward the principles I first encountered in the earlier chapters*
>
> *of this book, this remarkable power will continue*
>
> *to flow through me.*

I do realize that there are sections of the *Big Book* that support the old-time religion philosophy—where God is separate and removes our shortcomings and character defects—but I take comfort in the fact that, maybe just for a moment, Bill W. stumbled into a belief that I have come to hold most precious; I *am* the miracle.

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

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The Virtue of Patience, Part I

John Newport, PhD

This is the first installment of a two-part series focusing on cultivating the virtue of patience and applying it to recovery from addiction.

I like to define patience as the ability to maintain one's composure in the midst of challenging circumstances. According to the dictionary, patience is synonymous with calmness, composure, and serenity (Merriam-Webster, 2007). Irritability, as you might suspect, is the antithesis of patience. Patience can also be defined as the ability to keep a calm, upbeat attitude when confronted with extremely frustrating or tedious circumstances beyond our control, such as getting caught in an unexpected traffic jam while driving home from work.

It is extremely challenging to maintain our patience in the midst of today's fast-paced society. All too often we are bombarded with challenges demanding an instant response, from the moment we wake until the end of the day when our head finally hits the pillow. We become so addicted to instant responses that texting replaces normal conversation and multitasking is the norm for many people. I spent most of my adult life in Southern California, which to me represents the epitome of a culture hard-wired to promote chronic impatience. One afternoon, while I was driving home from work, I actually witnessed a fellow driver hastily brushing his teeth as he forged ahead on the freeway!

The Value of Patience in Recovery

Those of us in recovery from or still struggling with addictive disorders tend to be an impatient lot. This is not surprising, as part and parcel of the addictive process is the obsessive search for instant gratification, instant solutions to life's problems, and the promise of an instant escape whenever we are confronted with circumstances we believe are just too difficult to bear. The latter reminds me of the old joke about the man praying for guidance to help him develop the quality of patience, saying "Lord, grant me the virtue of patience—and give it to me RIGHT NOW!!!"

Physiologically, the overingestion of stimulants—including caffeine, nicotine, alcohol, and sugar, which many alcoholics and/or addicts often binge on when they give up their drug of choice—contributes to the addict's baseline state of accentuated impatience and irritability.

In contrast to the addictive lifestyle, recovery entails a lifelong journey of growth and healing that challenges us to bring forth the qualities of patience and fortitude in all of our affairs. This is particularly true during the early stages of sobriety, where we often feel irritated and out of sorts as both our minds and our bodies are attempting to attain a new state of equilibrium in the absence of drugs and alcohol. Manifesting the quality of patience can also be extremely difficult whenever we are confronted with a major challenge that we feel ill-prepared to cope with, such as the loss of a job, a divorce or a serious illness. Using basic tools of the program, particularly turning to our Higher Power and the Serenity Prayer, can be most helpful in striving for spiritual grounding in the midst of these challenging times.

A Personal Quest for Patience

I consider myself to be in recovery from chronic impatience. My tendency toward impatience is triggered in part by acquired familial traits—my father was extremely impatient, as are both my brothers. I am also a perfectionist with highly critical tendencies. These traits were also heavily influenced by environmental conditions; both of my parents were rather critical school teachers, and I have spent a considerable portion of my adult life in academic

settings that foster both perfectionism and a critical outlook. I also believe that my chronic impatience was exacerbated by my choosing to spend thirty-five years of my life living and working in a very fast-paced environment.

Almost forty years ago I attempted to counter my impatience by taking up a form of meditation called "transcendental meditation," which I have faithfully practiced twice a day since becoming a meditator. In recent years my quest for serenity has included moving to a more relaxing environment and a conscious effort to deepen my connection with my Higher Power, as well as with valued members of my family and friends.

Since relocating to Tucson four years ago, I greet the day with a contemplative period of prayer and meditation, followed by an hour-long hike in the beautiful foothills that virtually lie at my doorstep. I also find that the pleasant year-round climate, including an abundance of sunshine on most days, together with the fact that our community of over half a million people has somehow managed to retain a friendly, small-town quality, are very conducive to infusing my life with patience and serenity.

I am painfully aware of the severe toll impatience can take on our personal relationships. Close to nine years ago upon retiring, my wife and I moved 1,200 miles from our home of over thirty-five years to an isolated community on Washington's Olympic peninsula. While I am sure that many old-timers enjoy the abundance of fresh air, forest land, and snowcapped peaks, we rapidly discovered that this environment was not our cup of tea. Confronted with seemingly endless gloom and wind-chill, compounded by an acute sense of isolation from family, friends, and professional peers, we both lapsed into rather severe depression. While we toughed it out for close to five years, our perceived harshness of this strange environment took a heavy toll on our relationship. Predictably, our mutual discontent fed into an escalating cycle of irritability and impatience with each other.

As I was typing this article, I was reminded of a quote I recently read in Unity's Daily Word that really hit home. Quoting from the reading, "If I am having trouble being patient, it is a clue that I have moved away from being kind and loving" (Daily Word, 2013). Writing these words of wisdom down on an affirmation card, I added "I take a deep breath and experience God's love flowing through my entire being and outward toward those around me." I find that these words, which I reread every morning, are extremely helpful in honoring my daily vow to be consciously kind and loving in my communications with my wife and others around me.

Based on my own experience, I have come to believe that turning to our Higher Power for guidance on a daily basis is essential to progressing on our ongoing quest for lasting patience and contentment. I especially call upon my Higher Power to guide me in striving to instill in my life a good balance and blending between pride, confidence, and humility.

Concurrent with our move to Tucson, I began attending a local church with my wife to support her in her desire to return to her childhood faith. While I do not currently identify with any particular form of organized religion, I find the sermons to be extremely helpful in deepening my connection with my Higher Power, and draw both support and nurturance through a church-based men's group I recently joined.

I hope the above reflections may be of help to you and your clients in nurturing the quality of patience in your own lives. The second and final installment of this two-part series on patience will deal with the value of patience in our ongoing quest to strengthen our recovery through integrating a wellness-oriented lifestyle into our personal recovery program.

Until then—to your health!

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

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Planting Springtime Seeds

Sheri Laine, LAc, Dipl. Ac

As springtime draws to a close, I wanted to focus on some important nutritional and psychological benefits that the season can bring to our lives.

Springtime gives us all the opportunity to see and experience growth and change. In this time of year, we see the beginnings of new life and the renewal of nature's bounty. Spring fever is associated with a newfound energy and vibrancy of movement—a desire to get up and out. Spring cleaning calls to mind the desire to rid oneself of the old and make room for the new, the unexpected, and the creation of something else.

Oriental medicine depends on the five element system to diagnose and treat, and utilizes acupuncture, herbal medicines, diet, exercise, and meditation. Each element has an associated season, balancing element, flavor, time, color, taste, direction, and organ.

The element related to springtime is wood. Its organs are the liver and the gallbladder. Its color is green and its growth factor is regeneration.

The liver houses our ethereal soul, which is said to influence our sense of direction in life, our emotions, and our capacity to plan our life's pursuits. Another important function of the liver is to nourish and bathe the tendons, ligaments, joints, and muscles with moisture, allowing for suppleness and flexibility.

The gallbladder is responsible for our decision-making. Its function is to store and secrete bile, which is produced by the liver. The liver's job is to control the movement and flow of *Qi* (our life force) and blood within our bodies.

Acupuncture supports the liver's process as the needles enhance the free-flowing

action of *Qi* and blood while vitalizing and relaxing the body, mind, and spirit.

Just as new wooden branches bend into light spring winds, we too can use this time as an opportunity to awaken, stretching and lengthening our tendons and muscles. Spending time in nature, taking long walks, running along the ocean's edge or biking along trails are other opportunities to move and revitalize our *Qi*.

Springtime is a wonderful time to start a meditative, deep breathing, and positive thinking practice. This time of growth and regeneration supports flexible thinking, promoting inner growth, and spiritual movement. Positive thoughts, speech, and deeds are akin to planting springtime seeds and flowers. Watch your thoughts and listen to how you speak, remembering that your surroundings serve as windows of awareness into the world in which you see.

In Western medicine, the liver works to detoxify the body; spring is the perfect time for this cleansing. It is the time to add foods to your diet that enhance the body's ability for strength and vitality.

The liver/gallbladder taste is sour—lemons, limes, and grapefruits contain vitamin C and antioxidants, which detoxify and aid the liver in cleansing the body of free radicals while helping to increase and stimulate digestive enzymes. Proper hydration supports the digestive function and detoxification process. Pickled and fermented foods are also very helpful to aid in digestion and enhance the immune system by strengthening the intestinal flora.

The liver color is a vibrant green when it is at its healthiest. A bounty of leafy green vegetables such as Swiss chard, collard greens, beet greens, kale, spinach, bok choy, asparagus, baby lettuce, artichokes, fava beans, green garlic, and green onions will add variety to your diet, support the immune system, provide your body with vitamins antioxidants and fiber, and serve as a diuretic to help rid the body of toxins.

Adding energizing foods to our diets allows us to support our bodies' wellness process. Organic green juicing is another way to enhance your nutritive process. Educate yourself about super foods and explore recipes that include them in your diet throughout the week.

The liver and gallbladder's optimal time is 11:00 PM to 3:00 AM. This time frame is the energetic "on" switch for stimulating the processes we have been discussing. It is best to be in bed by 10:00 PM, which is a bit early for some and easier for others. If you cannot sleep, relax into the sanctuary of your bedroom. Practice deep, slow, rhythmic breathing. Include transformative music into your bedtime ritual.

By giving your body time to rest, regenerate, and refresh, your mind and unconscious thoughts can begin anew to fertilize conscious desires. The cycle of life continues as the darkness of night blooms into the new light of tomorrow. C

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

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

Dennis C. Daley, PhD

This column will begin a three-part series on motivation from the client's perspective. I chose this topic because motivation to change often fluctuates during the early phases of recovery, and how a client deals with motivation is a significant factor in sustaining recovery, making positive life changes, and relapsing.

Meet Matt and Anita

Matt, a thirty-four-year-old married father of two children, recently said the following during a group discussion:

> *I was working hard at recovery, doing well, felt highly motivated to stay sober, and put my life together. I quit drinking for ten months, and my depression and family life improved. Things were clicking for me. Gradually, I got tired of recovery and lost my motivation, blowing off counseling and AA meetings. Since I didn't talk about this and stopped following my plan, my recovery went in the shitter. I knew things could get bad if I stopped working my recovery, yet I still did this.*

Matt moved from working a good, solid recovery program to relapse as a result of a gradual decrease in his motivation to change, which impacted on his participation in treatment and AA. Not sharing his motivational change got the best of him, interfering with his recovery and leading to relapse.

After years of addiction controlling her life, Anita completed a rehab program and followed it with outpatient counseling and active involvement in NA. She was going to meetings, working with a sponsor, and working the Steps. To reach her goal of a career in the medical field, she worked part-time and attended school full-time. To get to her morning classes, she had to get up early and take two busses. Anita said, "My desire to make something of myself was so strong I wouldn't let anything get in my way. Even though I had little time to myself, it was worth it. I worked hard every day to reach my goals." She now works full-time in a job she enjoys and is still active in NA.

We have all had clients like Matt who expressed verbally, or in their behavior, that they lost or were losing interest in treatment and/or recovery. They had mixed feelings about managing their disorder(s), working towards their goals, and changing their lives. Or, they were interested in relief from psychiatric or addictive symptoms provided by medications, with little or no interest in psychosocial treatments or mutual support programs. Some had been in treatment so many times they were "tired" of attending sessions and just wanted medications. The key issue with clients evidenced by Matt's experience is not whether motivation will decline in recovery as it often does, but whether the client is aware of this shift, takes action to stay on track, and works through low motivation.

Hopefully we have also had clients like Anita, whose motivation was so strong that she balanced the demands of work, school, and recovery. Her desire to succeed was so strong that she excelled in her classes, graduating with a high average. Anita's case shows that having specific goals can be a strong motivating factor to succeed. However, life goals cannot supplant recovery goals or push them aside, as failure to sustain recovery can adversely impact on other goals.

As these two different situations show, motivation is a significant issue for many clients with behavioral health disorders. It impacts their recovery and ability to reach their life goals. In addition, it ultimately affects their well-being. Therefore, it is important to assess behavioral health clients' levels of motivation or readiness to change.

Motivation as a State

In behavioral health care, motivation refers to the client's desire to get involved in treatment to change and manage a substance use, psychiatric, or co-occurring disorder. Motivation affects treatment entry, engagement, adherence, and retention, as well as ultimately determines whether the client engages in and sustains long-term recovery (Daley & Thase, 2004). Early on, even clients who enter treatment are often ambivalent about changing their substance use habits (DiClemente, Garay, & Gemmell, 2008). Initial motivation is often external as the client may enter treatment to save a job or a marriage, maintain or get custody of children, or resolve legal problems related to driving under the influence, or criminal charges involving alcohol, drugs and other behaviors. In cases of more severe psychiatric disorders, the client may initially engage in treatment as a result of an involuntary commitment initiated by others concerned about the client's suicidality, homicidality, or ability to take care of basic needs.

Levels of motivation can be viewed as a "state" on a continuum. Clients can vary from being unmotivated to get help or change, to being highly motivated to change and willing to get help. Clinicians are better equipped to help if they understand how clients think about and experience motivation in relation to changing or managing their disorder. Changes in client motivation, as well as external and internal factors impacting motivation, should be monitored and explored in treatment.

Levels of Motivation to Change

Motivation can waiver at any time during treatment or recovery, particularly in the early phases. For example, I recently asked eighteen residents in a long-term therapeutic community and over twenty clients in early recovery intensive outpatient programs—almost all of who had substance use and psychiatric disorders, and a history of multiple relapses—to rate their current levels of motivation to recover and change their lives and/or to work a recovery program (one=low, five=moderate, ten=high). Most rated their motivation as moderate (four or five) while some rated it low (two or three) and others rated it high (eight to ten). Just about every client acknowledged significant fluctuations in motivation in current or past attempts at recovery, and many stated this was a factor in relapse to their substance use or psychiatric disorder. They often decreased their attendance or dropped out of treatment and mutual support programs when struggling with low motivation. Interestingly, clients stated they knew of coping strategies to help them deal with low motivation, but they often failed to use these. Their negative thinking snowballed and led to reduced interest in doing the work of recovery or working towards their goals. Furthermore, they kept motivational struggles to themselves rather than getting support from a counselor, sponsor or peer in recovery, or other trusted confidante.

Clients also stated that motivation can affect any area of life including health, relationships, work or school, spirituality or religious practices, finances and other lifestyle issues. It is not unusual for a client's motivation to vary across areas of life. For example, one client reported "Recovery is my number one priority and I work hard to stay sober. However, I still struggle with my weight and following a plan to control it. This is harder for me than my sobriety."

Some stated they were more likely to make an impulsive decision not in their best interest when feeling less motivated in recovery. For example, one woman said "When I got laid off, I pouted and put myself into a depression. Rather than look for another job, I gave up and sat at home." Others acknowledged that they used past experiences to motivate them to get their lives together. One man with substantial recovery time—whose addiction once led to losing everything important in his life, including his freedom—said "I learned you don't get what you want or think you deserve from society. You only get what you work for." While keeping his recovery a high priority, he worked his way through school and reached his goal of a career working with troubled youth, which brings him much fulfillment.

Clients also shared examples of how motivation can be negative. One woman said "I wanted to make money so bad that I got involved in illegal activities, not thinking how this could affect my recovery or sense of self-worth, not to mention how this could lead to jail time." Another man with a history of violence said "I'm working hard to get rid of the 'mental demon' that motivated me to get revenge if I was mistreated or disrespected by someone else. It isn't easy, but I'm keeping a lid on any desire for revenge."

Observations

- Motivation is a significant issue for many clients with behavioral health disorders and needs to be addressed during treatment.
- The American Society on Addiction Medicine (ASAM) addresses "readiness to change" as one of the major domains of functioning to assess, which is an important factor in determining level of care needed.
- I reviewed the indexes of the DSM-5 and seven major textbooks on psychiatry and specific disorders. Less than one-third of 1 percent of pages address motivational issues. When they do, it is mainly related to substance use disorders. The mental health field clearly needs to focus more on motivational issues.

Questions to Consider

- Do you think of client motivation as an important domain to consider in clinical work?
- Do you regularly assess your clients' motivational levels to help them identify and address these issues? C

Dennis C. Daley, PhD, *served for fourteen years as the chief of Addiction Medicine Services (AMS) at Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh School of Medicine. Dr. Daley has been with WPIC since 1986 and previously served as director of Family Studies and Social Work. He is currently involved in clinical care, teaching, and research.*

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Do Your Clients Need Cognitive Rehab?

Michael J. Taleff, PhD, CSAC, MAC

It goes without saying that many of our clients come to treatment with obvious or hidden cognitive impairment. They have a difficult time understanding, reasoning, and remembering. Cognitive impairment has been shown to impact the quality of treatment, especially if the impairments are unaddressed. If unaddressed in treatment, the eventual course of recovery will also be affected (Fals-Steward & Lam, 2010), but why?

