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### **Do You Accept Self-Empowering Recovery?**

By Tom Horvath, PhD

Discusses the Surgeon General's Report, describes a self-empowering approach to treatment, and outlines a dialogue for counselors.



### **Eating Disorders: Separating** the Patient from the Disease

By Vicki Berkus, MD, PhD, CEDS

Lists characteristics of eating disorders, presents ideas on how to treat patients, and discusses when to refer to a higher level of care.



### Women in the Behavioral **Health Industry:** Why Executive Leadership Needs a New, Female Face

By Andrea G. Barthwell, MD, DFASAM, & Cherlyne Short Majors, PhD

Presents statistics on women in the workplace and describes how women can impact the industry.





From the **Journal of Substance** Abuse Treatment

**Continuing Care Plan Adherence Following Residential Addiction** Treatment

By Steven L. Proctor, PhD

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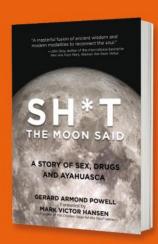
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# MY STORY OF ADDICTION





One man's miraculous, mystical journey from a life of addiction and pain to lasting peace, happiness, and prosperity

ON SALE JANUARY 30, 2018 My name is Gerard Armond Powell, I was 41 years old, I just sold my latest company for more than \$89 million dollars. I had five houses, two airplanes, 23 cars, a boat, a race horse and everything else a human could possibly imagine.

And yet, I couldn't figure out why I wanted to commit suicide. I could manifest anything... and yet every new thing that I manifested ultimately made me feel worse about myself. I was using alcohol, drugs, sex and anything else imaginable to mask my pain. I was a miserable human being, a bad father and an even worse husband.

After moving to California for a fresh start, I failed again and got divorced. I was miserable and near the end. I undertook thousands of hours of counseling and it simply wouldn't work. And then, I was introduced to Reverend Michael Bernard Beckwith and started going to AGAPE, and for the first time in my life began to have hope. Reverend Beckwith assigned me the most amazing Reverend, Kathleen McNamara, to assist me. And although I saw improvements I was still plagued by unhappiness. I was so far gone that even though the teachings were perfect, and I could understand them, I still could not feel the joy of being alive. I noticed that if I went to mass on Sunday, by the time Wednesday rolled around I was in trouble again. I still wasn't happy.

On a vacation in the Philippines I visited with a friend who was a shaman - she had a colleague with similar problems to me and he found a solution. She told me about a plant medicine that was being served in Costa Rica and how it cured her friend. I was honestly near the end of my rope again, so I said what the heck I'll go down and give it a try. So I went to Costa Rica and tried plant medicine. It was a night that changed my life. I spent the evening with God who reaffirmed the metaphysical lessons I learned.

I got to see firsthand that love was holding the universe together, that we were all connected, and witnessed other universal truths directly from source. The next morning, I was a different person. A miracle occurred in my life. I swore that day that I would do the right thing with my wealth and share the secret with as many people as I could. I realized that it wasn't the plant medicine alone but it was the combination of healthy food, metaphysical teachings, colonic cleanses, breathwork, meditation, yoga and plant medicine that brought around this miraculous change in my life.

So I teamed up with my friend Reverend Michael Beckwith, yoga teacher Shiva Rea, and raw food sensation Meg Pearson to start the world's first medically licensed naturopathic spiritual center and everything-included wellness resort that uses ceremonial plant medicines for therapeutic benefit.

I purchased a gorgeous luxury resort in beautiful Costa Rica where we collectively designed programs that produce miracles in people's life. Complete life transformations happen every day. Never has there been an establishment like this, where a person can check in and within a week has a new life.

I was then joined by the first of many in my co-creative team, Dr. Jeffrey McNairy and Brandee Alessandra. Dr. Jeff was one of my counselors for the six years during my deep struggle and could not believe the change in me. He was so impressed he dropped his lucrative California practice to move to Costa Rica and help bring this project to life. Brandee, the love of my life, and now wife, joined to help bring the vision to reality.

It was our goal to provide all of the things that were used to evoke my awakening in one all-inclusive experience. Meaning, you have access to all the things that took me years to find available to you in one week, in one location. We further guaranteed that we would provide these services for one low price. You check in and have no additional charges everything would be covered; spa visits, massage, plant medicine, doctor consultations, counseling, metaphysical classes, farm-to-table organic food, yoga, colonics and more. Visitors never have to spend an additional dollar, not one red cent.

Now miracles are happening every single day. More than 90% of the people who check out of the resort cry because they've had a true miracle in their life. Many are booking their next trip before they even leave the resort.

Come and visit me, I'm here every day, living my own dream and teaching a class called About Your Miracle, including an introduction to our plant medicine program to ensure your success. If you're unable to join me, you can learn more about my story and find tips on accessing your miracle through our Rythmic Breath Work in my first book, Sh\*t the Moon Said.

# ...AND A MIRACLE CURE



# Dr. Jeff McNairy, Psy.D., M.P.H. has been working in the health care field for 25 years.

He has worked in a variety of medical environments and has seen the struggle individuals have experienced when actually trying to heal. The current Western system of heath care is deficient in healing the population. It is more concerned with managing symptoms and using external sources for "change."

Through Dr. McNairy's intense experience with the most desperate patient populations (addition, acute mental health, and trauma), he has seen that the only real healing can come from within.

As the Chief Medical Officer of Rythmia Life Advancement Center, located in Guanacaste, Costa Rica, Jeff has committed himself to bridging ancient modalities with western psychology to heal guests.

# Plant Medicine Questions & Answers with Dr. Jeff McNairy, Psy.D., M.P.H.

# How is plant medicine different than the Western model for healing clients?

The Western medical model struggles to effectively heal people in relation to addiction, trauma, physical, and mental health conditions. Symptom management is not the answer to health. Finding the root cause of your unhappiness, health concern, and discontent, then resolving it is the only way to truly find peace. I often say, "One plant medicine session conducted in a safe environment that is clinically appropriate can be as effective as 10 years of psychotherapy."

### What do you do to ensure safety for guests?

During the resort booking process, we conduct a thorough medical questionnaire that addresses medication issues, health concerns, and chronic conditions. Once cleared to attend the Rythmia program, upon admission in Costa Rica, the medical team conducts a full evaluation to ensure that each guest is appropriate to participate in the plant medicine sessions. Every plant medicine session is medically supervised to guarantee safety and clinical appropriateness.

### How does the plant medicine help your clients?

Having worked at Rythmia since its inception, I have witnessed plant medicine successfully treat many health concerns including trauma, anxiety, and depression. It has effects on mood and thoughtfulness, and activates the frontal and paralimbic regions of the brain. Another interesting component is that it leads to better impulse control and increases long-term planning abilities.

### How do you help guests once they leave the resort?

We have an optional after-care program available to our guests so they may continue to be connected to the Rythmia community and our many offerings throughout the week. Further, I host a highly interactive webinar twice a month where former guests can share their experiences and ask questions about how to cope with their new-found clarity.









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# **Change: The Only Constant**

ongtime readers of *Counselor* will recognize that we are smaller, down from sixty-four pages to forty-eight pages. Let me assure you that this will not diminish the quality of content in our independent publication. While we may be thinner, we are committed to provide our loyal readers, in print and online, with content designed to enhance clinical experience and expertise.

In these days of widespread divisiveness, it is noteworthy that many articles in this issue emphasize the need to be inclusive in our approach to treating both behavioral and chemical addictions. We have come to understand, finally, that one size does not fit all.

The world of addiction, treatment, and recovery, and indeed the industry itself, is changing fast.

Dr. Tom Horvath, the founding president of SMART Recovery, points out (page 22) that the increased use of the "self-empowering approach," medication-assisted treatment (e.g., Suboxone for opiates), moderation and harm reduction, online mutual aid groups, and even online treatment are among today's most successful approaches.

In his comprehensive overview, Dr. Horvath acknowledges a role for professionals who take only one approach (e.g., a Twelve Step approach) "provided they refrain from the broader role of assessment, treatment planning, and referral."

In another important article on treatment professionals (page 32), Dr. Andrea G. Barthwell and Dr. Cherlyne Short Majors point out that the shortage of women in leadership is not unique to the behavioral health field, with less than 10 percent of women retained as CEOs.

Drs. Barthwell and Majors note that the health care industry is in a vulnerable state and ready to accept more women in top leadership positions: "The healer field needs more female talent in order to sustain the innovation, visibility, and quality of its services, as well as its financial success."

Additionally, in her article titled "Eating Disorders: Separating the Patient from the Disease" (page 28), Dr. Vicki Berkus points out that the comorbidity of substance abuse and eating disorders is common and requires a team approach based on a good understanding of eating disorders as well as substance abuse.

This issue's adaptation from the *Journal of Substance Abuse Treatment* features an article by Dr. Steven L. Proctor (page 38), who reports on a recent study on continuing care plan adherence after residential addiction treatment. Dr. Proctor writes that a well-thought-out aftercare program is essential for patients to aspire to positive long-term outcomes.

In our columns, we say "Happy Birthday" to the National Association for Children of Alcoholics (NACoA), now the National Association for Children of Addiction, which is celebrating its thirty-fifth anniversary. Few advocates have made more of a lasting impact than NACoA.

In this retrospective, Dr. Claudia Black, a founding member, writes, "As I look back, I realize this was an emerging time, a tipping point when young professionals were utilizing the strength of their own experiences of being raised with parental substance use disorders to give voice to the experience of those with whom they were working."

Thirty-five years later, NACoA continues to educate everyone from clergy to social workers and physicians. We owe a debt of gratitude to longtime CEO Sis Wenger, who continues to grace our pages with a regular column.

Turning to Pete Nielsen, the tireless leader of CCAPP and this issue's CCAPP column author, we get a better understanding of what it means to be "client-centered" and how to really "meet clients where they are." He points out it is near impossible to be "competent" in any culture, but it is possible to be "sensitive" to a culture that is not our own.

While we bid farewell, with much appreciation, to two of our long-standing columnists—Reverend Leo Booth (From Leo's Desk) and Sheri Laine (The Integrative Piece)—we forge ahead with our regular contributors: Dr. Dennis C. Daley (Topics in Behavioral Health), Gerald Shulman (Counselor Concerns), Dr. John Newport (Wellness), and Maxim W. Furek (Cultural Trends). And, if we left anything unanswered, you can always refer to Dr. Toni Galardi (Ask the LifeQuake Doctor).

From all of us to all of you, we wish you a happy and healthy year.



**Gary Seidler** 

Cylichy

Consulting Executive Editor Counselor, The Magazine for Addiction & Behavioral Health Professionals, A Health Communications, Inc. Publication



# The **Need** for **Cross-Cultural Counseling** in **Addiction Treatment**

Pete Nielsen, CADC-II

The new push for addiction counselors these days is to be client centered. This means a focus on compassion, collaboration, and especially meeting clients where they are, but what does that really mean? To meet clients where they are, should we have to understand their cultures? And if so, how do we do so? In this column, I will define culture, speak to the concept of "cultural sensitivity" versus "cultural competency," and demonstrate the importance of culture in the addiction counseling process.

Counselors are required to be respectful of clients of all cultures and backgrounds. Many people call this "cultural competence," though "competence" would mean that we fully understand everything about clients' positions or cultures. While it is likely impossible to be "competent" in any

culture, including our own, it is possible to be *sensitive* to a culture that is not ours.

### **Definitions**

Cultural differences exist in clients' socioeconomic status, racial or ethnic identification, gender, sexual orientation, physicality, cognitive ability, religion, and more. So what do we mean by "culture?" According to Alley Dog, an online psychological glossary,

Culture is the set of ideas, behaviors, attitudes, and traditions that exist within large groups of people (usually of a common religion, family, or something similar). These ideas, behaviors, traditions, etc. are passed on from one generation to the next and are typically resistant to change over time. Cultures vary widely not only across the world, but even right next door. For example, if you live in America and then visit different areas of Europe, you may notice that people often get closer to each other physically in

social settings—tables are often closer together at restaurants, people stand closer to each other when they speak, etc. These are examples of cultural differences ("Culture," n.d.).

Another definition, found on Merriam-Webster's website, defines culture in three different ways (n.d.):

- "The customary beliefs, customs, arts, etc., of a particular society, group, place or time"
- "A particular society that has its own beliefs, ways of life, art, etc."
- "A way of thinking, behaving or working that exists in a place or organization (such as a business)."

To delve into this concept a little deeper, let us look at the definition of multicultural counseling. Multicultural counseling is, according to Sue and Torino,

Both a helping role and process employing strategies and goals congruent with individuals' experiences and cultural values; recognizes persons' identities in individual, group, and universal dimensions; advocates using universal and culture-specific techniques and roles in the healing process (1994).

Counselors may use this definition interchangeably with "cross-cultural counseling," but perhaps a better definition of cross-cultural counseling is,

The pursuit and application of universal and indigenous theories, strategies (e.g., direct service, consultation, training, education, prevention), and research paradigms of counseling and mental health help seeking, grounded in an in-depth examination, understanding, and appreciation of the cultural and epistemological underpinnings of countries located worldwide (Altmaier & Hansen, 2011).

This leads to asking the following question: "Should someone's counselor be someone from that client's culture or can the counselor be someone who is culturally sensitive?" (Akutsu, Lin, & Zane, 1990). According to Akutsu et al., "It seems that the culturally responsive nature of the counselor is most important here, since empathetic involvement has

been demonstrated to be a key predictor of counselor credibility" (1990).

### **Families**

Any cross-cultural addiction counseling must also demonstrate a benefit for families as a whole. The role of each family member must be respected in counseling, and counseling should be conducted in accordance with the family and cultural values. For instance, it would be helpful to conduct sessions in an environment comfortable and familiar to the participants—a school or church might be a better choice than a treatment center or agency. Individuals should not be pushed to a level of participation with which they are not comfortable.

### **Communication**

Within the concept of culture there is a wide variety of identities, languages, and subcultures. Also, within each of these cultural aspects, differences in values, behaviors, and attitudes will vary based on the generation, acculturation, ethnic experiences, socioeconomic status, enculturation, gender, religion, region, age, sexual orientation, visibility, and history of discrimination. Many or all these factors can mold people's perspectives of themselves as well as influence how they view life. To provide more effective cross-cultural counseling, counselors must be aware of their

communication style, counseling style, and client expectations. Having and utilizing a large repertoire of verbal and nonverbal behaviors will be beneficial to this goal (Zhang & Dixon, 2001).

How addiction counselors speak to clients is as important as what counselors say in all counseling, and especially in cross-cultural counseling. Consider the following aspects:

- Tone of voice, (pleasant, with volume audible, but not too loud)
- Articulation of each word (important, especially with clients whose native language is not English)
- Checking with clients regarding rate of speech (i.e., not too slow or fast)
- Avoiding slang, technical jargon, and the use of ethnic communication styles that are not naturally a counselor's own

In some cultures, verbal communication may be more formal than it often is in the greater American culture. Counselors should not assume that a first-name basis is appropriate for all client relationships. Assume formality when in doubt, or ask clients how they prefer to be addressed. Too much chatting, too many questions or being "too nice" may cause clients to feel uneasy or suspicious. Beginning

Continued on page 43



### CCAPP is unifying the addiction field

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# **Happy Birthday, NACoA**

Claudia Black, PhD, MSW



NACoA's vision is a world in which no child who struggles because of family addiction will be left unsupported.

The Adverse Childhood Experience study (ACE) has been available for over twenty years. The research is clear. Without building protective factors in these young people's lives, their risk factors will dictate their lives, and we will continue to see the generational repetition of trauma and addiction.

We must continue to be the voice for these children. Our knowledge base needs to be systematically integrated into the education of all primary health care, mental health, and addiction professionals as well as our educational systems and faith communities. We all need to take responsibility where we can and collaborate within our communities as one.

Thank you, NACoA, for continuing to be the voice and advocate for our nation's most vulnerable young people.

hirty-five years ago, twenty young professionals in the fields of addiction, mental health, and education gathered in Santa Barbara to discuss their work with young and adult children from alcoholic families. From that gathering, the National Association for Children of Alcoholics (NACoA) became a reality. As I look back, I realize this was an emerging time, a tipping point when many young professionals were utilizing the strength of their own experiences of being raised with parental substance use disorders (SUDs) to give voice to the experiences of those with whom they were working. Few of us had any experience with building or running a nonprofit organization. Though Robert "Bob" Ackerman often called us "missionaries," more realistically, we were "passion-aries." We were not willing to sit in fear about what we did not know. We mobilized with trust and faith that the experiences of those affected by addiction in their families was more powerful than the shame of the disease. In many cases we just moved blindly forward.