Consider that most all of therapy is verbally-based. Therapy requires a lot of cognitive processing. For example, clients need to be capable of attending to new information, assimilating that new information, and most importantly translating all that into behavioral change. Where does all that information come from? It comes from all the treatment programs across the country that use cognitive interventions such as lectures, books, worksheets, goal setting, and treatment planning. In addition, clients are exposed to skill-building exercises to offset potential internal and external substance eliciting cues, as well as other relapse triggers. All this cognitive education is directed at clients who need that training to help resolve everyday addiction problems without slipping back into substances (NIDA, 2003).

To take in all of this education and therapy, clients need a complex set of intact executive functions that are undamaged. Clients need to be able to manage sobriety-oriented information, recall and organize that information in their mind, and remember that information when needed. Eventually, this means building a solid behavioral change plan that applies outside of a treatment setting. Again, the very nature of counseling involves receiving, encoding, and assimilating information to help bring about change. If not addressed, cognitive impairment is likely to interfere with necessary learning and lead to poorer treatment outcomes.

In the past, the cognitive impairment was rarely addressed; when a client did not progress, he/she was often blamed for not being motivated, or accused of being in some level of denial. However, with the new research we have, such conclusions need to be rethought.

How Cognitive Impairment Affects Treatment

Fals-Steward and Lam (2010) reviewed a host of literature and found that cognitive impairment has affected:

- Lower treatment adherence
- More frequent rule violations
- Lower likelihood of treatment completion
- A slower achievement of gaining drinking refusal skills
- Lower levels of treatment engagement
- Less of a readiness to change
- Lower self-efficacy
- Decreased insight
- Increased levels of denial of substance use and associated problems.

These cognitively-impaired problems add considerably to the list of issues the addiction counselor already faces.

Assessing Cognitive Impairment

Should all this begin to resonate with you so the possibility of actually doing something about it becomes a reality, then the first question that should come to mind is this: "How do I assess cognitive impairment in the first place?" This is a respectable question and the answer has a multitude of possibilities. A good starting point to set you on your way is the good ol' internet. Simply punch "test questionnaires for cognitive impairment" into a good browser. There is a plethora of instruments out there. The Fals-Steward and Lam (2010) study cited for this column used the Neuropsychology Assessment Battery-Screening Module. Also, you may consider the Ross Information Processing Assessment. Just punch this title into a browser and you will find a number of companies that handled this questionnaire.

Another suggestion is to find a good book on psychological testing and go to the cognitive impairment chapter. Lastly, consider doing a Mental Status Exam. A book like *The Psychiatric Mental Status Examination* (Trzepacz & Baker, 1993) or latter edition is a good place to find instructions on how to conduct a reasonably good cognitive impairment evaluation. Any psychiatric text or psychological testing book would do just as well. With a little investigation you can find what seems to work in your

program. Once you get the assessment down we are ready to turn to the next phase.

Cognitive Rehabilitation

What exactly is cognitive rehabilitation? Essentially it is a process by which clients get exposed to exercises to strengthen problem-solving, attention, memory, and abstract thinking, among other cognitive abilities (Fals-Steward & Lam, 2010). At this time in cognitive rehabilitation skill development, the methods seem to divide into two tracks: use of a set of computer-based programs and a noncomputer-based approach.

As for computer-assisted rehabilitation programs, there seems to be a growing number of available programs out there. The Fals-Steward and Lam (2010) research used a program called the PSS CogReHab from Psychological Software Services, Inc. Another is called CBT4CBT, and information can be found in Kiluk, Nich, Babuscio, and Carrol (2010). There are others around. Some can be a bit expensive, yet with some searching you may well come across something that fits your needs.

In terms of noncomputerized suggestions, here is a list of ideas you could easily adapt into your program (NIDA, 2003). They include:

- Decreasing therapy session length; the cognitively impaired may fatigue easily, or become overwhelmed by long sessions.
- Increasing the frequency of sessions; short, frequent sessions may help with information retention.
- Repeating the presentation of counseling material; this also assists with information retention.
- Using multimodal forms of information presentation. This would include:
  - » The usual verbal interventions, but adding extra touches such as using a selection of synonyms for an impaired brain to understand, varying your tone, and using simple language.
  - » Utilizing visual presentations of recovery elements, such as graphs, photographs, and PowerPoint presentations.
  - » Experiential exercises that include role-playing a variety of recovery-oriented situations, as well as acting out refusal skills.
- Using memory aids such as appointment books, calendars, and mnemonics.
- Utilizing stress management skills to allow for more attention and concentration.
- Using abstract therapy concepts later in treatment, to give the brain a longer chance to recover, and then tackle the abstract elements of therapy.
- Lastly, avoiding challenging therapeutic content early in treatment.

Remember, the point of all this is to get those clients with cognitive impairment to rehabilitate their impairments for a bit, so they can understand treatment concepts and then improve their chances of recovery.

Try It

This column has not suggested a research project you could try for some time. The subject matter of this particular column would be a nice way to reestablish this segment. The suggestion is to do a survey directed at the possible level of cognitive impairment in your client population. The main question to ask is "Does my program have clients who have cognitive impairment?" A subsidiary question might be, if there are clients in my program with cognitive impairment, "What is the percentage of the total population?"

The first thing to do with this survey is to select a good test questionnaire. It should be a pencil and paper test—or if you could find it, a computer-based test—with good psychometrics. That means the test will give you reliable results. Some of the suggestions mentioned above should lead you to a good selection.

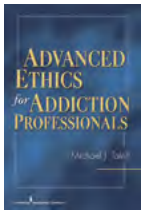
Now with a test instrument in hand, consider that it would not be wise to administer that questionnaire to your entire client population as it stands right now. That might give you a biased result. Why? Because those at the end of the treatment experience are going to have a period of established recovery, and that means that any possible cognitive impairment would have begun to heal. While that is good for the clients, it's not so good for your survey. What you need to do is test all clients who are initially admitted. This way you will get a better reading on how many clients are indeed exhibiting cognitive impairment. Your sample should exceed fifty subjects.

When the new arrivals walk into your program, ask if they would be willing to take a little test. If they say yes, administer the test, obtain the results from that sample, and then calculate the percentage of those who demonstrated some level of cognitive impairment according to the test results.

If you establish that a percentage of initially admitted clients do indeed demonstrate some level of cognitive impairment, the next question is what are you going to do about it?

As always, I remain interested in your results. C

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



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Social Emotional Learning as An Evidence-Based Prevention Practice

Fred J. Dyer, MA, CADC

The public health model of disease and disorders involves assessing the epidemiology of a targeted problem, identifying risk factors associated with the problem, applying interventions known to reduce these risk factors, enhancing protective factors that buffer against the effects of risk, and monitoring the impact of these interventions on the incidence and prevalence of the targeted disease, disorder or problem behaviors (Hawkins, Catalano, & Arthur, 2002).

The public health approach over the years has recognized several adolescent problem behaviors as public health problems with a needed focus on prevention. In a 1994 report, the Institute of Medicine (IOM) proposed a new framework for classifying prevention (Springer & Phillips, 1994). The IOM model divides the continuum of services into three parts: prevention, treatment, and maintenance. The prevention category itself is divided into three classifications: universal, selective, and indicated. Not all adolescents or populations are at the same risk of developing behavioral health problems. Preventive interventions are most effective when they are appropriately matched to their target population's level of risk.

With that as a context, the IOM has defined three broad types of prevention interventions. The first is universal—designed to reach the entire population without regard to individual risk factors—and is intended to reach a very large audience. The second prevention intervention is selective, which targets subgroups of the general population that are determined to be at risk for substance abuse. Recipients of selective prevention strategies are known to have specific risks for substance abuse and are recruited to participate in the prevention effort because of that group's profile. The third intervention is indicated, which identifies individuals who are experiencing early signs of substance abuse and other related problem behaviors associated with substance abuse and targets them with special programs.

The selective prevention intervention is reflective of an approach that is evidence-based, efficacious, culturally competent, gender-responsive, and has been effective in interrupting and preventing adolescent substance abuse, delinquency, and other

corresponding negative behaviors. The approach is social emotional learning (SEL), which was first introduced by the Fetzer Group as a conceptual framework to address both the needs of young people and the fragmentation that typically characterizes the response of schools and communities (Elias, Zins, & Weissberg, 1997). The Fetzer Group further believed that, unlike the many categorical prevention programs that target specific problems, SEL programs can address underlying causes of problem behaviors while supporting prosocial skills, activity development, and academic achievement. Fredericks offers the following as a definition of SEL: "the process of developing fundamental social and emotional competencies in youth" (2003). SEL programming is based on the understanding that the best learning emerges from supportive and challenging relationships, and that many different kinds of factors are caused by the same risk factors. Botvin, Baker, Dusenbury, Botvin, and Diaz (1995), and Scheier, Botvin, Diaz, and Griffin (1999), provide the following benefits of establishing an after-school drug prevention program for middle and high school youth, incorporating the theory, concepts, and skill sets of social emotional. The benefits of such a program are as follows:

- Promotes youth contact and interaction with positive prosocial adults
- Affords student opportunities to further develop, operationalize, and practice social emotional learning skills relating to alcohol and drug prevention. These skills include alcohol and drug prevention skills; life skills and social competencies; health promotion and problem prevention skills; coping skills and social support for transitions and crises, a vital point with regard to youth ages eleven to seventeen who are transitioning developmentally, cognitively, emotionally, and sexually; and positive, contributory services
- Provides youth with safe environments with clear and responsible adult supervision
- Exposes youth to skill development, instruction, and positive prosocial skill development within a safe, encouraging, and reinforcing environment
- Promotes alternatives to delinquent and alcohol and drug behavior attitudes, while incorporating the additional social emotional learning skills of self-awareness, social awareness, self-management and organization, and relationship management through instruction, practice, modeling, recreation, and small group discussions
- Promotes an after-school alcohol and drug prevention program for middle and high school youth that increases academic and social competence with the following skills: study habits and academic support, communication, peer relationships, self-efficacy and assertiveness, drug resistance skills, reinforcement of antidrug attitudes, strengthening of personal commitments against drug abuse, decrease in school expulsions, and increase in school attendance

Elias and Bruene-Butler (1999) offer the following suggestions that addiction counselors can use to build skill sets with youth individually and through group work:

- Begin with an opening, orienting activity.
- Introduce background concepts and definitions.
- Introduce the skill and establish a rationale/motivation to use the skill.
- Describe and model the skill by separating it into concrete behavioral components.
- Establish skill prompts or cues.
- Assign or create practice activities with corrective feedback.
- Give assignments for skill practice to promote transfer and generalization.

Social emotional learning is an evidence-based approach used in conjunction with the indicated prevention intervention as an effective approach for substance abuse counselors, SAP workers, community-based mental health workers, and school personnel. Lastly, SEL is an effective approach for those youth who have challenges with cognitive processing skills. Social emotional learning is an approach worth considering for addictions counselors and youth advocates. C

Fred Dyer, MA, CADC, *is an internationally recognized speaker, trainer, author and consultant who services juvenile justice/detention/residential programs, child welfare/foster care agencies, child and adolescent residential facilities, mental health facilities, and adolescent substance abuse prevention programs in the areas of implementation and utilization of evidence-based, gender-responsive, culturally competent, and developmentally and age appropriate practices.*

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Ask the LifeQuake Doctor

Dr. Toni Galardi

Dear Dr. Toni:

I am a female psychotherapist who specializes in process addictions. Mostly I work with people who are the Adult Children of Alcoholics and Addicts who have codependency issues and love addiction challenges. I myself am the adult child of a process addict whose addiction was gambling. Recently I broke up with a man whom I had been involved with on and off for three years.

Every time we end the relationship, the loss of intimacy takes me right into the toilet. I live alone and work out of my home. I am writing a new book, but have no inspiration for it. I have no idea when you will publish this or if you will, but I thought it was worth writing for other therapists who work solo. How do you find the energy to serve others when your heart is hurting? I find it difficult to get up in the morning. I am not sleeping well.

Do you have any suggestions for moving on joyfully?

–Dazed and Confused

Dear Reader:

It is indeed difficult for someone who is isolated in his or her lifestyle to adjust to the loss of a partner or lover. You don't mention it, but I would encourage you to cultivate female friendships right now. Women have a more difficult time moving on than men do because they require eight times the amount of oxytocin as men to have balanced neurotransmitters. Oxytocin is the bonding hormone that produces a feeling of calm and well-being.

Socializing with other women in the early stages of grief can help. It has been known to stimulate oxytocin for women when they are with women they feel safe and loved by.

Here are some more tips to get you through this difficult time:

Make sure you are feeding your heart and brain. When we lose our love connection, the grief that ensues can cause a loss of appetite or it can increase the desire for chocolate, which mimics the feeling of being in love.

What the brain loves are essential fats like salmon, sardines, and flax oil. The heart loves to be calm, so feeding it lots of leafy greens will alkalinize the body tissue and calm the nervous system. I would avoid artificial stimulants like caffeinated drinks or sugar.

If sleep is an issue, find an acupuncturist or naturopathic doctor who can prescribe herbs or supplements that can help with sleep. Melatonin and tryptophan have been known to help some people.

Supporting your adrenals is so important for getting enough sleep at night so you are not tired or wired during the day. Vitamin C several times a day helps the adrenals. Some people find taking herbs like ashwaghanda and rhodiola help.

Gentle yoga or walks in nature can be very uplifting to the soul and strengthening to the circulation of the body.

Feeding your spirit before you get out of bed in the morning, or perhaps doing some kind of gratitude ritual can help, as well as simply spending time dropping into your body and connecting with your body through your breath.

Going to Al-Anon meetings or Sex and Love Addicts Anonymous for group support is enormously helpful if you are not already doing this.

Either with another therapist or by yourself you may want to look at the patterns that have shown up in all your relationships and do some somatic reprocessing on early childhood bonding patterns. By doing this you can strengthen the part of you that can be a good mother and a good father to yourself—nurturing and yet setting good boundaries with both yourself and others.

Moving on joyfully may take some time. I would suggest in the meantime that you take some time at the end of each day to reflect on what used to give you joy. Keep a journal of joyful moments.

"The Dark Night of the Soul" has been written about by many mystics as a time when the ego has the opportunity to withdraw from the world and journey toward the soul. These dark nights often come at major transition moments and can be the catalyst for great transformation.

Blessings to you.

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.*

THE HIDDEN EPIDEMIC: SUBSTANCE ABUSE IN THE ELDERLY

Sylvia Dobrow, BS, MPH, ABD

There is a secret epidemic that targets those who are alone in their homes, suffering from health problems associated with both age and drug use: the elderly. Today, 13 percent of the total United States population is over sixty-five years of age and 17 percent of this population abuse drugs (Blow, 1998). In 1998, the US Department of Health & Human Services predicted that by 2030, 20 percent of the US population will be over sixty-five and as many as one in four of these older adults will be addicted to drugs.

The aging addict is also very likely to experience one or more lifestyle-associated morbidities. The leading causes of death today are heart disease, cancer, and accidental death. All three are noninfectious lifestyle morbidities, but they are often related to addiction. These potential morbidity and mortality problems have enormous cost implications, both financial and humane. How do we identify these groups of aging addicts?

The Four Subsets of Aging Addicts

Early-Onset Alcoholics

These older adults generally began drinking in their early teens and were often alcohol dependent by twenty-five years of age. A high population of this group is male with a heavy genetic component. This subset has many social and medical problems including impulsiveness and aggressiveness (Dom, Hulstijn, & Sabbe, 2006); two-thirds of all older adult alcoholics fall into this group.

Late-Onset Alcoholics

Late-onset alcoholics usually do not start drinking until their fifties or sixties and some even later. In a 1991 study, Adams and Waskel described this population as the most educated and most affluent of the subsets. While late-onset alcoholism requires genetic predisposition, there appears to be less family history of alcoholism. Late-onset alcoholics may be more receptive to treatment and, because their drinking years are fewer, they have less severe medical complications.

The Baby Boomer Generation

The Baby Boomer's first generation turned sixty-five in 2011. They are expected to have a larger proportion of aging addicts in comparison to previous generations. It appears as though many have carried the substance abuse of their youth into old age. Thus, the Boomers have had a longer lifetime experience with drug use. Colliver, Compton, Gfroerer, and Condon projected drug use among the aging Baby Boomers to peak in 2020 (2006). They conclude there will be a marked increase in drug use in the aging population, particularly in the numbers of marijuana and psychotherapeutic drug users. The Substance Abuse and Mental Health Services Administration (SAMSHA) findings for 2010–11 reaffirm the predictions with an estimated 4.8 million adults aged fifty and over using an illicit drug in the past year, marijuana being the most commonly used substance followed by the nonmedical use of prescription drugs (2011).

Prescription Drug Abusers

The elderly consume one-third of the prescription drugs sold in the United States. Eighty-three percent of this population takes at least one prescription drug per day and 30 percent take eight or more (Inaba & Cohen, 2007). Older adults also purchase three-fourths of all the over-the-counter (OTC) medications. This population is at a high risk for prescription drug dependence because they are more likely to have both medical and psychiatric problems. This population may believe they are following doctor's orders. Poor vision, misunderstanding instructions, and mental confusion account for some drug misuse (Colleran & Jay, 2002), yet there are other older adults who purposely abuse prescription drugs. There is evidence that people with alcohol use disorders are at a high risk to abuse prescription drugs (Culberson & Ziska, 2008). Some older alcoholics transition from alcohol to benzodiazepines because this age group is two to three times more likely to be prescribed benzodiazepines than younger age groups (Benshoff, Harrawood, & Koch, 2003). Combining alcohol with benzodiazepines and/or medications can result in death. One study found forty-one percent of hospital inpatients age sixty-five and over, used both alcohol and benzodiazepines in excess of the recommended level (SAMHSA, 2010).

The sixty-five and over population generally seek treatment from more than one physician with one or more chronic health conditions. The older average adult consults at least two specialists in their medical history lifetime besides their primary care physician. This aids the aging, drug-seeking addict in "physician shopping" for multiple prescriptions.

Physicians are a part of prescription drug dependency in the older adult. Physicians may renew pain prescriptions routinely even when the prescription was intended for short-term relief. For physicians "time is money," and reexamining the patient takes time that a simple phone call to the pharmacist could save. There are also unethical physicians who readily provide pills to the addicted older adult. In 2012, *The Washington Times* reported that the Los Angeles District County Attorney's office charged a doctor with murder in the prescription drug overdose deaths of three patients (Deutsch & Risling, 2012).

With the steadily increasing abuse of all these drugs among the elderly it is surprising that the epidemic is so silent. Bill Urell, author of an article titled *Alcohol Abuse and the Elderly: The Hidden Population*, states that "few wish to talk about a problem for which even fewer seek treatment on their own" (n.d.).

Barriers to Diagnosis

Endogenous Barriers

Bereavement: As adults age, lifetime relationships fall away, spouses die, and best friends relocate perhaps to live with children or to live in retirement communities, many elders are left alone and isolated without love and support. It is within this population of elderly men and women, widows and widowers, and divorcees that alcohol and drug abuse is found. In fact, the fastest growing population of alcoholics is the seventy-five year old widower (Colleran & Jay, 2002).

Retirement: Occupations often provide individuals with their identity. Retirement, even if it is a welcomed occasion and a time to fulfill dreams, travel or pursue hobbies, can mean the loss of a social support system, life structure, financial security, and self-esteem.

Health: As adults age, hearing and sight gradually diminish while pain from chronic diseases increase. Many older adults expect to suffer from ill health, so when the aging addict suffers from any of the leading causes of death it is easier to blame age rather than substance abuse for these ailments. The truth is that addiction doesn't make this process any easier. Alcohol is the most damaging drug of all, as it increases the workload on the heart, elevating the cholesterol and fatty acids level. Alcohol also causes abnormalities of heart rhythms and can cause hypertension and stroke. Cancer of the esophagus is six times greater for alcoholics and thirty-eight times greater for those who both smoke and drink. Cancer of the mouth, stomach, and intestines is highly correlated to heavy alcohol consumption. Hepatitis and cirrhosis of the liver are particularly prevalent with early-onset male alcoholics. Alcohol affects the brain as well as judgment; memory, coordination, and speech are all affected by alcohol. When addicts seek treatment for any of these noninfectious lifestyle-related diseases and are provided a "legitimate" diagnosis by their physicians, denial of their primary disease (i.e. drug abuse) is easier to maintain.

Denial: Denial is known to be part of the disease of addiction for any age, but it is particularly true for the elderly. Those over sixty-five are less likely to be confronted by the consequences of the legal systems as they are less likely to drive or to face the consequences of the workplace. Denial along with the toxic effect of drug abuse on both memory and judgment make the addict the least likely person to recognize and accept his or her condition (Inaba & Cohen, 2007).

Morality: This aging generation may be the last to suffer from the endogenous barrier of "morality" or "sin." Before World War I, today's aging alcoholics' mothers and grandmothers were marching for the "yes" vote on Prohibition. These marching women were often members of The Christian Women's Temperance Union who viewed their crusade as a war against poverty—poverty caused by men who spent their paychecks in bars. These intoxicated men then abused their wives and children. From this historic view, alcoholism was perceived as a character defect of the weak that were

born without enough willpower or moral values to resist "the drink." This is the world in which many aging alcoholics were born. It was not until 1992 that the American Society of Addiction Medicine (ASAM) finally defined alcoholism as a primary chronic disease. It is hard for the aging generation to have this new concept override the moral teachings of their past—a good reason to hide their self-perceived moral failures (Stofle, 1999).

Exogenous Barriers

Underdetection: Alcohol may affect any body system (Gurnack, Atkinson, & Osgood, 2002). The diagnosis of drug abuse in older adults is made more difficult because the effects of drugs often mimic those effects of aging. Because nonaddicted adults over sixty-five also suffer from confusion, falls, and memory loss, physicians may believe this is normal behavior for the older adult (Colleran & Jay, 2002).

Misdiagnosis: Misdiagnosis may also occur when the physician diagnoses and treats the secondary, instead of the primary, disease. Epidemiologists label disease primary and secondary when they coexist in a patient's medical history. For example, gastrointestinal disorders often have alcoholism as their primary disease. When the primary disease is not detected or treated, the secondary condition will escalate in severity or reoccur.

Complicity: Another exogenous barrier to the recognition of substance abuse is complicity in the abuse process. Family members and caregivers often have a difficult time confronting their elder's substance abuse. Relatives, like the addicts themselves, suffer from denial. Others may view the use with disgust but not as the real problem (Benshoff, Harrawood, & Koch, 2003). Many may be ashamed or fear confrontation of an older loved one. Still others believe that their elders "deserve a little pleasure in their old age" and "they should be allowed to enjoy the little time they have left."

Physicians also may have difficulty seeing signs of abuse in patients who have never had a substance abuse problem in the past. Physicians may also be reluctant to question the older addict regarding their addiction. This often occurs if the patient does not fit their stereotype of an aging addict or has been a patient for a long time. This happens more frequently among older adults of higher socioeconomic and educational levels (Benshoff, Harrawood, & Koch, 2003).

Screening

Primary care practitioners, physician assistants, nurse practitioners, and registered nurses have a potentially powerful role in the screening of aging addicts. The prevalence of alcohol use disorders is significantly higher among elderly patients visiting a primary care practitioner than among the general population. Obvious symptoms the primary care staff can observe are disorientation, falls, bruises, memory loss, poor hygiene, and poor nutrition. The drug-abusing elderly patient may complain of anxiety, depression, blackouts, elder abuse, incontinence, an increased tolerance to medication, difficulties in decision making, sleep problems or idiopathic

seizures (Dar, 2006). Elevations of liver enzymes often indicate chronic alcohol abusers.

Psychological screening can be accomplished with the Short Michigan Alcoholism Screening Test Geriatric Version (SMASTG). Tests can be self-administered or completed by a clinician or computer. The benefit of the primary care setting is the older addicted adult patient expects inquiry by the primary care staff and a level of trust has already been established (Naegle, 2008). The Alcohol Related Problems Survey (ARPS) is a sixty-question survey that aims to detect the older adult population who is at risk for, or already experiencing, problems with alcohol or drug use in combination with their comorbidities and medication use (Fink et al., 2002).

Screening should not necessarily be limited to the primary care setting. Clinical specialists and emergency room personnel, as well as members of the helping professions, hospital staff, clergy, and social workers all have opportunities to appropriately screen for substance abuse. Some hospitals already have a substance abuse counselor on staff. Screening does not need to be limited to the medical or psychiatric setting; other areas may include senior housing and adult senior recreation centers. Dom, Hulstijn, and Sabbe (2006) emphasize three important reasons to screen: the incidence of elder substance abuse is high enough to justify screening, the adverse effects of ongoing abuse are significant, and effective treatment options exist which are cost effective and life changing.

Treatment

Regardless of the type of drug abused, preserving an older person's dignity is a primary goal of age-specific treatment (Colleran & Jay, 2002). The older addict's treatment needs are different from the younger addicted population. The older adult in treatment is both cognitively and physically slower. They may need rest periods or more time between sessions. In process groups, this older generation may be reluctant to participate with younger patients and older women may be hesitant to discuss personal issues with men present.

Addiction doesn't discriminate by age.

Neither should recovery.

- Age-specific group treatment that is non-confrontational and aims to build or rebuild the patient's self-esteem.
- Coping with depression, loneliness and loss.
- A focus on rebuilding or establishing a social support network.
- Staff members with experience and genuine interest in working with older adults.
- Expertise in managing co-occurring physical and medical problems.
- A focus on positive aging.
- Re-establishing a sense of purpose and meaning.

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Both dialectic behavior therapy (DBT) and cognitive behavioral therapy (CBT) have been shown to be successful with older adults (Blow, 2003). These therapy methods can teach relationship skills, allowing patients to rebuild social support networks, as well as using self-awareness approaches to overcome grief, loneliness, and depression.

The SAMHSA consensus panel summarizes the needs of an elderly substance abuse treatment program as follows:

- Age-specific treatment that is supportive and nonconfrontational
- Focuses on coping with age-related loss or loneliness
- Emphasis on rebuilding individual social support
- Pace and content that is age appropriate
- Staff members who are experienced and interested in serving the older population
- Linkage with medical and aging services
- Linkage with other medical services and case management (Blow, 1998)

Types of Treatment

Whatever the type of treatment selected, the time spent in treatment is directly related to success in recovery (Colleran & Jay, 2002). The choice of treatment setting is influenced both by the physical and mental condition of the patient as well as the ability of the patient to pay. Insurance coverage varies according to plan. Medicare covers most of the cost for acute detoxification and day treatment in a partial hospital program (PHP)—PHP/day treatment is more affordable as the patient returns home at night. Residential or hospital inpatient care may be the most appropriate for the older adult with comorbid conditions that require medical care.

Selection of treatment type may also be influenced by the aging addict subset. The early-onset alcoholic with a long drinking history and accompanying medical issues may need a longer, more intensive program than the late-onset alcoholic who has a shorter alcoholic history; research has shown they respond better to treatment and have a higher sobriety success rate. Baby Boomers have been reported to negatively relate to other older alcoholic patients who may be judgmental of the Baby Boomers' illicit drug abuse history. One treatment facility has a treatment program specifically for Baby Boomers separate from their program for other older adults. The Boomers could not identify with the seventy-eight-year-olds. As far as prescription drug treatment, Gurnack, Atkinson, and Osgood state, "Until we have more data concerning treatment outcomes, we assume much of the experience with alcohol treatment can be translated to prescription drug users" (2002).

Is treatment worth it? Research has shown the elderly can learn new things and have successful treatment results. In fact, Gurnack et al. concludes that "the aging addict follows treatment regimens more thoroughly and has good, if not better, treatment outcomes than much younger patients" (2002).

Remember, it is never too late to develop an alcohol or drug problem, it is never too late to intervene, and it is never too late to recover. C

Sylvia Dobrow *is a group facilitator for Hemet Valley Recovery Center.*

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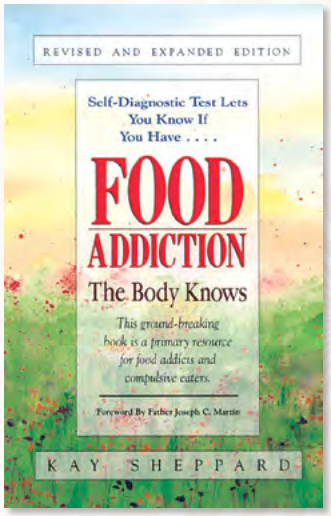

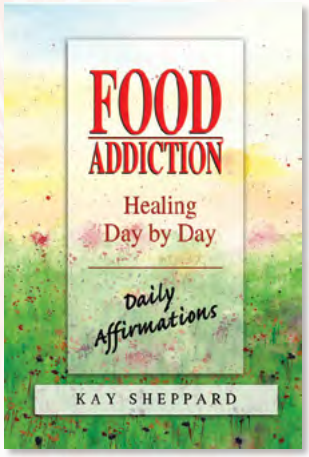

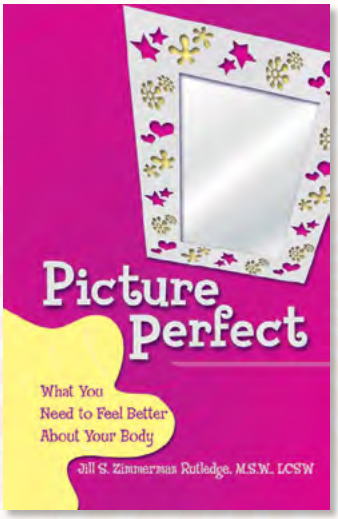

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WHAT'S NEW IN THE DSM-5 FOR SUBSTANCE USE DISORDERS

GERALD SHULMAN, MA, MAC, FACATA

The American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5), was published in May 2013. It has brought about significant changes in the diagnosis of substance use disorders.

Major Changes

One of the major changes affecting all of the diagnoses is the elimination of the Multiaxial Assessment System, or "five axis system," for organizing diagnoses. I recommend that counselors keep the five axis system in their heads as a way of organizing their assessments. I also recommend keeping Axes three, four, and five, not for purposes of diagnoses, but for purposes of informing assessments. For example, chronic pain disorders serve as a trigger for relapse to opioids in persons with such disorders. Chronic pain disorders would previously be coded on Axis III (General Medical Conditions), the stressors listed in Axis IV (Psychosocial and Environmental Problems) can be used as a basis for developing a relapse prevention plan, and information from Axis V (Global Assessment of Functioning) can furnish counselors with a basis for understanding a client's level of functioning, particularly if the assessment is done on the level of current functioning compared to the highest level in the last year. This can provide us with additional information about whether the client's functioning has been improving, deteriorating or remaining stable.

Another major change is the elimination of the "substance dependence" and "substance abuse" diagnoses. Instead, there is a determination of severity. The seven criteria for dependence and the four criteria for abuse have been collapsed into a total of eleven criteria. The criterion for the previous abuse diagnosis of recurrent substance-related legal problems has been eliminated and new criterion of craving the substance has been added, still with a total of eleven criteria. The following show how the determination of severity is made:

- Meeting none or one of the criteria results in no diagnosis.
- Meeting two or three results in a determination of "mild" severity, most comparable to the old abuse diagnosis.
- Meeting four or five of the criteria results in a determination of "moderate" severity, which could be comparable to either the old abuse or dependence criteria.
- Meeting six or more of the criteria results in a determination of "severe," which is comparable to the old dependence criteria.

The elimination of "substance dependence" may have some unintended consequences. One of the indicators for admission into residential or inpatient treatment in the previous and current editions of the *ASAM Criteria* is a diagnosis of substance dependence. In terms of admission criteria for methadone maintenance programs, a requirement is that the person be assessed as "addicted" to an opioid for at least one year. Physiological dependence was a specifier in the DSM-IV, not in the DSM-5. Since there is a difference between addiction—meaning compulsion, loss of control, continued use in spite of adverse consequences, and craving—and a diagnosis of severe opioid use disorder, which is the equivalent of the DSM-IV diagnosis of opioid dependence, how will methadone programs determine what one year of addiction is?

I believe that the change from the DSM-IV in which the categorical diagnoses were replaced with continuums of severity in the DSM-5 is a significant improvement. Before, there were either enough signs and symptoms to meet the diagnosis or there weren't—a client either had the disorder or did not have it. There are individuals who, under the DSM-IV, would not have met a diagnosis because they were "sub-threshold," but who would have a diagnosis under the DSM-5. As an example, say that a counselor has a client who met the dependence criteria of the substance taken in larger amounts or over a longer period of time than intended and a persistent desire or unsuccessful efforts to cut down or control substance

use, both indicators of loss of control. Under the DSM-IV, that client would meet neither a diagnosis of dependence nor of abuse; however, the client would meet a diagnosis of mild substance use disorder under the DSM-5.

An examination of the DSM-5's elimination of the legal problems criterion from the old abuse diagnosis presents a mixed analysis. The reasons supporting the elimination include the fact that people of color, those who are poorly educated, and those of lower socioeconomic status are overrepresented on the criminal justice system. There are geographic inequalities too; for example, recreational use of marijuana is legal in Colorado, but crossing the state line into Utah with one ounce or less opens the person to a misdemeanor charge with the potential of six months incarceration and/or a one thousand dollar fine. In the past, individuals with a single DUI and no other indicators of abuse have been incorrectly diagnosed with abuse. In addition, the criterion of legal problems carries with it little diagnostic weight.