There were so many firsts that were occurring. For me one of those was my work being written about in a full page article in *Newsweek* (May 1979) that acknowledged the phenomena of young and adult children. That article led to my appearing on The Phil Donahue Show—a nationally syndicated television show that preceded the Oprah Winfrey Show-with five young children between the ages of nine and twelve talking about their experiences in addicted families. Never before had this topic been aired on national television. From the mouths of babesfor sixty minutes they talked and shared personal artwork that depicted their lives. In the next few years books were written by many NACoA founders, including myself, Bob Ackerman, Sharon Wegscheider-Cruse, Cathleen Brooks Weiss, Timmen Cermak, Julie Bowden, Herb Gravitz, and others. While she was not a founder, Janet Woititz's book, Adult Children of Alcoholics, was also extremely critical to the adult child movement. In essence, a language was being developed, and a framework was being offered that helped people raised in such families begin to speak out and break the emotional isolation of shame, fear, and loneliness that was so pervasive in their lives.

While some of these professionals' work was focused on children still in the home, others focused on this group of people being named the "adult children." In my mind this term was meant to indicate people now of adult age who had been raised in alcoholic or other drug-addicted family systems. The birth of NACoA was a moment where we who had come together knew that collectively we could do so much more than as individuals.

A significant part of NACoA's early mission was about education, and for several years it offered conferences throughout the country. At the time, these conferences were moments of great validation and healing and also became the initial training ground for clinicians. Thirty-five years later, NACoA continues to educate everyone from clergy to social workers and physicians. It is a major advocacy organization on the part of young and adult children, with its name now the National Association for Children of Addiction, referring to those impacted by any addiction, not just alcoholism.

As the opioid crisis continues to climb, claiming more victims and leading to more deaths, our children are falling through the cracks.

There have been many gifts within this early movement. The work of NACoA created a foundation for the codependency field. We began recognizing the delayed responses, those behaviors that often did not show as problematic until people were out of their family systems. Today, with breakthroughs in neuroscience, we have a highly developed understanding of the science of trauma. However, it was the early work that empowered the masses.

By looking at addiction in the family, we could see the impact of physical and sexual violence and the resulting mood and anxiety disorders. We were recognizing the generational repetition that included the switching of addictions and process addictions. This helped to create a bridge between the addiction and mental health fields.

While we as professionals have grown in our understanding of the effects of addiction on young people, addiction continues to be rampant and children are still being hurt by the disruption it causes in families. There are between fifteen and eighteen million children whose daily lives are influenced by chronic inconsistency and unpredictability. They live with arguing and fighting and the

disappointment of parents being preoccupied elsewhere. With the current opioid epidemic, particularly the use of heroin, children are experiencing more neglect than ever before and face a far greater likelihood of death in the family.

Social media images of parents passed out in cars from drugs while their children are sitting in the back seats have gone viral. The online video of a two-year-old in a store trying to wake her mother who passed out from an overdose has been seen by millions. As more and more parents become addicted to opioids, thousands more children are being placed into foster care systems. Overdose deaths have surged and claimed more lives in 2015 than homicides by guns (AP, 2016). Children are witnessing overdoses and having to learn how to use Narcan to save the lives of parents or siblings. As the opioid crisis continues to climb, claiming more victims and leading to more deaths, our children are falling through the cracks. It is our children who are the hidden victims, unable to protect themselves from this drug use.

Jerry Moe, vice president of The Betty Ford Center and director of its national children's program, and Brian Maus, the program director of Camp Mariposa, with fifteen camps for children of addiction throughout the United States, both tell me how shocked these children are to meet other kids who have similar experiences. They truly feel totally alone. Sadly, what I wrote about in *It Will Never* 

*Happen to Me* in the early 1980s is still relevant. They have learned the three rules: do not feel, do not trust, and do not talk. They are scared, sad, angry, and so lonely. Many are already engaging in self-destructive behaviors such as cutting. Many show signs of depression, and are certainly anxious. It is our job to be there for them and offer resources that tap into their strengths, reinforce their worth and value, give them coping skills, assist them in problem solving, and possibly most important, teach them how to ask for help. Back in the 1970s, Margaret Cork of the Addiction Research Foundation in Toronto, Canada, eloquently referred to these youngsters as the "forgotten children" (1969). It is our job to see that is no longer true. ©

### **About the Author**

Claudia Black, PhD, MSW, is clinical architect of the Claudia Black Young Adult Center at The Meadows in Arizona. She has been a senior fellow and clinical consultant at The Meadows since 1998. Her seminal



work with children impacted by substance abuse in the late 1970s created the foundation for the adult child movement. Dr. Black is the author of over fifteen books and a trainer internationally recognized for her pioneering and contemporary work with family systems and addictive disorders. She sits on the advisory board for NACOA and the advisory council of the Moyer Foundation.

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# **Last Call for Alcohol**

Maxim W. Furek, MA, CADC, ICADC

It is cunning, baffling, and powerful. It is also cheap, accessible, and legal. Yes, alcohol wins the trifecta hands down. Alcohol is a formidable opponent and survivor, and has overcome the attacks of the Temperance movement and the thirteen-year-long stranglehold of Prohibition. It does not seem to be going away anytime soon.

As alcohol is heavily marketed and promoted, we witness its use and abuse on innumerable television programs and Hollywood films. Alcohol manufacturing and sales are a major industry worldwide today. US alcohol sales amount to about \$160 billion annually, and they rose by 20 percent in the 2010–2011 period during the faltering economy (Smith, 2011).

Research shows that alcohol in moderation may be beneficial to those who are not alcoholic or heavy drinkers. But there is

clearly more to the discussion and it is imperative to consider the dangers of this sedating substance that can quickly conquer and slowly kill. Alcohol is a dangerous, addictive substance that has destroyed countless lives. In this article, we will count the ways.

The data is troubling. According to the Centers for Disease Control and Prevention (CDC),

Excessive alcohol use is responsible for 88,000 deaths in the US each year. It also accounts for one of ten deaths among working-age adults and shortens the lives of those who die by an average of thirty years. Excessive drinking includes binge drinking, heavy drinking, and any alcohol use by pregnant women or anyone younger than age twenty-one. In 2010, excessive alcohol use cost the US economy \$249 billion, or \$2.05 per drink, and \$2.00 of every \$5.00 of these costs were paid by the public (2016).

### **New Research**

The evidence is clear. Technological advances in neuroimaging allow scientists to observe alcohol's effect on the brain and body with greater accuracy. A series of recent studies show that alcohol abuse does even more damage than was previously known. According to an article about the negative effects of alcohol,

New research published in Alcoholism: Clinical & Experimental Research shows that chronic alcohol abuse leads to thinning of the cerebral cortex, the region of the brain that supports highlevel thinking. Alcohol affects all areas of the brain, but most significantly the frontal and temporal lobes of the brain, which are responsible for learning new information and regulating impulses. This means that heavy drinking damages the parts of the brain that would help them overcome alcoholism. It's like drowning in the ocean and tearing up your life jacket ("More negative," 2011).

Excessive drinking causes lasting damage to your brain. According to the National Institute of Alcohol Abuse and Alcoholism (NIAAA), brain scans of heavy drinkers "reveal reduced white matter, which controls inhibitions," while multiple other studies "show chronic heavy drinking causes shrinking of the brain's frontal cortex—the home of higher-order thinking skills" (Shah, 2016).

# **Binge Drinking versus Heavy Drinking**

Heavy drinking and binge drinking have compounded the problem for decades. The NIAAA defines binge drinking "as a pattern of drinking that brings blood alcohol concentration (BAC) levels to 0.08 g/dL. This typically occurs after four drinks for women and five drinks for men—in about two hours" (n.d.).

Heavy drinking is a slow downward spiral of self-destruction. For men, heavy drinking is typically defined as consuming fifteen drinks or more per week. For women, heavy drinking is typically defined as consuming eight drinks or more per week (CDC, 2017).

### **Alcohol Poisoning**

Acute intoxication from ingesting large amounts of alcohol is a leading cause of death in the US and remains a common practice across American college campuses. A survey by the Harvard School of Public Health determined alcohol consumption is responsible for 1,700 deaths and 600,000 injuries every year among college students (Wechsler

& Nelson, 2008). An additional report from the Centers for Disease Control and Prevention (CDC) reveals that alcohol poisoning kills an average of six people per day and that a total of 2,200 Americans die from alcohol poisoning each year (Leonard, 2015).

An unfortunate example was the case of eighteen-year-old Kimberly Ostien, who died in her dorm room in Aston, Pennsylvania. The Neumann College freshman had consumed twenty to twenty-four shots of citrus vodka within a three- to four-hour period. She died of alcohol poisoning and was pronounced dead at the hospital on November 25, 2003 ("Kim's awareness," 2010).

Kim's Awareness Cards, provided by the Foundation, "give clear directions on how to tell if someone may have alcohol poisoning and what to do in that situation" ("Kim's awareness," 2010). The cards are recommended as gifts for young adults turning twenty-one years old or students entering college.

### **Sexual Assault**

Since then the issue has been repeatedly addressed, but remains persistently unresolved. The incidence of binge drinking on American campuses, often underreported, is rampant and continues unabated decade after decade. Binge drinking—often accompanied with blackouts, violence, and sexual assault—affects both the individual and the surrounding campus community.

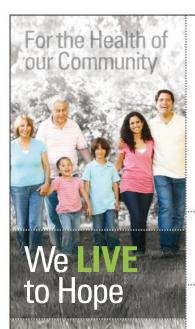
On June 23, 2013, four former Vanderbilt University football players were accused of dorm-room sexual assault, aggravated rape, and aggravated battery ("Vanderbilt rape," 2016). While several individuals looked on, an unconscious woman was raped. The accused included Cory Batey, Brandon Vandenburg, Brandon Banks, and Jaborian McKenzie. Shockingly, the defense attempted to use prevailing campus culture as a defense.

According to an article in the *Chicago Tribune*, "Neuropsychologist James Walker testified... that wide receiver Cory Batey told him he had between fourteen to twenty-two drinks before the players dragged the incapacitated woman into star recruit Brandon Vandenburg's dorm room" ("In Vanderbilt," 2015). He stated, "Yes, at that age peer pressure is critical because you're just going out on your own, you're not fully an adult, you're not fully a child... You tend to take on the behavior of people around you" ("In Vanderbilt," 2015).

Ultimately, that defensive argument did not work. On July 14, 2016, Batey received the minimum prison term of fifteen years in a Tennessee prison and a lifetime on the sex offender registry. According to the *Tennessean*,

Vandenburg is sentenced to seventeen years in prison, two years longer than the minimum term allowed by law. The victim, who was dating Vandenburg at

Continued on page 18



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# **Survey Says: How Listening to Client Feedback Improves Clinical Care**

Ruchi Dhami, MA

s consumers, we live in a constant state of infor-Amation overload. Just try to order a product off Amazon and that point becomes very clear; suddenly there are thousands of options at your fingertips, all of which are seemingly very similar. It can be overwhelming to make a decision on something as

simple as the best coffee maker, much less addiction treatment.

With more than fourteen thousand residential treatment centers across the US to evaluate (Goldsmith, 2017), how do consumers go about making their decisions? Most may think this is a job for the marketing department, but truth be told, a positive, well-respected reputation that attracts potential clients actually begins with the quality of care.

There is no better way to learn if your facility and its clinical care are in good health than by maintaining a close pulse on client feedback. One of the simplest ways to do this is through posttreatment surveys, a tactic that can be implemented by centers of any size. What is often most surprising is that even though clinical care and operations might seem like two separate entities, they contribute to the overall ex-

If you are thinking about implementing posttreatment surveys, here are some things you will want to keep in mind.

**Timing is Everything** 

perience for consumers.

If people have a bad restaurant experience, they are more likely to write a negative review. On the contrary, even if everything went flawlessly, those people are less likely to write a review if too much time passes. As a drug rehab center, if you wait too long to ask for feedback, people may forget what made their experience positive or not complete it at all. By capturing feedback during treatment discharge, you will obtain a higher response rate and more accurate evaluations. This ensures a streamlined and consistent system. Plus, it will fit right into an already existing process.

**A Holistic Approach is Most Telling** 

At first it might seem extraneous to consider client feedback about areas outside the clinical program. But if you look through the eyes of the clients, you can see how other areas matter. Their experiences with each facet of the facility illustrates their level of satisfaction. Think holistically about operations and clinical care as you outline

survey questions. This will shed light on how to better prepare clients for recovery.

Here is how insight about operations are connected to care:

The environment and community of a facility provides a safe zone for clients. If clients feel comfortable within the confines of the space, they will be more open to engaging in therapy and receiving treatment.

Internal communication among all staff members plays a large role in clients' experiences. If clients need to repeat their stories over and over during each discussion due to a lack of internal communication, they might become

frustrated and stop speaking freely with staff.

■ Meals (especially breakfast) and a good night's sleep are the foundation for having a great day. However, an unsatisfying meal (no matter the time of day) or an uncomfortable bed can make clients moody and frustrated, which can reflect in therapy and their willingness to participate.

### Assorted Questions Lead to Actionable Items

Each question should serve a purpose based on what a facility wants to learn and improve. The first rule of thumb is to create concise and limited questions. Second, ensure that the questions incite a variety of feedback that is both measurable (quantitative) and open-ended (qualitative) to capture a holistic outlook.

By capturing feedback during treatment discharge, you will obtain a higher response rate and more accurate evaluations.

Quantitative feedback allows for easy comparison and aggregation of responses. Most of the time these type of questions are structured using a rating system, such as a Likert scale or multiple choice. You might ask about the frequency clients saw

their therapists, how long they waited to be seen, how easy it was to get in touch with staff, and/or how clear clinicians were about therapy.

Qualitative feedback provides a deeper look into clients' personal experiences by asking open-ended questions. Certain aspects of treatment are best suited for these types of questions, such as comments and suggestions for staff members, or a further explanation of their favorite aspect of treatment. Just remember not to look too narrowly on these responses, but more high-level to see if there are trends.

### **Aggregate Your Data**

It is easy to get caught up on one bad survey response. Even so, it is important not to get too granular when analyzing your facility data. Trends are actually more telling than individual responses, so categorizing each question's answers together shows where there is a divide and consensus in opinions. Additionally, you can identify what items need to be prioritized based on these trends. You might be surprised what you will learn. Maybe you will find out the majority of respondents

thought it was easy to reach a therapist or the beds were more comfortable than they hoped, which uplifted their mood and willingness to participate in therapy.

At the end of the day, it is always ideal when you have the budget to hire a team of researchers that can help create, disseminate, and analyze a survey and its data properly. But do not let that stop you from taking action now. Client feedback is well within your reach and will be invaluable for any facility at any stage of growth. •

### **About the Author**

Ruchi Dhami, MA, is the director of market research and development at Recovery Brands, where she oversees the development and implementation of research investigations to aid in the decision-making process of those seeking addiction treatment. She is an

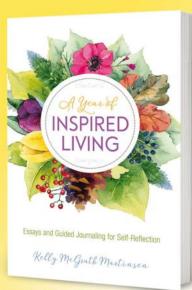


expert in quantitative methodologies, with extensive experience in utilizing survey tools to develop products and programs to increase efficiency. Dhami also authored several peer-reviewed publications, including a public call to action for the development of vital multimetric outcomes measurements to improve the quality of care in the addiction industry.

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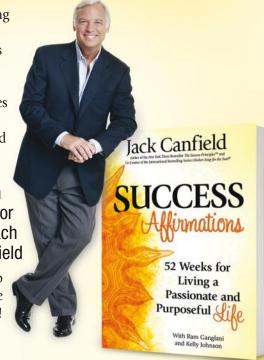
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# **Embracing** the **Quality** of **Patience**, Part II

John Newport, PhD

This is the final installment in a two-column series focusing on embracing the quality of patience in enhancing both the successfulness and overall quality of recovery from alcoholism and/or drug addiction. The initial installment expounded on the quality of patience and its ramifications in promoting a more indepth experience of recovery, while attaining higher levels of both physical and mental-emotional health and well-being. This final installment focuses on identifying and discussing a variety of practical steps both you and your clients can take to more fully integrate the quality of patience into your lives.

Here are some items I have found particularly helpful in cultivating the quality of patience in my own life.

### **Deepen Our Relationship with Our Higher Power**

This was powerfully driven home to me thirteen years ago when I retired from my day job. Losing the sense of identity, social supports, and grounding I derived from my employment—coupled with moving 1,200 miles from Southern California, which had been my home for the past thirty-five years—left me unexpectedly feeling adrift and ungrounded. At that point I had no choice but to get down on my knees each day and fervently pray for guidance and the fortitude to carry on. I also learned to lay down for several minutes when I felt particularly off balance, and listen to that still, small voice within. I also resumed going to church, a practice I had let fall by the wayside for decades, and began a serious reevaluation of the spiritual side of my life.