On the other hand, there are concerns about the removal of the legal problems criterion. For some individuals, legal problems may serve a Screening, Brief Intervention, and Referral to Treatment (SBIRT) function of intervening earlier in the progression of a substance use problem. Legal problems often serve as the impetus for treatment. As legal problems are removed, if the individual does not meet at least two other criteria, thereby not generating a substance use diagnosis, what will happen to drug court clients for whom treatment would normally be reimbursed by insurance?

Other substance use disorder changes in the DSM-5 are the change from nicotine disorder to tobacco disorder, the inclusion of caffeine withdrawal for the first time—the DSM-IV had a diagnosis of "caffeine intoxication" but no withdrawal—and the inclusion of cannabis withdrawal. Cannabis withdrawal is particularly important because some of the symptoms can be long-lasting and misinterpreted as willful noncompliance with treatment, which may result in an inappropriate decision by staff to terminate treatment administratively.

An interesting factoid is that cocaine use disorder appears nowhere in the index under "cocaine" and it doesn't appear in the index in the list of different substance use disorders. However, it does appear in the body of the DSM in a section titled "Stimulant-Related Disorders."

Terms and Specifiers

The term "addiction" is used for the first time in the history of the DSM in the section titled "Substance-Related and Addictive Disorders" and refers to gambling. The diagnosis of "pathological gambling" in the DSM-IV—commonly referred to as "compulsive gambling" and listed as an impulse control disorder—is now moved to the Substance-Related and Addictive Disorders section and is named "gambling disorder." It might be useful for counselors to view the diagnostic criteria for gambling disorder and see how closely they mirror the criteria for substance use disorders.

The specifier for "with physiological dependence" has been eliminated, as well as the one for "polysubstance dependence." The specifier of "sustained partial remission"—meaning the full criteria for dependence has not been met for twelve months or longer, but one or more of the criteria for dependence or abuse has been met—has been replaced with "in early remission," meaning that no criteria was met for at least three months but less than twelve months with the exception of craving. "Sustained partial remission" and "early sustained remission" have been eliminated completely.

Under the DSM-IV, a client could be in "early partial remission," which refers to not meeting full criteria for at least one month but less than twelve months, but the individual could meet one or more of the abuse or dependence criteria. Many counselors had great difficulty with the suggestion that

a client could still be using and yet be in remission. "Sustained full remission"—meaning no criteria met at any time during a period of twelve months or longer—has been replaced with "sustained remission", which means that no criteria was met at any time during a period of twelve months or longer with the exception of craving. The specifier "on agonist therapy" has been eliminated but "in a controlled environment" remains.

Weight

I previously mentioned the concept of weight in determining diagnostic criteria. Think of criterion weight as the influence or impact of that specific criterion in determining the diagnosis. The assumption in both the DSM-IV and DSM-5 is that all of the criteria carry equal weight, resulting in diagnoses being made by simply adding up the number of criteria met.

In point of fact, this is not so. Criteria most likely to be associated with the severe categories of a substance use disorder include: wanting to cut down or control use but being unable to do so; withdrawal; failure to fulfill major role obligations; important social, occupational, or recreational activities are given up or reduced because of the substance use; and compulsion, when the substance is taken in larger amounts or over a longer period of time than was intended. These are referred to as the "Big Five" and this is the pattern that most addiction counselors associate with addiction.

On the other hand, tolerance and dangerous use are actually in common among those with no diagnosis. This makes sense when you realize that tolerance is a function of practice. For example, if "social drinkers" stop drinking for a period of time and then resume drinking at the same level, they will find that they get a greater effect from the same amount of alcohol as they used before they stopped. An individual may drive impaired, whether or not he or she is arrested, because of foolishness (e.g., a father drinking too much to celebrate his daughters wedding). This is the pattern that counselors are more likely to associate with abuse because there is no loss of control.

Implications

It appears that those in the mild designation and who meet none of the Big Five may be able to benefit from harm reduction or moderation management strategies. Think of the DUI offender who does not meet any of the criteria for a substance use disorder; in the DSM-IV, he or she might have met only the legal criteria. Alternatively, those in the severe designation who meet at least of three of the "Big Five" might need more intensive and/or extended treatment services and have a greater potential for relapse.

For me, this model helps to resolve a conundrum. The terms "alcoholism" and "alcoholic" are very important and have significant implications, as when an AA member stands up at a meeting and says, "My name is John and I am an alcoholic." However, the terms are neither diagnostic nor precise. We have all occasionally observed people who were labeled "alcoholic" and who appeared to return to nonproblem drinking, which creates cognitive dissonance because of the belief that alcoholism is an insidious, progressive, incurable, and fatal disease. Is it possible that awareness of criteria weight could resolve the dissonance? An added benefit may be the resolution of the ongoing conflict that exists between those clinicians who subscribe to the harm reduction or moderation management models, and those who believe in the disease and abstinence model.

The main conclusion is that the changes in the DSM-5 relative to substance use disorders more likely reflect the reality of clients who present with substance use disorders and the issue of criterion weight may resolve some lingering dilemmas.

Dedication: *I would like to dedicate this article to the memory of David Powell, PhD, who was a major force in the field with his most significant contributions being in the area of clinical supervision, and who was my colleague and dear friend for thirty-five years. I hope I can do you proud, David.*

Gerald Shulman, MA, MAC, FACATA, *the president of Shulman & Associates Training & Consulting in Behavioral Health for the last twenty years, is a licensed clinical psychologist and Fellow of the American College of Addiction Treatment Administrators. He has been providing treatment, clinically or administratively supervising, and managing the delivery of care to alcoholics and drug addicts full-time since 1962.*

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CANNABIS CONCERNS, PART II

MENTAL HEALTH TREATMENT & CO-OCCURING CANNABIS USE DISORDERS

JERROLD POLLAK, PHD

Individuals who have one or more mental health conditions and coexisting substance use disorders (SUDs)—known as "dual-diagnosis" clients—are increasingly common in contemporary clinical practices (Drake, Mueser, Brunette, & McHugo, 2004). According to the National Alliance on Mental Illness (NAMI), over a one year period nearly 15 percent of persons with a mental health diagnosis have at least one associated SUD (2012). Estimates of co-occurring SUDs are as high as 60 percent among clients with major mental illnesses (Minkoff, 2013).

Cannabis use disorders (CUDs) are among the most frequent co-occurring SUDs seen in mental health care. They are often underdiagnosed and, when identified, their pervasiveness and severity are frequently underestimated by counselors and other mental health clinicians. When clinicians "don't ask," many clients are disinclined to "tell," and do not acknowledge use. When formal inquiries are made, clients will often deny or minimize the extent of their consumption.

Reasons for incomplete and/or inaccurate reporting for cannabis use include:

- Fear of pressure from mental health clinicians and other health care professionals to reduce or curtail use
- Peer pressure to maintain use
- Fear of possible legal and social consequences, especially if engaged in diversion or sale
- Feelings of shame and fear of criticism and/or rejection
- Maladaptive beliefs regarding use, such as cannabis is not a drug, it is a harmless drug, it is necessary to cope with mental health and other problems, or peer group acceptance is predicted on continued use
- Consumption is simpatico with the person's lifestyle, outlook, and values
- Lack of insight into extent and pervasiveness of use
- Limited knowledge of concerning psychosocial, biomedical, and neuropsychiatric effects associated with consumption

Cannabis use continues to rise among adolescents and young adults and cannabis is now the most commonly used illicit substance in the United States (National Institute on Drug Abuse, 2012). In recent years, the success of movements to decriminalize and legalize this drug for medicinal and recreational purposes has made cannabis more socially acceptable and appears to have strengthened beliefs that it is a safe substance even for long-term and heavy users (Fawcett, 2013). In a recent survey, psychiatrists reported considerable concern about the burgeoning of adverse neuropsychiatric effects as a consequence of the prescribing of cannabis (Kweskin, 2013).

Enabling Factors

Mental health clinicians can enable consumption for some of the same reasons cited above including inadequate knowledge of the research base related to harmful effects. In addition, enabling can reflect a clinician's lack of confidence and feelings of inadequacy, which stem from a lack of requisite knowledge and/or skills to appropriately evaluate and treat dual-diagnosis clients. Moreover, feelings of helplessness are easily evoked by the limited access, nationwide, to timely evaluation and treatment services for SUDs in general and CUDs in particular due to the absence of an integrated system of medical, mental health, and substance abuse

care (Patel, 2013; Sharfstein, 2011). Together with frequent resistance to substance abuse treatment, this systemic problem can lead to clinician pessimism about the value of actively engaging clients in discussion about their use of cannabis.

Looking the other way regarding cannabis use and colluding with client denial, minimization, and rationalizations including the commonplace "I'm not using hard drugs, so leave me alone," is inevitably "a deal with the devil" as it often results in poor compliance, treatment impasse, and other undesirable outcomes. This collusive "hear no evil; see no evil" stance on the part of clients and clinicians may only be shattered when a crisis ensues in the treatment directly linked to use: Arrest for possession or sale, problems attaining or sustaining employment, disrupted schooling, a clear worsening of baseline neuropsychiatric symptoms, and/or the development of new onset neuropsychiatric difficulties.

In addition to undermining the treatment relationship, enabling has another consequence that is specific to the professional situation of the clinician: notably increasing the risk of a complaint to a supervisor, mental health licensing board, and/or the filing of a malpractice suit based on "negligent" diagnosis and treatment (Shapiro & Smith, 2011). This will be further illustrated in the first vignette provided towards the end of the article.

Negative Effects of Cannabis

There is an expanding research base attesting to the negative effects of cannabis. This includes links to a number of adverse psychosocial, biomedical, and neuropsychiatric consequences (Bashford, 2012; Budney, Hughes, Moore, & Vandrey, 2004; Fergusson & Boden, 2008; Fiorentini et al., 2011; Hides, Dawe, Kavanagh, & Young, 2006; Khan & Akella, 2009; Large, Sharma, Compton, Slade, & Nielssen, 2011; Lynch, Rabin, & George, 2012; Meier et al., 2012). Some of these consequences are:

- Elevated risk for a recurrent withdrawal syndrome characterized by irritability, anger, anxiety, restlessness, and sleep disturbance
- Enhanced risk for acute and chronic anxiety/panic and depression
- Transient confusional state/delirium
- Time-limited manic symptoms
- Impaired executive functioning including the development of a syndrome of apathy/amotivation as well as poor judgment and decision making
- A potentially irreversible decline in cognitive/intellectual functioning especially among adolescent-onset users
- Psychotic spectrum symptoms such as dialing back the age of onset of a first episode of psychosis; triggering episodes of recurrent psychosis which persist following acute periods of intoxication; provoking a persistent/stable course of psychotic spectrum illness; episodic exacerbation of established psychotic spectrum illness; contributing to poorer outcome in recurrent and persistent psychotic spectrum illness; and elevating risk for recurrence (relapse) of remitted or partially remitted psychotic symptoms

The recently published DSM-5 reviews a number of these negative consequences (American Psychiatric Association, 2013).

There is a 40 percent increased risk of psychotic symptoms in cannabis users when compared to nonusers (Lynch, Rabin, & George, 2012). Recurrent psychotic symptoms, notably auditory hallucinations and paranoid thinking, are reported by as many as 15 percent of cannabis users (Arseneault, Cannon, Witton, & Murray, 2004). This reaction may constitute a marker for an eventual diagnosis of a schizophrenic spectrum disorder (Arendt, Mortensen, Rosenberg, Pederson, & Waltoft, 2008). Moreover, about 50 percent of individuals with a first episode of psychosis have a history of significant cannabis use and about one third are current utilizers at the time of the initial psychotic break (Wisdom, Manuel, & Drake, 2011).

Onset of use in early adolescence—early initiation as well as frequent and sustained consumption

through the adolescent and young adult years—are significant risk factors for concerning psychosocial and neuropsychiatric outcomes, especially those pertaining to psychosis (Fiorentini et al., 2011). Frequent use increases the risk of psychotic symptoms by 50 to 200 percent compared to persons who do not consume cannabis (Lynch, Rabin, & George, 2012). Cannabis with higher concentrations of delta-9-tetrahydrocanniabinol (THC), the main psychoactive ingredient, appears to confer additional susceptibility to adverse events and outcomes when combined with familial, genetic, and other neurobiological and neuropsychiatric vulnerabilities (Di Forti et al., 2012; Le Bec, Fatséas, Denis, Lavie, & Auriacombe, 2009).

Implications for Clinical Practice and Risk Management

An initial mental health evaluation should include a set of standardized inquiries about past, recent, and current substance use to include cannabis. When clinical suspicion is high for cannabis use, these questions should preferably be supplemented by administration of one or more self-report screening tests targeting CUDs. These inventories can be helpful in quantifying the extent and severity of use (Bashford, 2010).

Based on the findings of a screening level assessment, referral may be indicated for a more in-depth evaluation by a licensed alcohol and drug counselor or to a formal outpatient or residential substance abuse treatment program, if the counselor or other mental health clinician working with the client is not in a position to provide these services. In some instances, initiation of mental health services may need to be postponed or ongoing treatment interrupted until appropriate evaluation and intervention is completed for the CUD.

Informed consent forms should include the clear expectation that the client will cooperate with inquiries and monitoring pertaining to cannabis and other substance use over the course of his or her mental health care.

Psychoeducational material should be considered for clients and their families which address signs and symptoms of concerning use and the negative effects of cannabis on mental health problems and their treatment.

Referral for psychological and neuropsychological testing, for clarification of diagnosis and to enhance treatment planning, can be useful for many dual-diagnosis clients, especially those with co-occurring CUDs. Psychometric testing can help to identify predisposing neurodevelopmental and personality/psychodynamic factors as well as any residual neurocognitive and executive functioning problems that result from use. However, testing is contraindicated for clients with active CUDs and other SUDs. Referral should be deferred until there has been a documented period of sustained abstinence of at least three months (Pollak, 2011). For an illustration of this, see the second vignette.

Vignette #1

C. F. was a nineteen-year-old young man living with his parents. He carried a presumptive diagnosis of bipolar II disorder.

C. F. had recently entered outpatient services at a community mental health center. He was being seen weekly for counseling and psychotherapy by a psychologist and monthly to bimonthly by a psychiatrist for medication management.

C. F. acknowledged occasional cannabis use. This was not thought to be of immediate concern to his treating clinicians with respect to his ongoing mental health care. C. F. had not been formally assessed for the possibility of more significant substance misuse.

Several weeks into services, C. F.'s mother called the psychologist stating that the previous weekend, her son had been on a "drug binge," which involved continuous use of cannabis and suspicion of more widespread drug use. In addition, the police had been to the home after some young adults had come to the house threatening her son's life apparently due to a dispute over a drug sale.

The psychologist stated that he would take mother's report under advisement as he continued to meet with C. F. The mother then asked what this clinician was planning to do about treatment for her son's cannabis and other substance use problems. The psychologist explained that the agency did not provide substance abuse services and that, in any event, his primary responsibility was to continue her son's counseling and psychotherapy.

In response, C. F.'s mother stated that as the primary clinician for her son, the psychologist had the responsibility to assess his substance use problems in a more comprehensive and thorough manner and either begin substance abuse treatment or initiate a referral for such services. She threatened to file a complaint with the agency against the psychologist for what was, in effect, negligent diagnosis and treatment regarding her son's mental health care.

Vignette #2

D. B. was a seventeen-year-old eleventh grade student from a divorced family who resided with his mother. For the past year, he was being seen in private practice by a clinical social worker for counseling and psychotherapy, and by a child and adolescent psychiatrist for medication management.

D. B. had a history of erratic scholastic achievement beginning around the fourth grade. His grades had declined since middle school and he appeared increasingly disengaged and disinterested in improving his academic standing.

The working diagnosis on the part of the two treating clinicians was a depressive disorder not otherwise specified. There were rule outs of an attention deficit disorder, predominately inattentive type, and/or one or more learning disorders as contributory to D. B.'s academic underachievement.

The psychiatrist had recently added Focalin, a stimulant for presumptive attention deficit disorder, to an antidepressant that D. B. had been taking for a number of months.

The clinical social worker referred D. B. for psychological and neuropsychological testing to further clarify his psychoeducational status, including whether D. B. might have an attention deficit disorder and/or one or more learning disorders. As part of the referral, this clinician did not report any concerns about possible substance misuse.

D. B. was interviewed by the consulting psychologist regarding substance use and administered self-report screening tests for alcohol and drug use. He screened positive for extensive use of cannabis. In the interview, D. B. acknowledged daily cannabis use since eighth grade with virtually no uninterrupted periods of abstinence. This young man said that he last used cannabis the night before the evaluation with the psychologist and had been using cannabis daily—often several times a day—over the past few weeks.

D. B. was assessed as having a CUD that was likely undermining the efficacy of his mental health care and also significantly contributing to his poor motivation and disinterest in academic achievement.

Psychometric test performance can be adversely affected by ongoing substance use including the use of cannabis (Meier et al., 2012). Therefore, the decision was made with D. B. and his mother to defer testing until he had been reliably abstinent from use of cannabis for at least three months, hopefully, as a consequence of timely entrance into substance abuse treatment.

The finding of a significant CUD in his case was greeted with dismay and surprise by D. B.'s mother and his mental health care providers.

Implications for Education, Training, and Research

Substance abuse evaluation and treatment should be a core competency taught in all counselor and other practitioner-based mental health graduate programs. At a minimum, this should include the development of skills in assessment screening and triage of dual-diagnosis clients.

Graduate school faculty, as well as state and national mental health professional organizations, need to strenuously advocate for the integration of mental health and substance abuse services within primary care and other health care settings.

Licensing examinations for mental health practices should include substantial coverage pertaining to the evaluation and treatment of CUDs and other high-frequency substance use disorders.

Data is needed regarding clinician knowledge of the evolving research base, pertaining specifically to the adverse consequences of cannabis use. There is also a paucity of information about the extent and effectiveness of formal screening for CUDs in community mental health, primary care, and private practice settings. In addition, little is known about institutional and clinical responses to this problem, once identified. More specifics are also needed about the impact of CUDs on compliance and other factors related to mental health treatment outcome.

Jerrold Pollak, PhD, *is a clinical and neuropsychologist for the program in Medical and Forsensic Neuropsychology at Seacoast Mental Health Center in Portsmouth, New Hampshire. He is also is a member of the Emergency Services Department at Seacoast.*

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ADDICTION TREATMENT AND CANCER TREATMENT: PERSONAL REFLECTIONS OF A LONG-TENURED ADDICTION PROFESSIONAL

William L. White, MA

More than a decade ago, Thomas McLellan and colleagues (2000) published a seminal article in the *Journal of the American Medical Association* comparing addiction to such chronic primary health disorders as cancer, diabetes, and hypertension. In their analysis of these conditions, they noted a similar mix of risk factors, recurrence patterns, and problems of patient adherence to recommended treatments and related lifestyle changes. The article defined addiction as a chronic health problem whose effective management should parallel proven approaches to other chronic medical disorders. The article, because of the prominence of the authors and the journal in which it was published, marked something of a "tipping point" in calls to extend addiction treatment from models of ever-briefer acute biopsychosocial stabilization to models that offered the option of sustained recovery management for those with the most severe, complex, and enduring substance use disorders.

In the years since the McLellan et al. publication, considerable progress has been made in conceptualizing this shift and defining how clinical practices would change within various approaches to recovery management. I have been deeply involved in this movement, particularly in marshaling the scientific evidence to guide this redesign process (White, 2008b; Kelly & White, 2011), but in recent years, personal encounters with cancer have afforded me an unexpected source of new insights into the following question: How would we treat addiction if we *really* believed it was a chronic disorder? This article draws from these personal experiences to compare the treatment of cancer and the treatment of addiction.

I have long feared that cancer was stalking me. Cancer ran in my family history, with two of my immediate family members and many extended family members experiencing cancer before my own diagnosis. I was also a very heavy smoker for more than two decades before quitting in 1988, and I feared I might not have escaped its long-term consequences. In the early 1990s, I was diagnosed with a blood disorder that has been continuously monitored due to the risk that it could morph into leukemia. In, 2010, a CT scan revealed a tumor on my right kidney that, due to its location and growth pattern, was suspected of being cancer by greater than 90 percent odds, but turned out to be benign when surgically removed. In 2012, I was diagnosed and treated for prostate cancer. These experiences have afforded a platform of personal experience about cancer treatment that I wish to contrast with prevailing addiction treatment practices.

Personal encounters with cancer have afforded me an unexpected source of new insights into the following question: How would we treat addiction if we *really* believed it was a chronic disorder?

Early Communication of Risk Factors

When the prostate specific antigen (PSA) scores in my routine annual physical doubled within one year, I was sent to a urologist who retested my blood only to find that the PSA score had risen considerably in a month's time. Even before I met the urologist, I filled out forms in his office that elicited four areas of information: my family history of cancer, which was extensive and included my father's death from prostate cancer; my history of exposure to alcohol, tobacco, and other drugs (also extensive); my exposure to environmental toxins, which was higher than normal because of my work as a young man in the construction trades; and co-occurring conditions that could influence future cancer treatment options—in my case, several conditions of potential concern. Several things happened as I filled out forms in the waiting room. First, my fear that I was at elevated risk for cancer was confirmed. Second, I knew a combination of family history, personal lifestyle, and environmental circumstances constituted the sources of that risk. Third, I knew that I had co-occurring medical conditions that would be factors in determining any needed treatment choices and my long-term treatment prognosis. Those conclusions were reinforced by the assessment forms, educational materials in the waiting room, and by my own Internet searches on prostate cancer. In short, I was psychologically prepared to enter this world of cancer treatment even before my cancer diagnosis was confirmed.

That state of readiness made me wonder: Are those sitting in the waiting rooms of addiction treatment programs similarly prepared?

Presentation of the Diagnosis and Stage Information

My diagnosis of cancer unfolded in series of five communications:

1. The latest elevation in your PSA calls for a biopsy.

2. Your biopsy reveals the presence of cancer in two of twelve samples.

3. Your Gleason Scores for the positive cancer samples are six and seven, out of ten, indicating a pattern of more aggressive growth.

4. You will need various scans to determine whether the cancer has spread outside the prostate.

5. You have prostate cancer that appears to be contained within the prostate and that is at an early to intermediate stage of development that will require treatment as soon as it can be conveniently scheduled.

What was striking about this was that each step involved objective data that could be compared to norms of men with and without prostate cancer and each step was accompanied by a teaching intervention. In short, I knew exactly the data the diagnosis was based upon and was taught to understand the meaning of each piece of information. Rather than having a diagnosis thrust upon me, I was invited as a full participant into the diagnostic process. This raised for me the question of how frequently or infrequently the presentation of such objective data, companion teaching interventions, and full participation in the diagnostic process occurs in addiction treatment. I suspect that much of what is characterized as "denial" and "resistance" in addiction treatment flows from the omission of the steps I experienced in my cancer treatment.

Education on Treatment Options

At the time my cancer diagnosis was made, the specialist informed me that the next step was to educate myself on the treatment options—there was no attempt to induct me into a particular form of treatment. Instead, my urologist provided me with information that outlined multiple treatment options with the risks and benefits of each objectively outlined. He reviewed these options with me and said that I would have to decide which would be best for me. When pushed by me for his recommendation, he recommended a particular type of surgery, explained why he recommended that treatment choice, but also insisted that I talk to other specialists about alternative treatment options, which his office helped to arrange.

I cannot recall a similar process in my four decades of professional involvement in addiction treatment. It would be rare indeed in addiction treatment to ask a person seeking help to interview people offering different levels of care and different modalities before making a decision about the treatment he or she thought would be best.

Open Acknowledgement of Professional Bias/Second and Third Opinions

In discussing treatment options with the urologist, he explained what his role would be if I chose various surgical options and if I chose various radiation therapies, but he was very clear in stating his bias towards surgery in my particular case and insisted because of that bias that I see others who specialized in nonsurgical alternatives. When I chose to compare reports and recommendations from the surgical and radiation specialists with the oncologist who had been monitoring my blood disorder for the past seven years, the urologist was delighted that I had this independent consultant who would not be directly involved in delivering any treatment that I chose. That attitude of acceptance of second and third opinions on treatment options, and linkage for such objective consultation, are quite rare in the world of addiction treatment as I have observed it.

Objective Comparison of Recurrence and Survival Rates

There is a precision and candidness in discussing cancer treatments that I found quite refreshing. Probabilities were given for the outcomes of no treatment and the respective treatment choices available to me in exact percentages, such as five-year rates of cancer recurrence and five- and ten-year survival rates. Not only was I made aware of such rates for each treatment I was considering, but I was also given rates matched to my particular circumstances which, in comparison to the general rates, quickly eliminated some treatment

options and made my best choices clearer. This was a type of "treatment matching" I had not encountered in the addictions field. For example, what data is provided to persons seeking treatment for opioid addiction to help guide their decision of multiple treatment options? In my tenure working in addiction treatment, I have never seen such comparative information routinely provided to persons/families seeking assistance. Why are such rates not available and provided for various addiction treatment options?

Candid Communication of Iatrogenic Risks

All of the providers—surgeons, radiologists, general oncologists—involved in my cancer treatment reviewed the potentially harmful effects of each treatment option I was considering. These spanned potential adverse effects during surgery (e.g., stroke, heart failure), risks resulting from hospitalization (e.g., blood clots, infection) and more prolonged postsurgical risks (e.g., incontinence, impotence). What was more remarkable was that they communicated the exact numerical probabilities of each of these risks and outlined the specific procedures that would be used to reduce these risks.

There is a long tradition of iatrogenic (i.e., harm in the name of help) effects within the history of addiction treatment (White, 1998; White & Kleber, 2008), but patients entering addiction treatment are not routinely apprised of such risks nor of their frequency of occurrence, even though some data related to such risks are available in the scientific literature (Ilgen & Moos, 2005; Moos, 2005).

Access to Experiential Knowledge

The sometimes clinical precision of information about the course of cancer, treatment options, and the outcomes of various cancer treatments was balanced by access to a very different type of knowledge—the experiential knowledge of patients in various stages of recovery who had experienced the exact treatment options I was considering. This was made available through face-to-face and Internet-based patient support groups and innumerable Web sites at which questions could be posed and answered by the broad experience of patients—both locally and from across the world. Imagine what it would mean to individuals and families considering addiction treatment to have access to that kind of experiential knowledge before, during, and after the treatment process.

Patient Choice, Partnership, and Family Involvement

Cancer is such a terrifying diagnosis that one might well imagine the value of a medical superhero riding in on a white horse to take control and save the day, but cancer treatment is often quite different than that image. I had a specialist who insisted that the choice of treatments was mine, not his, and that his role was to educate me about those choices and to execute as best he could the decisions that I made. In fact, after reviewing all of my choices, I had to practically pry out of him what he thought would be the best choice for me. It was clear that what we were entering into was an extended partnership rather than my being the passive recipient of his knowledge and expertise.

One fears the "If you only have a hammer, everything looks like a nail" phenomenon when facing such a life-threatening crisis—the fear that all surgeons want to cut, all radiologists want to radiate, etc.—but I had the novel experience of a surgeon talking positively about radiology treatment and a radiologist affirming that I was a good surgery candidate. What was most striking was that each specialist I saw treated me as an intelligent person who was capable of evaluating choices and making a good decision. Also striking was their comfort in including my wife in every step of the decision-making process. They listened to both of us and responded fully to all of our concerns. For example, I did not want my treatment to interfere with the forthcoming "robing ceremony" related to my daughter's PhD completion. Information was provided on risks related to the timing of treatment initiation, and treatment was scheduled to begin right after this important event in my life. I suspect few addiction treatment programs would have been so accommodating (White, 2008a).

Education on Treatment Procedures

Once a decision had been made on the type of cancer treatment that would be best for me, the urologist provided my wife and I further information on the procedure, including a DVD illustrating exactly how the procedure would be performed. He again went over the risks and side effects, as well as their prevalence both nationally, in his practice, and at the local hospital where my surgery would be conducted. Again, I understood why this procedure was one of the best choices for me, how it was to be done, the sequence of my care, and what I could realistically expect as an outcome. It isn't that in addiction treatment we don't

do that kind of patient education; we do. It is that the depth of patient education in the cancer arena far exceeds anything I have ever witnessed in the addiction treatment field.

Treatment Duration

I am sure there were arbitrary insurance-influenced limits on the length of my hospitalization following surgery, but the timing of my discharge was linked to very clear clinical benchmarks. These benchmarks included both factors that were not present—fever and other signs of infections—and measurable makers of postsurgical recovery, such as kidney functioning, reductions in pain, and mobility. In other words, my treatment was shaped by my personal response to treatment and not by an artificial length of stay. That made me wonder how that clinical benchmarking process could be more widely applied to the treatment of addiction.

Plan for Long-Term Monitoring

My diagnosis of cancer was accompanied by two communications consistently reinforced over the course of my treatment:

1. There is a risk of cancer recurrence even under the best of circumstances (i.e., risk of recurrence even with 100 percent compliance with all treatment protocol and follow-up recommendations for preventive care).
2. The morbidity and mortality associated with cancer recurrence can be significantly lowered by sustained monitoring of at least five years, and, if and when needed, early reintervention.

Part of the partnership involved not just getting through acute treatment, but participating in scheduled checkups, identifying at the earliest possible time any return of cancer and, in the face of any recurrence, assertively reintervening with renewed and potentially different treatment. So I voluntarily entered and committed myself to a partnership that I knew at a minimum would last five years and probably all of my life. That did not mean that I would be undergoing active treatment forever, but it did mean that the most important risk predictors would be monitored on a set and sustained schedule. Like many cancer patients, I also received information that if I achieved five years of sustained remission, the risk of future recurrence would significantly decline after that critical milestone.

At the time I was given this information, I had been researching an interesting question: When is present recovery from addiction predictive of lifetime recovery? What I had found consistently in my review of long-term treatment outcomes studies (White, 2008b) was that the stability point of addiction recovery—the point at which risk of future relapse in one's life dropped below 15 percent—was on average four to five years of sustained remission; precisely the range I was being given for stability of my long-term recovery from cancer. In the world of cancer treatment, patients are assertively monitored for the five years following treatment, but patients in addiction treatment receive no such sustained system of monitoring, support, and early reintervention. Why?

Absence of Contempt or Condescension

One could easily build a case that prostate cancer was for me simply a bad roll of the genetic dice, but when one looks at the larger risks of cancer in my lifetime there are clear areas of potential culpability. I was aware of my family history and yet chose heavy involvement in nicotine, alcohol, and other drug use. My overall health management (e.g., diet, exercise, stress, etc.) was not one that could be expected to lower my cancer risks, and yet my cancer treatment unfolded within service relationships completely free from judgment, contempt or condescension. In addition, I did not face any threats of punishment for the sin of noncompliance with treatment protocol. In short, I was treated like a patient who could fully and responsibly participate in my own treatment. I was not treated like a morally culpable criminal or recalcitrant child who needed to

be aggressively controlled by my moral superiors—attitudes that too often still permeate the milieus of addiction treatment.

Implications

If we really believed addiction was a chronic disorder on par with cancer and other chronic primary health disorders, we would provide every person seeking assistance:

- Clear and consistent communications regarding the intrapersonal, interpersonal, and environmental factors that contribute to the development of a substance use disorder (SUD)
- An assessment process that is comprehensive, transparent, and continual
- Objective data upon which a SUD diagnosis is based, with normative data for comparison to the general population and to other patients being treated for SUDs
- Objective information on the severity (stage) of the SUD
- Objective information on treatment options matched to the type and severity of the SUD
- A declaration of potential professional/institutional biases related to diagnosis and treatment recommendations
- A menu of treatment options before making a final decision on the course of treatment
- Access to the experiential knowledge of former patients who have experienced a variety of SUD treatments and who represent diverse pathways and styles of long-term recovery management
- Personalized refinements in treatment-based assessment data and individual responses to initial treatment
- At least five years of monitoring and support following completion of primary treatment
- Assertive reintervention and recovery restabilization in response to any signs of clinical deterioration
- A long-term, person- and family-centered recovery support relationship based on mutual respect, and free of contempt or condescension

It really is that simple. If we believe that addiction in its most severe forms is a chronic disorder, then let's treat it like we really believe it. C

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 four hundred 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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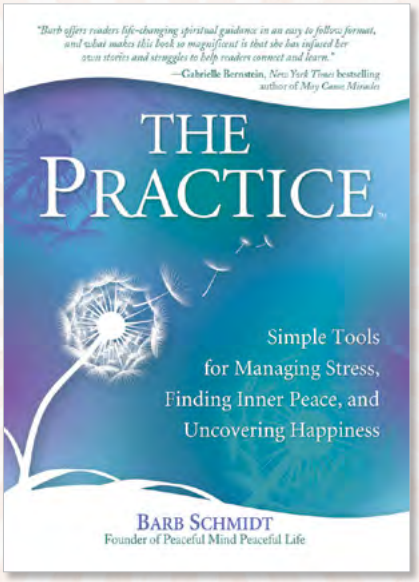

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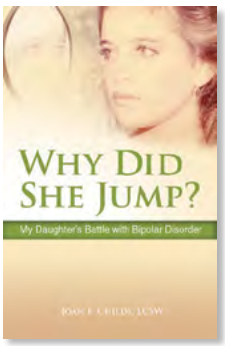

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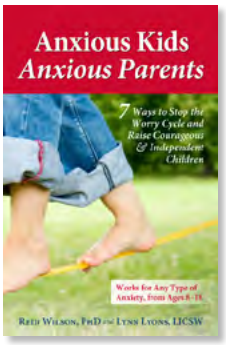

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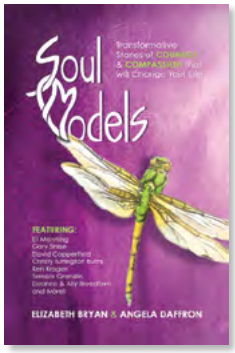