In times of trouble we may turn to our higher power for comfort and security. However, when things start getting better we have a tendency to go back to business as usual, while neglecting to seek day-to-day guidance from a higher realm. In doing so we deprive ourselves of the comfort, serenity, and ongoing growth that power is eager to bestow upon us, provided that we are willing to take the time to truly listen.

### **Practice the Serenity Prayer**

I carry a card reciting the serenity prayer in my wallet, which I constantly refer to. In my opinion this is the most powerful stress management tool ever invented.

# Take a Long-Range Perspective on Time

In today's fast-paced world it is all too easy to get caught up in frantically trying to do a million and one things all at once. That was particularly true of me during the half of my life I spent in Southern California. Allowing ourselves to be seduced by that mindset is the antithesis of patience.

Shortly after moving to California from the Midwest, I began practicing a popular form of meditation. I have found this immensely helpful in calming my restless mind and have continued that practice over the past forty years.

Taking a long-range perspective on time requires us to step aside and view the present moment within the context of our entire life span. It also helps to cultivate a true appreciation of the meaning of divine order in our lives.

As I type these words, I am reminded of the haunting lyrics of two songs from the 1970s that convey to me a deeper understanding of what taking a long-range perspective on time is truly all about. The first is "Fly Like an Eagle" by the Steve Miller Band, which begins with the refrain "time keeps on slipping, slipping, slipping into the future" (1976). The second is a two-track 1970 rendition of "Nights in White Satin" by Eric Burdon and War, originally by the The Moody Blues. Despite the turbulent tone of much of the first track, which to me has nothing to do with "Nights in White Satin," the track ends with a truly haunting soliloquy based on the theme "I live in an ocean of time" (1967).

Along these lines, the following analogy provides an image I like to turn to when I am obsessing over all the things I believe I need to do *right now*. Imagine observing a postal clerk facing a very long line of customers, as he calmly focuses

on the *one customer* he is currently assisting, patiently dealing with each person in line, one customer at a time.

### **Keep Breathing**

Throughout the ages, breath has been equated with spirit or life. The calming effect of deep breathing is a folk remedy that has stood the test of time (Axinia, 2008; MacKinnon, 2016). We all have been admonished many times to take a deep breath when we are stressed out.

In the context of the overwhelmingly fast-paced times in which we live, it behooves us to consciously take time out throughout the day to "smell the roses."

A recent article on *Time* magazine's website claims that deep breathing is the fastest way to calm down, and discusses findings that shed light on how deep breathing can indeed induce a profound sensation of calmness and tranquility (Park, 2017). Briefly stated, research conducted at Stanford has discovered that "a group of nerves in the brain that regulates breathing has a direct connection to the arousal center of the brain" (Park, 2017). Quoting from lead researcher, Mark Krasnow, "This liaison to the rest of the brain means that if we can slow breathing down...these neurons then don't signal the arousal center . . . So you can calm your breathing and also calm your mind" (Park, 2017).

I have been aware of the calming effects of deep breathing for many years, and attempt to engage in deep breathing whenever my anxiety or irritability is getting the best of me. The following is one of my favorite deep breathing exercises, which I learned from the integrative medicine guru Dr. Andrew Weil a few years back: Slowly breathe in through your nostrils to the count of four, hold the breath to the count of five, and slowly exhale through the mouth to the count of six. Repeat this exercise four or more times. I have discovered that when I take the time

to do this exercise when I am deeply stressed, I invariably experience a noticeable calming effect.

### **Practice Mindfulness**

In essence, mindfulness entails living fully in the present and savoring the pleasurable aspects of whatever we are doing right now. For example, as I type these words I am aware of my dog resting peacefully by my side and the awesome view out the window of Tucson's Catalina Mountains. Fully focusing on this here-and-now experience, I feel profoundly relaxed as I look forward to whatever lies before me.

Some of the more popular means of cultivating mindfulness include meditation, yoga, and other forms of moving meditation, together with consciously reminding ourselves throughout the day to simply *be here now.* In the context of the overwhelmingly fast-paced times in which we live, it behooves us to consciously take time out throughout the day to "smell the roses."

I hope the above pointers will inspire both you and your clients to make a conscious effort to cultivate the quality of patience. After all, we have the rest of our lives ahead of us, so why not slow down a bit and enjoy the journey? Until next time—to your health!

### About the Author

John Newport, PhD, is an addiction specialist, writer, and speaker living in Tucson, Arizona. He is author of *The Wellness-Recovery Connection: Charting Your Pathway to Optimal Health While Recovering from Alcoholism and Drug Addiction*, You may visit his website.

Addiction. You may visit his website www.wellnessandrecovery.com for information on wellness and recovery trainings, wellness coaching by telephone, and program consultation services that he is available to provide.

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# **Prescription Drug Misuse** and **Addiction,** Part I: An **Overview** of the **Problem**

Dennis C. Daley, PhD

This first article discusses the problem of prescription drug misuse and addiction. It reviews signs and symptoms, reasons for using these drugs, and their effects on drug users and their families. The next article will discuss treatment and recovery for individuals and family members affected by the more serious problem of prescription drug addiction.

Many of us have a family member, friend or colleague who misuses or is addicted to prescription opioids, sedatives, tranquilizers or stimulants. This represents a serious public health problem due to the prevalence of this issue, especially among young adults ages eighteen to twenty-five, older adults (who often use multiple medications including those with addictive potential), and girls between twelve to seventeen years old (NIDA, 2016). Youth who misuse prescription drugs also have higher rates of cigarette smoking and heavy and episodic alcohol use, marijuana, cocaine, and other illicit drug use (NIDA, 2016). They are also at increased risk for injury (Wunsch, Gonzalez, Hopper, McMasters, & Boyd, 2014).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 119 million people in the US used these psychotherapeutic drugs in 2015, representing 44.5 percent of the population ages twelve or older (SAMHSA, 2016, 2017). The most common of these drugs included

■ Pain relievers such as hydrocodone, oxycodone, morphine, fentanyl, and other related opioid products (97.5 million)

- Tranquilizers, also referred to as CNS depressants, such as benzodiazepines and barbiturates used for anxiety and muscle relaxants (39.3 million)
- Sedatives used for sleep problems (18.6 million)
- Stimulants such as amphetamine products used for attention deficit disorder or anorectics used for weight loss (17.2 million)

Nearly nineteen million people misused these drugs in 2015, and two million developed an addiction (SAMHSA, 2017). Some of these individuals also have problems with other drugs or alcohol. A small yet significant number transfer their prescription opioid drug addiction to cheaper and illicit drugs like heroin or fentanyl, which is over fifty times more potent than morphine and potentially deadly (Compton, Jones, & Baldwin, 2016; Rudd, Seth, David, & Scholl, 2016). Heroin users are nearly four times as likely to report nonmedical use of opioids and nearly three times as likely to report an opioid use disorder compared to persons who did not use heroin (Compton et al., 2016).

### **Signs of Prescription Drug Misuse and Addiction**

A common form of drug misuse is the intentional or unintentional use of one of these medications not prescribed to the user. Over half of the people who misuse or become addicted to prescription drugs receive, borrow, buy or steal these drugs from family or friends.

Other signs of misuse include taking more medications than prescribed, getting prescriptions from more than one physician, doctor shopping, exaggerating or lying to the prescriber about symptoms, claiming the prescription was lost or stolen, and mixing alcohol or other medications with these drugs, which increases the risk of negative effects. For example, 46 to 71 percent of patients receiving medication-assisted therapy (MAT) for opioid addiction use benzodiazepines (Douaihy & Daley, 2013).



reduced or stopped. The other physical sign of addiction is an increase in tolerance to the drug where more is needed to achieve the desired effect. Although some of these medications are initially intended for brief periods of use, many people use them for lengthy periods of time, develop a physical dependence, and suffer withdrawal if they do not gradually taper off of them.

Compulsion or a strong desire or craving to use drugs despite their negative effects is the hallmark of addiction. Related to this is obsession, or an intense mental focus on getting the drug. Drugs become far too important and may become the central focus of the patients' lives. Other signs of addiction include being unable to stop once drugs are taken, using greater quantities than intended, strong cravings for the drug or continuing drug use despite medical, psychological, family, or other problems that are caused or worsened by use.

Once addicted, the feelings caused by drugs in the brain may become more important than food, sex, work, relationships, or accomplishments. What happens is that addiction "hijacks" the brain and leads to an increase in the amount of release of certain brain chemicals, which produce euphoria. Drugs affect areas of the brain that control judgement, memory, decision making, self-control, and pleasure. This is why most people with addiction do not accept they have a problem or believe they need help. It also helps to explain why some addicted people do anything to get drugs, regardless of the negative consequences or risks they take.