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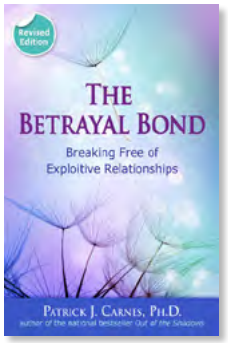

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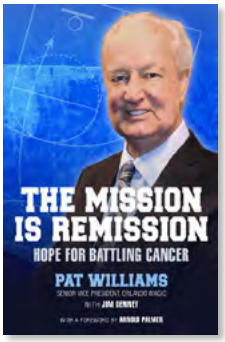

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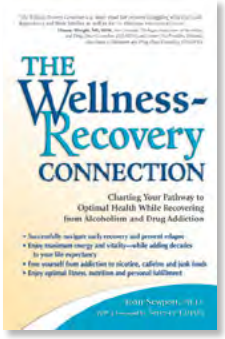

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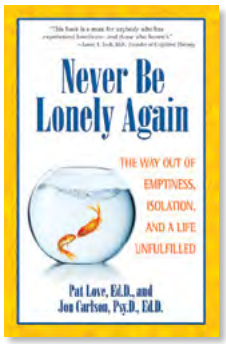

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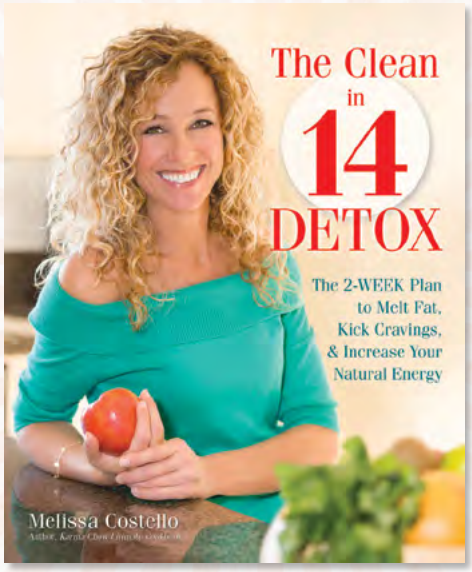

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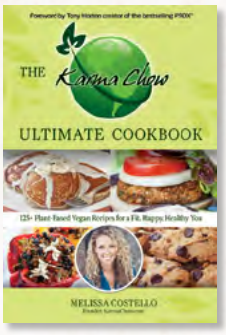

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UNDERSTANDING TWELVE STEP INVOLVEMENT from a Research Perspective

John M. Majer, PhD, Leonard A. Jason, PhD, & Joe Ferrari, PhD

THERE HAS BEEN INCREASED INTEREST AMONG SOCIAL SCIENTISTS in understanding Twelve Step groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) in the past two decades. It seems as though things took off in the mid-1980s shortly after Edward J. Khantzian, MD, posited his "self-medication hypothesis" in a short piece in the *American Journal of Psychiatry*, claiming that addicted persons turn to their substances of choice to deal with their "painful affect states." Dr. Khantzian was one of the first advocates for Twelve Step recovery in scientific literature, claiming that AA was the shining prototype of Twelve Step groups.

By the mid-1990s, more recovery-related articles were getting published in scholarly journals and it seemed as though there were more alcohol- and drug-related journals available in university settings. The days where psychologists and psychiatrists argued through published letters, case studies, and studies—ones that used very small clinical samples aiming to prove which theoretical approach to psychotherapy worked best in treating problem drinking and narcotic addiction—finally gave way to more scholarly reports based on rigorous scientific methods and research designs for understanding Twelve Step involvement among persons in rehabilitative programs for substance use disorders.

Twelve Step Involvement

Operational definitions—such as subjecting participants to various conditions, operations, and procedures in order to obtain observed responses that can be measured and analyzed through statistical analyses—are important elements of scientific methods that permit researchers to examine concepts that cannot be directly measured. "Twelve Step involvement" is a term that has been operationally defined in several ways through the use of established surveys. Investigations on Twelve Step groups such as AA and NA have used terms including "affiliation," "participation," "investment," and "involvement" that seem to tap into the general construct counselors in the field refer to as "living the program." For the sake of argument, we simply refer to one's active participation in various activities practiced and discussed at Twelve Step groups—the kind of active participation that is typically

encouraged in Twelve-Step-oriented treatment and in Twelve Step groups—as "involvement" in this article.

The Alcoholics Anonymous Affiliation Scale (AAAS) and the Alcoholics Anonymous Involvement Scale (AAIS) are two of the most commonly used measures in assessing Twelve Step involvement (Humphreys, Kaskutas, & Weisner, 1998; Tonigan, Connors, & Miller, 1998). Scores derived from these measures typically consist of summary scores that include rates of Twelve Step meeting attendance. Although "meeting makers make it," as the saying goes, there are some mixed results with respect to meeting attendance in the literature. Some researchers have found frequent meeting attendance as being related to good outcomes whereas other researchers have found frequent meeting attendance was related to negative outcomes. The latter seems to make sense when thinking of folks who are court-ordered to Twelve Step groups; some might attend meetings for the sake of placating the courts but have no real interest in getting involved with Twelve-Step-based recovery. However, there is some evidence to suggest that the duration of meeting attendance is perhaps more important than the frequency of meeting attendance. In other words, the number of meetings attended each week may not be as important as the ongoing attendance to Twelve Step meetings.

We argue that involvement in Twelve Step groups like AA and NA might be better understood when examining activities apart from meeting attendance. Meeting attendance, especially in the beginning of one's recovery, is highly instrumental in getting one involved in personal recovery, but it's not sufficient because there is more to recovery than meeting attendance. For instance, "old-timers" who have been clean or sober for decades may not necessarily attend the same number of meetings they did early in their recovery, but they continue to attend meetings and chances are they are involved in their recovery by engaging in a number of Twelve Step activities and practices aside from attending meetings.

In addition to meeting attendance, Twelve Step involvement has been assessed with measures that consist of items regarding specific Twelve Step activities. This has led to the calculation of summary scores across a number of activities, including meeting attendance, thereby creating a dimensional approach to assessing Twelve Step involvement. This common practice in research renders a scale score with higher scores indicating greater Twelve Step involvement.

However, some researchers have examined individual Twelve Step activities—having a sponsor, working the Steps, having a homegroup, being involved in service—apart from meeting attendance as a measure of Twelve Step involvement. Individual Twelve Step activities have been significantly related to outcomes in various studies, but findings are not highly consistent across studies. Consistency of findings across research studies is necessary in providing confidence that such findings are reliable, so inconsistent findings regarding specific Twelve Step activities becomes problematic.

Perhaps more importantly, there is a lack of theoretical basis to support the use of these approaches, such as averaging and/or summarizing responses across various activities, and examining individual Twelve Step activities, toward measuring involvement in AA and NA groups. One major problem with a summary score approach to measuring Twelve Step involvement lies in the fact that a summary score approach does inflate and reduce actual involvement in any one Twelve Step activity, within the set of individual activities, covered by these measures. For example, someone who does not have a sponsor, does not work steps, and is not involved in Twelve Step service, but considers oneself as a member, claims to have had a spiritual awakening, and attends meetings, could complete a measure like the AAAS or AAIS and receive a scale score of Twelve Step involvement. This score, in turn, really reflects an averaged-like rate of involvement across all Twelve Step activities listed in the measure where partial credit is given for being involved in some activities.

Another major problem with using specific items of these commonly used measures of Twelve Step involvement is that some items do not necessarily reflect actual involvement or involvement that is suggested to newcomers. Although most Twelve Step activities listed in the AAAS are very similar to those in the AAIS, both instruments include other items that are not directly relevant to new members (e.g., sponsoring others), are not direct behaviors/activities but more of a perception (e.g., considering oneself as being a "member"), or appear to be more of a consequence of an action (e.g., having had a "spiritual awakening" or recovery "birthday"). In addition, there are other Twelve Step activities commonly practiced by members, such as the application of the Twelve Steps, practicing spiritual principles, helping the newcomer, and participating in the group conscience of one's home group, that aren't covered in these measures.

Nonetheless, we believe that measures such as the AAAS and AAIS have been highly instrumental in raising awareness into the benefits of Twelve Step groups. They have historic significance in Twelve Step research and as a result scientists have learned quite a bit about involvement in AA and NA. Only recently have some researchers taken alternative approaches to scoring these valuable instruments, like examining independent activities such as having a sponsor. However, AA/NA members endeavor to engage in several Twelve Step activities simultaneously—assessing Twelve Step involvement should reflect this practice. That is why we have recently assessed involvement in Twelve Step groups categorically.

"Categorical Twelve Step involvement" is a term used to indicate simultaneous involvement in several Twelve Step activities. It has been argued that involvement in various Twelve Step activities should be measured categorically because it is a representative assessment of what members are encouraged to do for their recovery (Majer, Droege, & Jason, 2010). In addition, a categorical approach to

assessing Twelve Step involvement controls for artificial reduction or inflation of true scores (for individual activities) created by summary score approaches that are typically used. Recent investigations have demonstrated that categorical Twelve Step involvement in several Twelve Step activities is a significant factor related to increases in important cognitive resources and coping skills for recovery, and a better predictor of abstinence rates compared to summary scores of Twelve Step involvement (Majer, Droege, & Jason, 2012; Majer, Jason, Ferrari, & Miller, 2011).

Abstinence

Abstinence-related outcomes in Twelve Step involvement research investigations have been measured in various ways, including substance use in the past thirty days, substance use in the past ninety days, reductions in substance use, and reductions in alcohol-related problems. In addition, many investigations have measured alcohol and drug use separately. However, these abstinence-related outcomes do not fully capture a major aim of Twelve Step groups; complete and continuous abstinence. Thus it is important to measure continuous abstinence from both alcohol and illicit drugs, not including medications prescribed by a licensed professional, among Twelve Step members while investigating representative involvement in Twelve Step groups. In recent years, we have conducted studies related to Twelve Step involvement by sampling residents living in Oxford Houses.

Oxford House

For over twenty years, researchers at DePaul University's Center for Community Research have scientifically evaluated the Oxford House model of care. Oxford Houses are self-run, communal-living settings comprised of recovering alcoholics and addicts (Jason & Ferrari, 2010). The first Oxford House opened in Silver Spring, Maryland, in 1975 when several recovering alcoholics who were living in a professionally-run halfway house were faced with being on the streets because their halfway house lost funding and had to close. Collectively, these recovering alcoholics sought help from a few fellow AA members who advised them to take over the house. In short, the first Oxford House was created, adapting AA's Twelve Traditions as a model for its direction. Residents were allowed to stay as long as they wanted to as long as they followed three basic tenets: no drinking and drugging (grounds for immediate eviction), partake in regular business-related House meetings, and contribute to the House in terms of rent and democratically-assigned chores.

Since then, over 1,600 Oxford Houses in the US, Australia, Canada, Ghana, and the UK have flourished. One longitudinal investigation found that patients who completed inpatient treatment for substance use disorders who were randomly assigned to living in an Oxford House—versus patients who were randomly assigned to a usual care condition upon discharge—had better outcomes at two years; including twice the amount of abstinence, double the amount of income, and only a third of criminal behavior involvement compared to those who were randomly assigned to usual care (Jason, Olson, Ferrari, & Lo Sasso, 2006). However, this investigation did not control for the effects of Twelve Step involvement.

One could argue that the results from this investigation were related to Twelve Step involvement because Oxford House living is sort of like twenty-four-hour residential AA or NA; nearly every Oxford House resident attends Twelve Step groups. Thus it was important to determine whether Twelve Step involvement was related to abstinence outcomes independent of condition and to raise the bar on abstinence outcomes by measuring continuous abstinence from both alcohol and illicit drug use at two years.

Examining Twelve Step Involvement and Oxford House

We examined categorical Twelve Step involvement and living in an Oxford House in relation to continuous abstinence among persons with substance use disorders exiting inpatient treatment over a two-year period. We hypothesized that participants who were categorically involved in Twelve Step activities, compared to participants who were not categorically involved, would be more likely to maintain continuous abstinence at two years. We hypothesized that participants who were randomly assigned to the Oxford House condition would be more likely to maintain continuous abstinence at two years than those who were randomly assigned to a usual care condition. We also hypothesized that categorical Twelve Step involvement would be a better predictor of continuous abstinence outcomes at two years compared to summary scores of Twelve Step involvement.

We recruited 150 persons exiting inpatient treatment centers located in northern Illinois. After participants entered the study, they were interviewed every six months over a two-year period, yielding a total of five assessment waves; baseline and six-, twelve-, eighteen-, and twenty-four-month follow-ups. The follow-up rate across the two-year study was comparable for the Oxford House (89 percent) and usual after-care (86 percent) conditions.

Categorical involvement in Twelve Step activities was assessed by positive endorsement of four of the following AAAS items at baseline: having a sponsor, reading Twelve Step literature, doing service work, and calling other members for help. Participants who endorsed all four of these items were

considered as being categorically involved in Twelve Step activities whereas those who endorsed three or less of these items were not, and thus served as a comparison group.

These four AAAS items were selected because they are recovery-related actions that new members who are early in their recovery are commonly encouraged to take in AA and NA groups, whereas the other three AAAS items—identifying as a member, having had a spiritual awakening, being a sponsor to others—were not. However, we calculated summary scores of the AAAS, which is commonly done in research, to see if summary scores of Twelve Step involvement, and/or our measure of categorical Twelve Step involvement, would be related to continuous abstinence two year later.

Simply put, our investigation sought to examine the independent effects of categorical Twelve Step involvement and condition, and Oxford House versus usual care—upon continuous abstinence from alcohol and illicit drug use two years later—while also testing whether categorical involvement or a summary score of Twelve Step involvement was the better predictor of continuous abstinence at two years.

Several findings were particularly revealing:

- Participants who were categorically involved in Twelve Step activities at baseline were 2.8 times more likely to maintain continuous abstinence from both alcohol and illicit drug use at two years.
- Participants who were randomly assigned to the Oxford House condition at baseline were 5.6 times more likely to maintain continuous abstinence at two years.
- Participants with high AAAS scores were only 0.7 times more likely to maintain continuous abstinence from both alcohol and illicit drug use at two years.
- When we ran our analytic model using both measures of Twelve Step involvement, categorical involvement, and AAAS scores, in addition to condition as predictor variables, only categorical Twelve Step involvement and the Oxford House condition were significant predictors of continuous abstinence at two years. AAAS summary scores were not significant predictors.

Implications

Participants who were categorically involved with Twelve Step activities, compared to those who were not, were more likely to maintain continuous abstinence at two years, consistent with Twelve Step ideology. Most treatment providers would agree that it is better to be involved in a number of Twelve Step activities for sustaining ongoing recovery and abstinence than it is to be partially involved. Our findings are consistent with the "basics" that are discussed at AA and NA meetings and affirm the Twelve Step cliché, "Half measures availed us nothing." Although a continuous measure of Twelve Step involvement, or the AAAS summary score, was related to abstinence outcomes, the likelihood of complete abstinence due to AAAS scores was not as robust as it was among participants who were categorically involved in Twelve Step activities. This suggested that a categorical approach to assessing Twelve Step involvement might be a better indication of actual involvement in Twelve Step groups, consistent with previous investigations (Majer, Droege, & Jason, 2012; Majer, Jason, Ferrari, & Miller, 2011). Our findings add empirical support to Twelve Step theory in this respect.

In addition, findings in the present study extend previous investigations in that we examined continuous abstinence from both alcohol and illicit drugs (together, not separately) throughout the course of two years instead of the past thirty or ninety days at key assessment intervals. Our use of corroborated self-reports through collateral informants provided some assurance of complete and continuous abstinence throughout the course of our investigation. We encourage researchers to examine continuous abstinence from both alcohol and illicit drugs in future investigations because this best reflects the aim of Twelve Step groups like AA and NA.

Furthermore, participants who were randomly assigned to the Oxford House condition were also more likely to remain completely abstinent throughout the course of the investigation. Our randomized clinical trial allowed us to examine more closely the effects of categorical Twelve Step involvement upon continuous abstinence, independent of condition and vice versa, as other investigations on categorical Twelve Step involvement were limited to Oxford House residents, did not include comparison groups, and did not examine continuous abstinence from both alcohol and illicit drugs over time (Majer, Droege, & Jason, 2012; Majer, Jason, Ferrari, & Miller, 2011).

Limitations, Recommendations, and Conclusion

Summary scores from the AAAS in the present study included participants' rates of Twelve Step meeting attendance—a Twelve Step activity that might not necessarily be directly related to positive outcomes. Although meeting attendance rates in the present longitudinal study were not controlled for throughout our two-year investigation, because we collected these data only at baseline, it is possible that meeting attendance rates might have accounted

for the weak relationship between AAAS scores and continuous abstinence at two-year follow-up. However, a recent longitudinal investigation that included multiple measures of Twelve Step involvement demonstrated that summary scores of Twelve Step involvement did not significantly predict abstinence outcomes when controlling for meeting attendance (Majer, Jason, Ferrari, & Miller, 2011). We believe that more investigations regarding Twelve Step meeting attendance rates and duration of attendance are needed to better understand this important activity in relation to categorical Twelve Step involvement, and to determine how and why members change their rates of meeting attendance over the course of long-term recovery in maintaining their complete and continuous abstinence.