### Reasons for Using Prescription Drugs

According to SAMHSA, the most common reasons for misuse of these prescription drugs are to relieve pain (62.3 percent), feel good or get high (12.9 percent), relax or relieve tension (10.8 percent), help with emotions (3.9 percent), or help with sleep (3.3 percent; SAMHSA, 2016). Over half of the individuals who misused these medications were given, bought, or stole these drugs from a friend or relative. Only 36.8 percent got these from prescriptions from one or more physicians or dentists, and fraudulent prescriptions are sometimes used to get these drugs (SAMHSA, 2016).

# **Effects of Prescription Drug Misuse or Addiction**

The effects depend on the amount and types of drugs used, methods of use, and behavior and overall health of the drug user. Increases in prescription drug misuse in the past fifteen years has led to a significant increase in emergency room visits, unintentional deaths from drug overdoses (especially opioids with or without benzodiazepines), and admissions to treatment programs for drug addiction (Compton et al., 2016). Over half of emergency room visits for nonmedical use of these prescription drugs involved multiple drug use (Soyka, 2017).

Addiction is associated with a multiplicity of adverse medical, psychological, family, social, financial, legal, and spiritual problems for drug users (Douaihy & Daley, 2013). For example, use of benzodiazepines increases the risk of traffic accidents, falls, and fractures (Soyka, 2017). In addition, families and significant others are often harmed (Daley & Miller, 2001; Daley, 2017b).

Medical and dental health may also be neglected as addiction progresses. Intravenous drug use and risky sexual behaviors increase the risk of acquiring or transmitting HIV, hepatitis B or C, and/or STDs. Many other medical conditions can be caused or worsened by drug addiction. Furthermore, there is a risk of drug overdose, especially when opioids are combined with tranquilizers or sedatives. As a result of high rates of drug misuse and addiction, deaths from overdose have increased significantly in the past decade with over 59,000 in the US in 2016 (CDC, 2017). People who die from overdoses leave behind family members, including children and others who often suffer from their loss (Daley, 2017a).

In addition, there are high rates of psychiatric comorbidity associated with drug addiction, especially mood and personality disorders (Douaihy & Daley, 2013). Any other area of functioning can be harmed, including work or school, financial status, legal status, or spirituality.

### **The Impact on Family Members**

The problems drug misuse or addiction causes in families depends on the severity of the drug problem, the behavior of the affected people, the presence of other significant medical or psychiatric

problems, and the coping mechanisms and support available to family members. Not all families or members in the same family are affected similarly.

Drug problems often cause mistrust, worry, anxiety, fear, and anger among family members (Daley & Miller, 2001; Daley, 2017b). Family members may feel frustrated if they are unable to get their addicted loved ones to see their problem or get help for it. They worry their loved ones could overdose or experience other bad outcomes.

Addiction problems in families contribute to higher rates of separation, divorce, abuse or neglect, children being sent to foster care, financial problems, and physical or mental health problems of family members. Some become so depressed and anxious that they need psychiatric help for themselves.

Children of parents with a drug addiction are at increased risk for substance use, medical, psychological, academic, behavioral, or substance use disorders (Daley & Miller, 2001). Infants born to mothers addicted to opioids are at increased risk for neonatal abstinence syndrome (NAS; McQueen & Murphy-Oikonen, 2016). Over half of opioid-exposed babies experience NAS symptoms within three days of birth. NAS symptoms in infants include blotchy skin, difficulty sleeping and eating, diarrhea, sweating, hyperactive reflects, and being difficult to soothe.

Recent years have seen an increase in children of addicted parents placed with relatives or in foster care (NCSACW, 2017). I am aware of grandparents taking care of grandchildren because a single parent is or both parents are in active addiction and unable to provide adequate care. While grandparents would do anything for these children, those who are not retired did not envision taking care of infants or young kids during their retirement years.

It is clear that prescription drug misuse and addiction (and other substance problems) cause or worsen problems in any area of functioning. In addition, family members and significant others are affected in many ways.

The next article will focus on treatment and recovery for individuals with a drug problem and for their families. The good news is that there are many sources of

### **TOPICS IN BEHAVIORAL HEALTH CARE**

medical and psychological help for individuals and families from professionals and mutual support programs that address prescription drug addiction and other SUDs. •

### **About the Author**

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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# Cultural Trends Continued from page 11

the time of the rape, asked for the longest sentence, which would have been twenty-five years. Judge Monte Watkins said although Vandenburg seemed remorseful for this actions, Vandenburg betrayed the victim's trust and that warranted the longer sentence. Prosecutors say they'll begin plea discussions with the remaining two defendants: Jaborian "Tip" McKenzie and Brandon E. Banks ("Vanderbilt rape," 2016).

Although there is much data about binge drinking on college campuses, this trend is quite prevalent in mainstream society as well. Deaths from alcohol poisoning are highest among middle-age men and not among college students, whom we typically associate with binge drinking, and "more than thirty-eight million US adults report binge drinking an average of four times per month and consume an average of eight drinks per binge" (Leonard, 2015).

With today's medical information and scientific, evidence-based data, there should be few individuals unaware of the risks. Still, the seduction call of excessive drinking continues.

Spring break, happy hour, two-for-one, Jell-O shots, ladies' night, beer pong, mud in your eye, last call. Alcohol espouses

an artistic license and chorus of seductive poetry all its own. It sings out in every dingy bar and upscale club, in every big city and small town.

But there is nothing poetic about the long-term consequences of alcohol abuse, including brain damage and various forms of cancer. Some of the damage can be reversed with sobriety, while other changes appear to be permanent. Early treatment and a commitment to sobriety can have positive effects on the body, brain, and emotional well-being. Help is available for those who seek it, but regrettably, for some, it could be their last call. •

### **About the Author**

Maxim W. Furek, MA, CADC, ICADC, is an avid researcher and lecturer on contemporary drug trends. His rich background includes aspects of psychology, addictions, mental health, and music journal-



ism. His latest book, *Sheppton: The Myth, Miracle, & Music*, explores the psychological trauma of being trapped underground and is available at Amazon.com.

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# Some Thoughts about Drug Testing

Gerald Shulman, MA, MAC, FACATA 



When speaking with substance use disorder (SUD) counselors, the topic of drug testing often elicits mixed reactions. On the one hand, counselors may sometimes view it when used by others as punitive (e.g., concluding an employment application process; termination of employment as a result of a positive UDS; violation of conditions of probation or parole). On the other hand, it may be viewed as a therapeutic tool used to help people achieve recovery from addiction or in pain management (Jarvis et al., 2017).

### **Effectively Utilizing Drug Tests**

Drug testing can provide clinicians with an important tool. Part of the initial assessment of patients being evaluated involves discussions of different drugs used, for needs of detoxification and to assess for a diagnosis of opioid use as in methadone clinics.

Addiction treatment providers should utilize drug testing "to explore denial, motivation, and actual substance use behaviors" with patients (ASAM, 2017). If drug testing results contradict self-reports of use, this provides the opportunity for therapeutic discussions to take place. Providers should present drug testing to patients as a way of providing motivation and reinforcement for abstinence and should educate patients as to the value of drug testing to them. To the extent possible, persuade patients that drug testing is therapeutic, rather than punitive to avoid an "us versus them" mentality. If patients refuse a drug test, the refusal itself should be an area of focus in their treatment plan (ASAM, 2017).

including urine drug screening (UDS), which is the most common but the most prone to sample tampering through "dilution, substitution, or adulteration" (ASAM, 2017). There is also blood or saliva testing, or even breathalyzer tests, historically used for alcohol only, but "police might soon be able to detect more than just alcohol on their breathing test devices. A new Swedish-designed device can detect twelve different controlled substances, including methamphetamine, cocaine, heroin, morphine, and marijuana" (Koebler, 2013; Beck, Stephanson, Sandqvist, & Franck, 2013). Some testing methods are more invasive than others. For most substances, including alcohol, the window of detection is usually short. One exception is the testing of hair, which can identify drug use in up to the last three months. However, a drawback is that it will not detect the substance for a least seven days after use occurs, as the hair has to have the opportunity to grow. In addition, heavily chemically treated hair is

One area where the differing views is most apparent is in situations of criminal justice referrals to addiction treatment. The conflict is easily explainable: for the criminal justice system, the desired outcome is public safety, while for clinicians, it is recovery. This conflict is resolvable when considering that a positive outcome to a SUD is likely to reduce or eliminate the criminal behavior.

not appropriate for drug testing (Beck et al., 2013).

### The Value of Drug Testing

To be the master of the obvious, "alcoholics drink" and "drug addicts use drugs," and while this does occur, it does not make use acceptable during treatment. When viewed as a therapeutic tool, drug testing informs us about patient progress. When patients use during treatment, the message is that this is something inconsistent with their treatment progress and the response should be—I say "should" because there are treatment programs whose immediate response is administrative discharge—to revisit and revise the treatment plan. How do these administrative discharges for illicit use differ from discharging patients being treated for COPD for coughing, or discharging those who are being treated for psychosis for hallucinating? However, should substance use continue to occur during treatment, it is incumbent on clinicians to ask themselves whether patients are receiving the needed clinical services and/or the clinically appropriate level of care. Also, in terms of language we need to replace the terms for UDS results of "clean" or "dirty" with "positive" and "negative" to reduce stigma.

### **COUNSELOR CONCERNS**

The value of UDS as a treatment tool may be best illustrated by the success of physician health programs (PHP). In these programs, and in treatment in general, UDS works best when it is random. The use of UDS and/or breathalyzers is even more important in outpatient treatment or residential treatment services in which individuals spend time outside of the residence for part of the day (e.g., halfway houses). Explaining the rationale for drug testing to patients provides us with the opportunity to describe the power of addiction. Testing for illicit or nonprescribed substances not only measures patients' progress, but for many patients the threat of discovery adds to their motivation to remain abstinent.

### What Should We Test For?

UDS comes in different panels—for the number of different drugs or drug classes assessed—and generally more is better, but also more expensive and may have to be balanced by cost considerations. I once hired a physician as my program's medical director—oddly a heroin addict, and odd because of physicians' access to legal narcotics-who had successfully completed a five-year PHP in another state. When he came to us, he volunteered to enter our state's PHP and continue to be subject to random drug screening. After a while, the nurses began noting that when he was contacted in the middle of the night about patient issues, he seemed drug-affected, even though his UDS was always negative. What we eventually learned was that he was drinking heavily overnight, and because his drug of choice was heroin, the program never tested him for alcohol use. According to ASAM,

As a general principle, drug testing should be scheduled more frequently at the beginning of treatment.... As the patient becomes more stable in recovery, the frequency of drug testing should be decreased, but performed at least on a monthly basis. Individual consideration may be given for less frequent testing if a patient is in stable recovery (2017).

### **UDS Abuse and Other Concerns**

Some programs abused UDS by testing every patient, every day, and billing insurance for the procedures. These

programs were generating more revenue from the drug testing than from the treatment there were providing. The National Health Care Anti-Fraud Association (NHCAA) indicates that the majority of health care fraud is committed by a small minority of dishonest health care providers. Fraudulent providers take advantage of the confidence entrusted to them by their patients. The actions of these providers destroy the reputation of perhaps the most trusted and respected programs and physicians in our society.

For example,

The audit on MassHealth [the Medicaid Program in Massachusetts] generated the following findings: MassHealth paid for drug tests allocated to members on a daily basis for extended periods, sometimes surpassing a year. This process deviated from the guidelines recommended by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), and those of other substance abuse treatment professionals. It was found that MassHealth could have saved approximately \$7.8 million if the state's policies and procedures were adhered to (Walton, 2015).

Medicare wants to reduce the frequent use of confirmation tests by labs that charge for follow-up tests when initial tests show no sign of an illegal substance. Medicare says that some confirmation tests are not medically necessary and inflate charges for taxpayers who support Medicare.

Other issues can be associated with drug testing. An inpatient addiction treatment program which both drug tested its patients and did random searches had a policy that if patients were found to be "holding" (i.e., in possession of illicit drugs), those people were discharged on the first offense. However, the policy stipulated that patients could have two positive UDS results before being administratively discharged. When the news went throughout the facility that a search was in process, patients who had drugs in their possession, but had not previously had a positive UDS result, used the drugs they had. There may be a message in this about unintended consequences of certain policies.

Here is another dilemma. The DSM-5 states that remission requires that patients meet none of the eleven diagnostic criteria

for a SUD for a year with the possible exception of craving (APA, 2013). The DSM-5 further maintains that there are three different severities of the disorder: mild, moderate, and severe. While it is clear that those with a severe SUD are addicted (i.e., have compulsion, loss of control, and continued use in spite of adverse consequences and craving), we cannot consider those in the mild category as addicted (i.e., diagnosed with abuse in the DSM-4). These folks may be in an environment which fosters abusive use (e.g., college or the military) and after leaving that environment, the continued problematic use, enough to be diagnosable, stops. There are also those individuals who often resort to the use of substances to cope with difficult or overwhelming situations. However, if they develop the necessary coping skills and/or the situation changes for the better, they may continue to use without problems but still have positive breathalyzer or UDS results if tested. What is the clinically appropriate response to individuals who have a positive breathalyzer or UDS who have been previously diagnosed with some SUD of mild severity? •

### **About the Author**

Gerald Shulman, MA, MAC, FACATA, is a clinical psychologist and fellow of the American College of Addiction Treatment Administrators. He has been providing treatment or clinically or administratively supervising the delivery of care to alcoholics and drug addicts since 1962.



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# **Ask** the **LifeQuake Doctor**

Toni Galardi, PhD

### Dear Dr. Galardi.

I'm a forty-two-year old female executive working with a Fortune 500 company. In the last year, with the help of my doctor, I've lost 130 pounds. I have about forty pounds left to go. Recently I started to plateau in my weight loss and started eating more. Although I'm Caucasian, my boyfriend is black and I met him when I was 320 pounds. A few weeks ago, he told me he didn't want me to lose any more weight and in fact, liked me better when I was fat. I should also tell you that I found pictures in his e-mail of women he was conversing with who are slender.

He is of normal weight and has a cocaine habit. I went to Overeaters Anonymous (OA), but I couldn't really relate to the people there, so I quit. I do acknowledge that I haven't addressed my emotional relationship with food. I think my case is complicated because there are so many parts to it. I was sexually molested by my father when I was thirteen years old. He's a billionaire and I rely on him for business advice. He hates my boyfriend.

My father paid for me to be in a residential treatment program for eating disorders, but I never told my therapist there that I'd been sexually molested by my dad out of fear that if they confronted him he'd withdraw his counsel and emotional support. I don't rely on him financially.

My question is this: I feel torn that if I keep losing weight, I'll lose my boyfriend. I'm curious as to what you think I should do to convince him that I won't leave him if I get thin. I want him to accept this new me that is emerging.

Please help.

- **Georgia** (fictitious name)

### Dear "Georgia,"

You are right, there are a number of issues here. You are triangulating with your father and boyfriend for starters. Firstly, my guess is that if your father hates your boyfriend, and you have unfinished business with him from your childhood, that

you are unconsciously, passive aggressively getting your power back by "giving the finger" to your dad. Secondly, your boyfriend is maintaining power by threatening to withdraw love as you allow the physical armor to come off. And thirdly, you are enabling your boyfriend by not confronting him on his inappropriate communications with other women and the lie he has perpetrated around his perferred body type.

I would recommend you return to the Twelve Step world, but instead of OA, that you go to both Al-Anon and Sex and Love Addicts Anonymous (SLAA). You may resonate with both or only one of these programs. Many people are in more than one Twelve Step program simultaneously. Al-Anon will give you some skills for discontinuing the enabling behavior of addicts, and SLAA will give you tools in dealing with your addiction to a relationship with a person who creates chaos and emotional unbalancing in your life. I suggest you get a sponsor who can help you monitor your thinking while you work the Steps of the program.