Findings in the present study suggest that categorical Twelve Step involvement and the Oxford House model are mutually exclusive factors related to recovery. Even though the vast majority of Oxford House residents are involved in Twelve Step groups, findings in the present study are consistent with previous research that found Oxford House living provides additional benefits to recovering persons apart from their Twelve Step involvement (Majer, Jason, & Olson, 2004). Nonetheless, the use of clinical samples in the present study might be a limitation, and future investigations with community-based samples would help us further understand the effects of categorical Twelve Step involvement.

In addition, findings in the present study suggest that categorical involvement in a set of Twelve Step activities that are encouraged at AA and NA meetings, and Oxford House living, is likely to empower persons with substance use disorders in maintaining their abstinence. Clinicians should encourage clients' active and concurrent involvement in a number of Twelve Step activities early in their recovery such as the ones used in the present study, and consider referrals to self-run, communal-living settings like Oxford Houses. The Oxford House network of substance abuse recovery homes has been endorsed by SAMSHA as being effective (SAMHSA, 2013). C

John M. Majer, PhD, *is an associate professor of psychology at Harry S. Truman College and a consultant for DePaul University's Center for Community Research in Chicago, IL. He earned his MA in counseling psychology at Bowie State University and worked as a direct service provider in the addictions field for over ten years prior to earning his doctorate in clinical-community psychology at DePaul University. He has published over twenty articles involving persons with substance use disorders and serves as a reviewer and consulting editor for a number of peer-reviewed journals.*

Leonard A. Jason, PhD, *is a professor of psychology at DePaul University and the director of the Center for Community Research. Jason is a former president of the Division of Community Psychology of the American Psychological Association (APA). He has edited or written twenty-three books, and he has published over six hundred articles and seventy-five book chapters.*

Joe Ferrari, PhD, *is a professor of psychology and St. Vincent de Paul Professor at DePaul University. He also serves as the editor of* The Journal of Prevention & Intervention in the Community.

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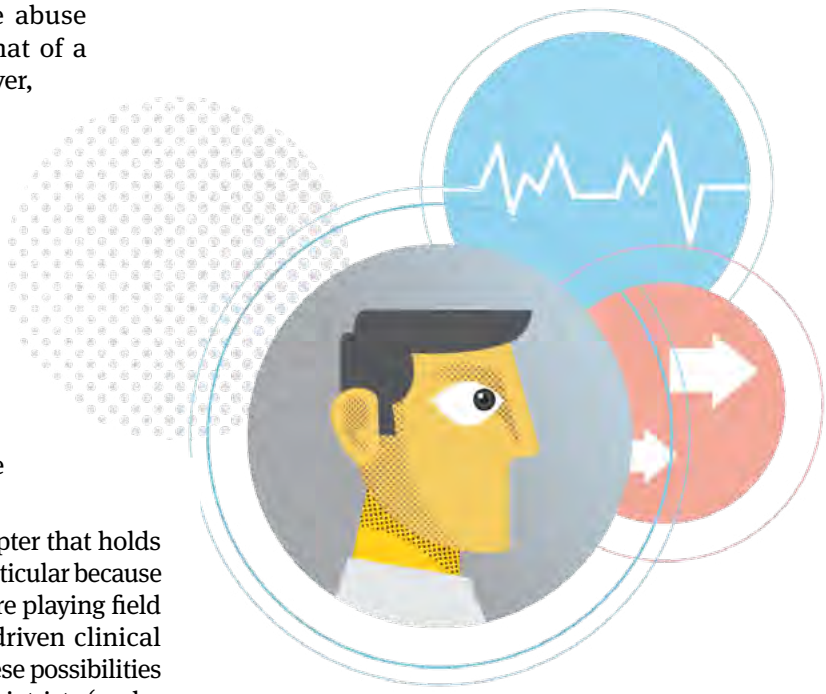
RELATING CLINICAL ASSESSMENT CONSIDERATIONS TO EHR MEANINGFUL USE PART II

LAVERNE H. STEVENS, PHD, NCC, LPC

"Meaningful use" (MU) is the term associated with the move toward nationwide health care infrastructure improvement through the use and sharing of electronic health records (EHR). Toward that goal, the Health Information Technology for Economic and Clinical Health (HITECH) Act, under the 2009 American Recovery and Reinvestment Act (ARRA), authorized programs to provide Medicare and Medicaid incentive payments to health care providers and hospitals when they adopt and use certified EHR technology to improve the efficiency, quality, and safety of health care. The goal is to improve health care outcomes and reduce health care costs. The push toward meaningful use has precipitated the question of whether MU and EHR can reasonably be implemented in the treatment of substance use and mental health—commonly referred to in combination as "behavioral health"—disorders. With notable differences in both the formal and informal world of physical and behavioral health, this article offers a candid discussion of some of the concerns related to MU for behavioral health, as well as some recommendations for substance abuse treatment professionals who are working to incorporate EHR into their daily clinical practice in a meaningful and measurable way.

Behavioral health, especially substance abuse treatment, has historically been somewhat of a stepchild within the medical world. However, the past twenty years have brought monumental changes. Those changes have professionalized the field of substance use treatment through increased funding for research and treatment, mandated use of evidence-based rather than anecdotally-based practices, and many state-legislated credentialing standards for providers. Still, significant differences in both form and function continue to perpetuate operational and organizational disparities when behavioral health is put side by side with general health care.



In 2014, MU enters its second phase—a chapter that holds promise for behavioral health providers in particular because of the possibilities for leveling the health care playing field with improved client care through data-driven clinical planning. It could be easy to miss some of these possibilities because in behavioral health care only psychiatrists (under Medicare and Medicaid) and nurse practitioners (under Medicaid only) qualify an agency to receive the MU incentive payment. The licensed professional counselors, licensed clinical social workers, and certified addictions counselors might assume that MU has little relevance for them, but the most significant value in MU for behavioral health is in the data-driven clinical decision support and data-based program planning and evaluation potential.

This article is the second in a two-part series on the implications of bringing the meaningful use of EHR into the world of behavioral health care with the same level of effectiveness and efficiency as general health care. The previous article in *Counselor*—"Relating Clinical Assessment Considerations to EHR Meaningful Use, Part I," found in the February 2014 issue—provided an introduction to MU with an overview of the rationale and benefits of the HITECH standards, based on the Institute of Medicine's Quality Chasm Report (QCR). This article addresses some of the ways that MU of EHR can help mitigate formative and functional differences between behavioral health care and general health care.

Recognizing the historical differences and separation of Mental Health/Substance Abuse (MH/SA) treatment from other components of the health care system, the QCR supports the inclusion of MH/SA in the redesign of the US health care system. The overarching recommendation is that the aims, rules, and strategies for health care redesign should be applied to mental and substance use health care on a day-to-day operational basis, but should be tailored to reflect the unique issues that distinguish behavioral health care from general health care (Institute of Medicine, 2006)

For the purposes of this discussion, we consider two broad categories of differences between behavioral health care and general health care. There are operative (functional) differences and there are organizational (formative) differences. Operative differences relate to the "soft" or societal factors. Organizational differences are found in the structure of the delivery system itself.

Operative Differences

Workforce

For substance use disorders, the social recovery network has been historically central to improvement. These disorders have been viewed as social diseases and members of the recovery community have been regarded as the experts on healing. Whether in volunteer or paid positions, there is greater use of peer support and people in recovery as part of care. Provider requirements and qualifications vary by state, creating both inherent and legislated discrepancies between provider systems. This gives rise to a very educationally diverse workforce, with significant variation in the types of providers credentialed to diagnose and treat MH/SA disorders and variable levels of training and expertise in the field. Certified EHR technology, that meets meaningful use standards, stores data in a structured format to support greater uniformity in record-keeping, despite the diversity in provider training and/or record-keeping experience.

Stigmatization

With MH/SA disorders, there is still significant stigmatization of the diagnoses and those affected. Consumers may experience discrimination in housing, jobs or other areas if they have a mental health or substance use history. The implications of a mental health or substance use diagnosis have a broader, whole-life impact, with the potential for job loss, jeopardizing parental rights and child custody, loss of freedom or privileges through incarceration, and other legal consequences.

Organizational Differences

Infrastructure Disconnections

In MH/SA treatment, the service infrastructure has been significantly less developed and more difficult for clients and providers to co-navigate. When comparing behavioral health care patients with general medical patients, the recipients of MH/SU services tend to have greater involvement with justice, welfare, school, work or other formal systems. There is greater use of coercion by employers and the legal system to get people into treatment, and frequently there is a lack of coordination between multiple systems—all with different theories and models, as well as often competing requirements and objectives. For example, Family and Children's Services' requirements might interfere with Drug Court stipulations, or scheduling mental health appointments might conflict with maintaining steady employment.

As the behavioral health care industry is moving toward more client-centered care, providers need tools that help them work collaboratively with other caregivers. In an article about EHR meaningful use, Amanda Guerrero writes that "EHR software closes the communication gap among providers. It fosters care coordination and allows for the delivery of more comprehensive care. EHR software also reduces cost of care, as physicians with access to shared data are less likely to order duplicate tests or studies" (2012). EHR can help clients and those whom they authorize—providers, caregivers, family members—to have access to the records and reports they need to better understand their condition, their treatment, and their medications. Clients or their authorized designees can also share their discharge summaries and/or plans and provide this information to doctors, pharmacists, nurses, and other professionals in their continuum of care or coordination team.

Additionally, concurrent and collaborative use of data has the potential to engender client trust of the treatment process. As clients experience the benefits of coordinated care between their providers, the stage is set for less confusion, reduced treatment resistance, and stronger client buy-in.

Different Marketplace Structures

For consumers and purchasers of MH/SU treatment, the services are more likely to be publicly financed or subsidized, or in the private sector, "carved out." Private, third-party coverage is often limited, and health insurance carve-outs create a method to separate specific services from general health care contracts, so that a different contract and payment arrangement covers the designated services. As a result, access to behavioral health services can seem more complicated or humiliating for consumers.

Clinical Decision Making

The diagnosis and monitoring of MH/SA disorders rely more heavily on self-reported symptoms. Clients must effectively describe their experiences, feelings, thoughts, and interactions in order to be diagnosed. In the general health care arena, there are laboratory tests, protocols, and scientific measurements to assist with assessment. As a result, clinical decision making with behavioral health often seems more subjective and is more likely to be challenged by the consumer.

Clinical Decision Support (CDS) is an incentive benchmark for meaningful use in EHR. It is a process designed to aid directly in clinical decision making by ensuring that clinical planning is based on the individual needs and problems of each client. CDS should involve the use of specific, client-centered, and evidence-based assessments that lead to the development of a treatment plan with client-centered interventions and recommendations. With EHR, these can be shared with the client, or anyone else whom the client authorizes such as a family member, treatment team, or providers from other disciplines. The effective use of a clinical decision support system means patients get the right assessments, the right interventions, and the right referrals. For 2014 and the second stage of MU, eligible providers must show their use of EHR for CDS to improve performance on high-priority health conditions.

"The increased capability of the Clinical Decision Support Rules (CDSR) soon to be available in meaningful-use-certified EHRs is exciting because it brings with it a real opportunity to leverage data within the EHR in real time (at the point of delivery of service) to aid in making good clinical decisions. This EHR capability is valuable only if the data is current, complete, and accurate," says Mary Givens, the MU program manager for Qualifacts Systems, Inc. (2013). In her article, "Clinical Decision Rules Are Only as Valuable as the Data," Givens urges behavioral health professionals not to "miss the opportunity to gain real value for the clinical decision support rule capability of a certified EHR. It promises to bring great benefit to the health and safety of the clients you serve" (Givens, 2013).

Technology and Data Sharing Limitations

Historically, providers of MH/SU treatment have made less use of health IT and have had less pooled data available. Data collection and research studies in this arena have lagged far behind, so the infrastructure for measuring quality is less developed. In the mental health area, and especially with substance use treatment, there is tighter regulation on data sharing, even with a consumer's family members. While all health care providers must abide by HIPPA rules, those who provide treatment for substance use must also adhere to the more stringent federal restrictions of 42CFR.

Certified EHR technology gives assurance to purchasers and other users that an EHR system offers the necessary technological capability, functionality, and security to help them meet the meaningful use criteria. Certification also helps providers and patients be confident that the electronic health IT products and systems they use are secure, can maintain data confidentially, and can work with other systems to share information.

The following case study looks at one substance use program and shows how the measurable, meaningful use of data addressed both the functional differences and the formative differences described above, and transformed their program.

A Case Study: Transforming Burrell Behavioral Health's Adolescent Substance Abuse Program*

The Burrell Behavioral Health adolescent treatment program in Springfield, Missouri, runs a fourteen-bed residential coed program and outpatient services for a seven-county area. The program has undergone massive changes in recent years by using sharable assessment data to inform clinical decision making with individual clients and to guide program planning. The results: improved client engagement and retention, lower attrition rates, and better use of the state's treatment dollars. The secrets to their success were getting the buy-in of the program and the state funding sources to rethink the relationship between assessment and treatment decisions, and using an evidence-based assessment tool for gathering data that can be used in measurable and meaningful ways.

Here's the historical summary of the program's evolution. The Burrell adolescent substance abuse program is funded primarily by Missouri's Department of Mental Health (DMH). Consistent with state funding requirements, the program operated its intensive outpatient program (IOP) twelve hours per week, which included eleven hours of group and one hour of individual treatment for every client. Groups took place three nights per week for four hours. Most of Burrell's adolescent clients were mandated by the juvenile justice system to attend the groups; other referrals to the program came from schools and hospitals. Referrals were usually conducted via telephone.

For each referral, a staff consultation first resulted in a level of care placement for the client. When the client was admitted to that level of care, an initial assessment was completed. Group

sessions, typically including sixteen to twenty adolescents, focused primarily on state-recommended drug education and relapse prevention. All the adolescents went to the same groups and received the same services without regard for individual needs. Because of this broad stroke approach to treatment—which was commonplace in behavioral health care—an adolescent was often placed in a level of care and treatment groups that may not have been clinically indicated for them.

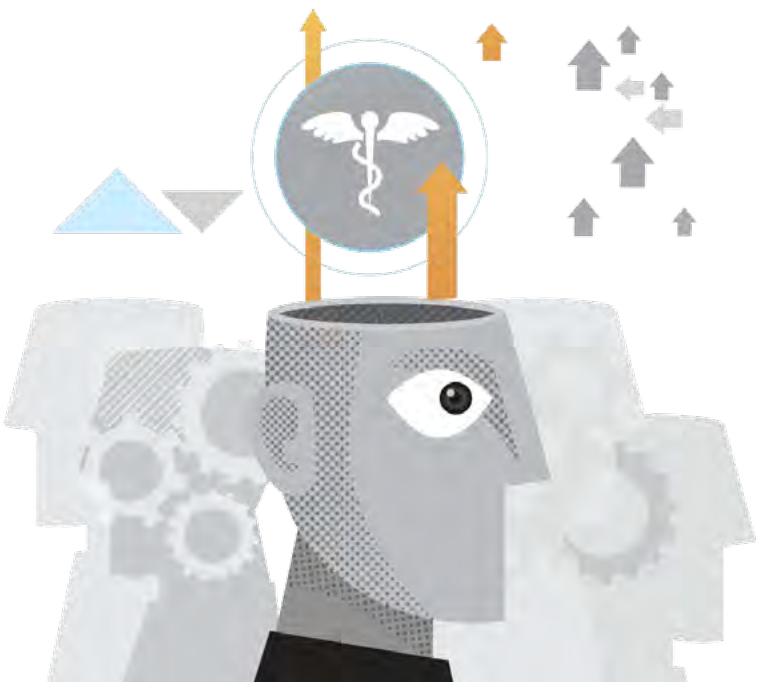
In 2008, the program began using a series of instruments referred to collectively as the Global Appraisal of Individual Needs (GAIN) as part of a federal grant that the agency received. Leslie Corbiere, clinical supervisor of Burrell's Youth Substance Abuse Services, was sent to trainings to use and clinically interpret the GAIN and says, "What we saw was what we intuitively knew, that the outpatient treatment program for our population of adolescents needed to be much more individualized. Finally we had an assessment tool that was made to be electronically shared, and would support clinical decision making for diagnosis, treatment planning, and level of care placement based on *individual* client needs" (Unsicker, 2012).

The program asked DMH to relax the state mandates so that Burrell could begin to first administer the GAIN assessment and then make treatment placement decisions based on the identified needs of the client, instead of placing a client in a level of care and then administering the assessment. They

made their appeal to the state on the premise that all kids don't need the same thing and they could achieve better client outcomes if they used assessment data to support individualized clinical decisions. With the state's approval, the program underwent a major redesign—to consider the individual needs of each client and to revise the curricula to meet these needs.

The groups were redesigned to address the actual needs identified by GAIN data. Burrell's success put them ahead of the curve with meaningful use through the development of programs to address issues the adolescents were experiencing: anger-management, stress-management, co-occurring disorders, criminal-thinking, decision-making skills, and relapse prevention. There is a Twelve Step education group designed for adolescents, and a prosocial education group that explores sober lifestyle options. Burrell even has a group in independent living skills for older teens who will soon be on their own.

These new groups are one hour in length and are now offered five afternoons a week instead of the previous three times a week. A choice of groups is offered each day for the clients. The maximum group size is now ten to twelve rather than sixteen to twenty. The same topic is offered in multiple time slots each week, and the kids can attend a group any time during the week. The groups are set for an eight-week period, but there is not a definite start and stop curriculum. A client can come into any of the groups at any point in time and not be behind. Every unit is self-contained in terms of a skill or idea and is applicable to any of the clients regardless of how long they have been in treatment. The kids roll in and out of groups constantly. When a group just doesn't work or there aren't enough kids who need it, a new group is created. A group can be offered again when the need arises, or it can be discontinued.



All adolescents have an individual session weekly. If they have a co-occurring disorder, they meet with a co-occurring therapist. If not, they have their session with a substance abuse counselor.

The decisions about which services each client receives are supported by the GAIN Recommendation and Referral Summary (GRRS), which maps onto DSM for diagnostic impressions and onto ASAM treatment areas. Leslie explains that level of care decisions are now informed by the GRRS recommendations and the clinical judgment of the professional staff, rather than being informed only by program tradition and convention. For example, if the GAIN shows that others in the client's environment are involved in illegal activity, getting drunk weekly, using drugs in the past ninety days, arguing and fighting most weeks, and not in AOD treatment or in recovery, then the client's schedule will target those specific problems. Similarly, if the client has a history of legal system involvement, then the client's treatment plan will include the criminal thinking group and other interventions targeted to reduce recidivism.

Burrell's clinical staff looks very closely at the mental health section of the GAIN report to help assess for co-occurring disorders such as major depressive disorder, generalized anxiety disorder, attention-deficit/hyperactivity disorder (ADHD), conduct disorder, provisional diagnoses of posttraumatic stress disorder (PTSD), acute stress disorder or other disorders of extreme stress. The staff is trained to use the GAIN's Substance Problem Scale to measure increasing severity of the client's substance use problems.

Leslie explains that when new clients enter the program, the staff initially sets a schedule to get them settled. A counselor works with the adolescent to see what they want and makes recommendations for groups based on that client's individual needs and situation. After doing the GAIN assessment and listening to the client, the staff gets an idea about what specific services are needed. They watch the recommendations from the GRRS to support their clinical judgment. For example, she says, they may think a client could use some work in anger management, and that is confirmed by the recommendation for anger management on the GRRS. The counselor and the client negotiate and set the schedule together, which really increases the client's buy-in. The client now feels a measure of control because he or she is part of the decision-making process. A client is asked to attend each group for eight weeks, but since it is a rolling schedule, the adolescent can attend at any time during the week. Leslie likens it to a school class schedule in the sense that there are different counselors and kids in different groups.

Many of the kids attend two afternoons each week and spend six to eight hours in groups per week, but they can come to more groups if necessary. Others may only attend one group per week depending on the need and their agreement with

the counselor. A client may say, "I really don't need to go to this session, but I want to attend that one," and the program is flexible enough to accommodate these wishes. Once they finish the first eight-week cycle, they may drop down to fewer hours or they can go to individual treatment that includes such services as substance abuse counseling, co-occurring therapy, trauma therapy, and family therapy. The opposite may also be true; if it is evident that a client is struggling, the number of hours in groups can be increased until the client stabilizes, and then the counselor can gradually decrease the hours again. This new system is very fluid, and as a result, treatment resistance has dropped dramatically and treatment motivation has increased because the clients do not have to be there all the time on a set schedule.

The clients attend only the groups that the counselors believe are necessary for them. They are much more engaged and no longer feel like sheep following a herder into the same sessions with the same counselors and the same kids at the same time each day. The counselors are invested in the program because they design the groups, and the kids are invested because they have a say in their treatment. There are kids now who don't want to complete treatment but who look forward to the next group because it's fun to attend. It's a win-win situation.

What makes the Burrell program stand out as a model for meaningful use of data? To answer that question, we will consider the two broad categories of differences between behavioral and general health care that were introduced in the main article: operative differences and organizational differences.

Burrell's Operative Differences

Workforce

The new system allows staff people with different licenses and certification levels to share the same language and to also have a structured format to support greater uniformity in record-keeping, despite differences in training or experience. Burrell's clinical staff was allowed to take ownership in redesigning the adolescent IOP and OP programs.

Stigmatization

At Burrell's adolescent program, the clients' active involvement in selecting their own groups helps take the stigmatization out of being a client because the adolescents feel more empowered as they choose which groups they want now vs. later. Clients feel less like they are being judged or objectified by an external decision maker.

Burrell's Organizational Differences

Infrastructure Disconnections

Burrell's use of an evidence-based assessment gives their clinicians the capability to share information with other service providers and most importantly, with their in-house psychiatrists. This also creates a platform where Burrell clinicians can talk to judges, probation officers, medical professionals, and other specialists in terms that are most understandable to those specialty areas. As a result, coordination of care is less cumbersome for both the client and the clinician.

Different Marketplace Structures

Burrell's primary funding source is the Missouri Department of Mental Health. The program redesign gives a publicly-funded program the kind of individualized treatment planning often only received in private treatment.

Clinical Decision Making

The use of the GAIN in clinical decision support allows the Burrell staff to provide the right assessments, the right interventions, and the right referrals. This helps to ensure that interventions are aimed at the right targets, that they avoid the broad-stroke approach where all clients get the same services, and that performance and outcomes are improved. With clients' baseline severity levels recorded at intake, the center can measure aggregate change and see which groups are associated with desired behavioral change in clients. This allows Burrell to evaluate the effectiveness of its program components with empirical data.

Technology and Data Sharing Limitations

At Burrell Behavioral Health adolescent treatment program, the EHR is not integrated with the GAIN yet, but the infrastructure for measuring change and quality improvement is in place. Leslie says that Burrell is working toward a full EHR system integration in the future. When that time comes, the strength of Burrell's measurable and meaningful use of data will bring benefits to clients and a broad range of providers. C

***LaVerne Stevens, PhD**, is a licensed professional counselor, master addictions counselor, and board certified coach. She is in private practice as the owner and clinical manager of New Seasons Counseling, Coaching and Consulting, LLC, in Peachtree City (Atlanta), GA.*

*Written by Joan Unsicker, MS, and LaVerne H. Stevens, PhD, NCC, LPC.

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AD INDEX

The Hidden Epidemic: Substance Abuse in the Elderly

1. What percentage of the elderly in the United States consumes at least eight or more prescription drugs a day?

Ⓐ Twenty percent
Ⓑ Thirty percent
Ⓒ Forty percent
Ⓓ None of the above

2. True or False. Today, 13 percent of the US population is over sixty-five years of age and 17 percent of this population abuses drugs.

Ⓐ True Ⓑ False

3. Which of the following were not listed as endogenous barriers to diagnosis of substance abuse in the elderly population?

Ⓐ Bereavement and retirement
Ⓑ Health and denial
Ⓒ Complicity and under-detection
Ⓓ Both A and B

4. True or False. The Alcohol Related Problems Survey (ARPS) is an eighty-question survey for the older adult population at risk for substance abuse.

Ⓐ True Ⓑ False

5. Which of the following was not listed by SAMHSA as something that elderly substance abuse treatment programs require?

Ⓐ Linkage with medical and aging services
Ⓑ Age-appropriate pace and content
Ⓒ Staff members who are experienced in serving the elderly population
Ⓓ None of the above, these are all valid requirements

Mental Health Treatment and Co-Occurring Cannabis Use Disorders

1. Which of the following was not listed as a reason for incomplete and/or inaccurate reporting for cannabis use disorders?

Ⓐ Peer pressure to maintain use
Ⓑ Maladaptive beliefs regarding use
Ⓒ Lack of insight into extent/pervasiveness of use
Ⓓ None of the above, these are all valid reasons

2. According to the National Alliance on Mental Illness (NAMI), what percent of people with a mental health diagnosis suffer from at least one comorbid substance use disorder?

Ⓐ Thirty percent
Ⓑ Eighteen percent
Ⓒ Fifteen percent
Ⓓ Twenty percent

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3. True or False. There is a 30 percent increased risk of psychotic symptoms in cannabis users when compared to non-users.

Ⓐ True Ⓑ False

4. Which of the following was not listed as a crisis that can ensue, during treatment, as a result of a "hear no evil, see no evil" stance on cannabis use taken by clinicians?

Ⓐ Development of anxiety
Ⓑ Disrupted schooling
Ⓒ Problems attaining employment
Ⓓ Arrest for possession or sale

5. True or False. Fifty percent of individuals with a first episode of psychosis have a history of significant cannabis use.

Ⓐ True Ⓑ False

What's New in the DSM-5 for Substance Use Disorders

1. True or False. The four criteria for dependence and the seven criteria for abuse have been combined into a total of eleven criteria in the DSM-5.

Ⓐ True Ⓑ False

2. Where does cocaine use disorder appear in the DSM-5?

Ⓐ Under "Cocaine"
Ⓑ Under "Substance Use Disorders"
Ⓒ Under "Stimulant-Related Disorders"
Ⓓ None of the above

3. All of the following are specifiers that have been removed from the DSM-5, except:

Ⓐ "With physiological dependence"
Ⓑ "Sustained partial remission"
Ⓒ "On agonist therapy"
Ⓓ None of the above, these have all been removed

4. True or False. The definition of "sustained partial remission" relates to when the full criteria for dependence has not been met for twelve months or longer, but one or more of the criteria for dependence or abuse has been met.

Ⓐ True Ⓑ False

5. All of the following are criteria most likely to be associated with the severe categories of a substance use disorder (i.e., "The Big Five"), except:

Ⓐ Withdrawal
Ⓑ Wanting to cut down use but being unable to
Ⓒ Compulsion
Ⓓ None of the above, these are all valid criteria

LEARNING OBJECTIVES:

The Hidden Epidemic: Substance Abuse in the Elderly

- Thirteen percent of the United States population is over the age of sixty-five. Of that population, 17 percent abuse drugs. Elderly addicts can be grouped into four subsets: early-onset, late-onset, Baby Boomer, and prescription drug users.
- There are many barriers to diagnosing substance abuse in the elderly. The endogenous barriers include bereavement, retirement, health, denial, and morality, while the exogenous barriers include under-detection, misdiagnosis, and complicity.
- Screening for substance abuse in the elderly requires physicians, nurses, and hospital staff to be observant of disorientation, falls, memory loss, poor hygiene, and poor nutrition in elderly alcoholics. In elderly prescription drug users, staff members need to be looking for anxiety, depression, blackouts, incontinence, difficulties in decision-making, and sleep problems, among other things.
- According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there are several needs of current substance abuse treatment programs for the elderly. Some of these include age-specific treatment, linkage with case management and other medical services, and a focus on coping with age-related loss and/or loneliness.

Mental Health Treatment and Co-Occurring Cannabis Use Disorders

- Approximately 60 percent of clients with a major mental illness suffer from co-occurring substance use disorders (SUD). Cannabis use disorder (CUD) is among the most common co-occurring disorders seen in mental health care.
- Enabling factors that can sometimes be found in clinicians dealing with a client who has a CUD include lack of confidence, feelings of inadequacy, lack of skills to appropriately treat dual-diagnosis clients, and feelings of helplessness evoked by limited access to services. In addition, frequent resistance to treatment can also lead to clinicians avoiding discussion with their patients about cannabis use.
- Negative effects of cannabis include, but are not limited to, time-limited manic symptoms, potentially irreversible decline in cognitive functioning, psychotic spectrum symptoms, and elevated risk for withdrawal syndrome, anxiety, and depression.
- Clinicians should include inquiries as to past, recent, and current cannabis use in their initial mental health evaluations. In addition, licensing exams for mental health practitioners should include coverage on the treatment and diagnosis of CUDs.

What's New in the DSM-5 for Substance Use Disorders

- There are several major changes in the new edition of the DSM. The elimination of the Multiaxial Assessment System, the elimination of the "substance abuse" and "substance dependence" diagnoses, and the elimination of the legal problems criteria are just some of the changes in this new edition.
- Some of the changes made to the DSM-5 will allow clinicians to better diagnose clients who were unable to be diagnosed under the DSM-IV. For example, there seems to be a new ability to diagnose clients who were previously "sub-threshold" according to the DSM-IV. This will allow many more patients to get help and be recognized as having a mild, moderate, or severe substance use disorder.
- The new criterion of craving a substance has a total of eleven criteria. A determination of severity is made by the following: meeting none or one of the criteria results in no diagnosis, meeting two or three of the criteria results in a diagnosis of "mild" severity, meeting four or five of the criteria results in a diagnosis of "moderate" severity, and meeting six or more of the criteria results in a diagnosis of "severe."
- The DSM-5 has eliminated several specifiers, such as "with physiological dependence," "sustained partial remission," "early sustained remission," and "on agonist therapy." Furthermore, the term "addiction" is used for the first time in the history of the DSM and it is present in the Substance-Related and Addictive Disorders section.

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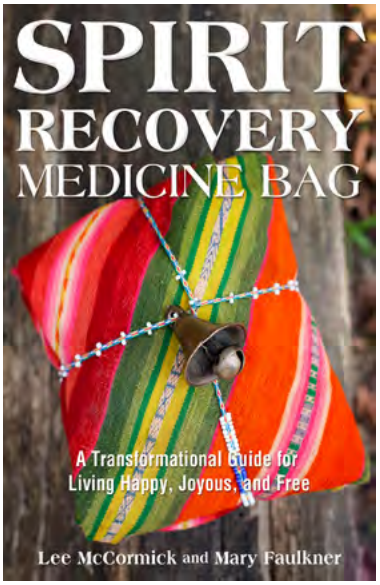
Spirit Recovery Medicine Bag: A Transformational Guide for Living Happy, Joyous, and Free

By Lee McCormick and Mary Faulkner

Reviewed by Leah Honarbakhsh



Spirit Recovery Medicine Bag is not your average self-help book. It teaches readers a whole new way to accept who they are, let go of the past, and begin the journey to wellness of the mind, body, and spirit. Through the principles of conscious connection, imagination, and transformation, readers will learn to be their authentic selves and find peace in their lives. McCormick and Faulkner guide readers through building their own reservoir of healing tools—a "medicine bag"—to help them transform their lives for the better.

The first half of the book is about McCormick's own story of recovery. He introduces readers to his family and his life before addiction; his brother's desperate need to live up to the expectations of their father, his sister's codependent relationships with alcoholics, and his father—a hard-working, not-to-be-messed-with contractor. "If you had asked me then who I was," McCormick writes, "I would have answered 'Ben's son' or 'a McCormick.'" He reminisces about growing up in Florida among the powerful men in his family and how, from a very early age, he felt subpar and unable to truly discover himself.

McCormick takes his readers on a journey from Florida to Colorado and everywhere in-between, through music-filled bars and taverns, on escapades with beautiful women, and to the first taste of mushrooms and cocaine. His on-again, off-again addiction to cocaine only worsened through the course of his tumultuous first marriage, which eventually culminated in divorce. Having had such a hard time with the divorce of his parents, McCormick's own divorce only exacerbated his growing addiction. When he finally put himself into treatment, McCormick began to learn how to push away the fears and doubts that fed his addiction through psychodrama, equine-assisted therapy, and group therapy.

After becoming more involved in equine-therapy and building a treatment center from the ground up less than two years after leaving treatment, McCormick's life began to change. It was his spiritual, other-worldly journey to Mexico and the pyramids of Teotihuacán, however, that truly struck him with peace, awareness, and the power to transform his life. McCormick details his experiences of soul-cleansing, connection, and spirituality in Teotihuacán and explains how readers can learn to do the same.

The second half of the book teaches the principles of spirit recovery to readers through the themes of conscious connection, imagination, and transformation. Readers are provided with ideas and practices they can keep in their own "medicine bag" of recovery. McCormick and Faulkner focus on lessons that come from a variety of sources including Twelve Step philosophy, Vedic teachings, Native American wisdom, and traditional psychology. *Spirit Recovery* is about growing, healing, and living your best life—a message that truly spans across substance abuse, trauma, mental health, and behavioral health treatment fields.

> *Spirit Recovery is for people who desire more out of life and are willing to put more of themselves into it and live more fully. It is for people who are willing to say yes to life—and sink their teeth into that commitment. It is for people who feel blocked by circumstances, substances, behaviors, attitudes, or beliefs and wonder if this is all there is. Your medicine bag will help you move beyond those internal walls and awaken your awareness of possibilities. It will help you uncover and recover your authentic self.*
> *—Spirit Recovery Medicine Bag* C

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