Another tool I would offer is that given how much physical armor you have been carrying, it is time to begin to feel your emotions in your body fully. Twice a day, at the beginning and end of

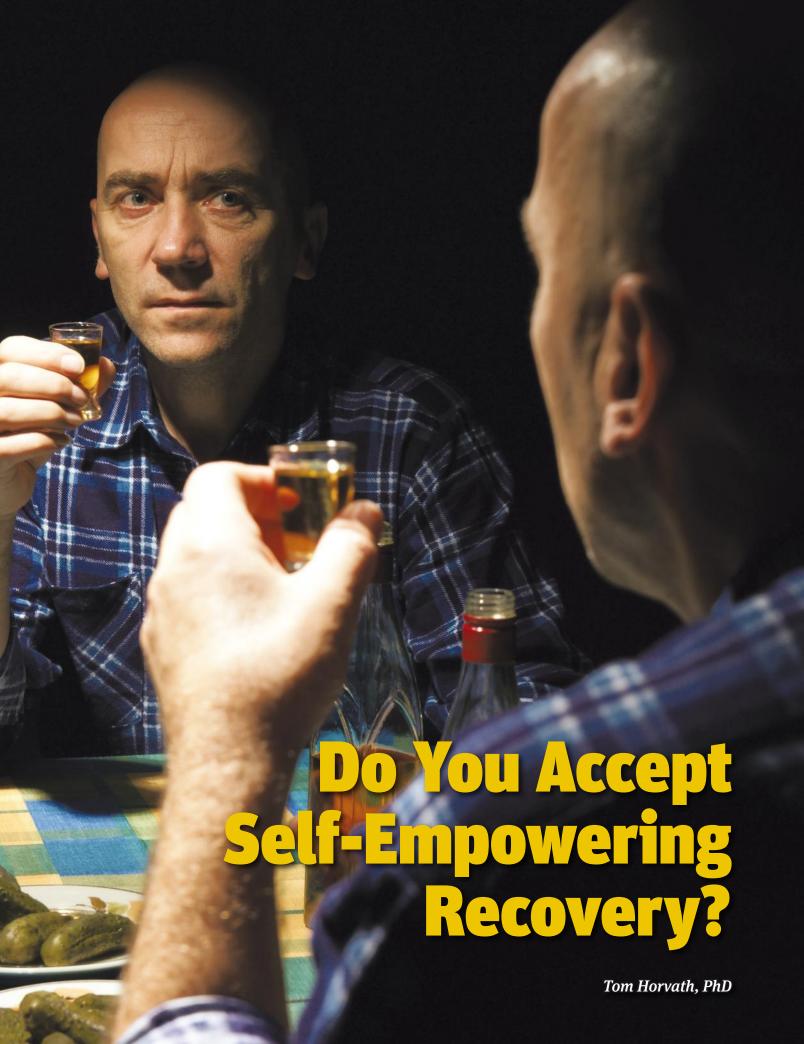
the day, spend fifteen minutes breathing into your body and noticing what emotions are present. Breathe through your mouth into those emotions as deeply as you can. The more you surrender into the feelings through allowing them and connecting with them, the more your body will feel you not abandoning it in the service of another person. Let every feeling up without judgement and allow your higher self to partner with you as you hold a container for these emotions with love and compassion.

Many people with weight issues have trouble reaching out for help. Begin with whatever you call your higher power—God, spirit, higher self, it does not matter. What matters is to admit you are unable to manage your life alone and begin a practice of receiving divine help. It will get easier, I promise. It requires the humility of recognizing that your conscious mind is not the most reliable source for guidance by itself.

I would also recommend working with a therapist who does somatic work, not just talk therapy.

Your weight loss in 2017 can be the beginning of you emerging from the chrysalis into the most beautiful, whole, self-loving butterfly in 2018!





### SELF-EMPOWERING RECOVERY

he world seems to change at a faster and faster pace. For instance, how many of us keep up enough to say we are "tech savvy?"

The world of addiction, treatment, and recovery is changing as well, including the increased use of the self-empowering approach (e.g., SMART Recovery); substitution medications (e.g., buprenorphine/Suboxone for opiates); preventive medications (e.g., naltrexone/Vivitrol for opiates, disulfiram/Antabuse for alcohol); electronic monitoring devices (e.g., SCRAM, Soberlink); online mutual help groups (e.g., IntheRooms.com); online treatment (e.g., Lion Rock Recovery) and assessment (e.g., CheckupandChoices.com); moderation and harm reduction approaches; and natural recovery as the broad framework for understanding the recovery process.

How much do we accept these changes? I suggest that it is now time for responsible addiction treatment professionals, when engaged in assessment, treatment planning, and making referrals, to

- have basic awareness about these and ongoing innovations (to the extent an innovation has an adequate scientific foundation)
- recommend them as suitable options for some individuals
- recognize that Twelve Step and disease model approaches are also suitable options for some individuals
- refrain from advocating for any particular approach
- help clients explore these options, so they can make informed decisions about how to change
- encourage progress (not perfection) by informing clients that success or at least substantial progress is ultimately likely for most

There remains a role for professionals who take only one approach (e.g., a Twelve Step approach), provided they refrain from the broader role of assessment, treatment planning, and referral. These professionals might say,

We recognize in the recovery field that there are multiple pathways to recovery. I specialize in the Twelve Step approach. I'm not familiar enough with other pathways to help you decide about them. If you want an assessment specifically for the services we offer, I'm happy to provide it. Otherwise I can refer you to a primary care addiction provider, a generalist who can help you make basic decisions about moving forward. It's possible that, having explored all your options, you'll still end up back here. If so, I look forward to working with you. Our Twelve Step approach is very helpful to the clients who choose it, but of course no approach works for everyone. Whatever you choose, I encourage you to be persistent in your efforts and patient about your progress. In time, almost everyone is successful in resolving addiction problems, or at least substantially improving them, even if the process is rocky at times.

"The world is nothing but change. Our life is only perception."

- Marcus Aurelius (850/2003)



### The Surgeon General's Perspective

How valid is the idea of multiple pathways? "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health," released in November 2016, states, "The diversity in pathways to recovery has sometimes provoked debate about the value of some pathways over others" (HHS, 2016, p. 5-4).

I suggest that the Surgeon General would like to end that debate. As Kana Enomoto, principal deputy administrator at the Substance Abuse and Mental Health Services Administration (SAMHSA), writes in her Foreword, the Report "provides a roadmap for working together to move our efforts forward" (HHS, 2016, p. iii). Will we do so? Consider the following statements from that Report.

### **Reducing Harm**

- "Substance use disorder treatment is designed to help individuals stop or reduce harmful substance misuse, improve their health and social function, and manage their risk for relapse" (HHS, 2016, p. 4-3).
- "The goals of early intervention are to reduce the harms associated with substance misuse" (HHS, 2016, p. 4-5).
- "Harm reduction programs provide public health-oriented, evidence-based, and cost-effective services to prevent and reduce substance-use-related risks among those actively using substances, and substantial evidence supports their effectiveness" (HHS, 2016; p. 4-10).

### SELF-EMPOWERING RECOVERY

### **Treatment Characteristics**

- "Treatment plans should be personalized and include engagement and retention strategies to promote participation, motivation, and adherence to the plan" (HHS, 2016, p. 4-17).
- "All substance use disorder treatment programs are expected to offer an individualized set of evidence-based clinical components" (HHS, 2016, p. 4-19).

# Medication-Assisted Treatment (MAT)

- "MAT [medication-assisted treatment] for patients with a chronic opioid use disorder must be delivered for an adequate duration in order to be effective. Patients who receive MAT for fewer than ninety days have not shown improved outcomes" (HHS, 2016, p. 4-21).
- "The research clearly demonstrates that MAT leads to better treatment outcomes compared to behavioral treatments alone. Moreover, withholding medications greatly increases the risk of relapse to illicit opioid use and overdose death" (HHS, 2016, p. 4-22).

### **Mutual Aid Groups**

"Given the common group and social orientation and the similar therapeutic factors operating across different mutual aid groups, participation in mutual aid groups other than AA might confer similar benefits at analogous levels of attendance" (HHS, 2016, p. 4-30).

### **Personal Views and Stigma**

- "Some people who have had severe substance use disorders in the past but no longer meet criteria for a substance use disorder do not think of themselves as operating from a recovery perspective or consider themselves part of a recovery movement" (HHS, 2016, p. 5-4).
- "In the general population, many people who once met diagnostic criteria for low-severity, 'mild' substance use disorders but who later drink or use drugs without related problems do not define

- themselves as being in recovery" (HHS, 2016, p. 5-5).
- "Despite negative stereotypes of 'hopeless addicts,' rigorous follow-up studies of treated adult populations, who tend to have the most chronic and severe disorders, show more than 50 percent achieving sustained remission, defined as remission that lasted for at least one year" (HHS, 2016, p. 5-6).

### **Criticisms**

The Surgeon General's Report also contains significant criticisms of the addiction treatment field:

- "Well-supported scientific evidence shows that behavioral therapies can be effective in treating substance use disorders, but most evidence-based behavioral therapies are often implemented with limited fidelity and are underused" (HHS, 2016, p. 4-2).
- "For evidence-based behavioral therapies to be delivered appropriately, they must be provided by qualified, trained providers.

  Despite this, many counselors and therapists working in substance use disorder treatment programs have not been trained to provide evidence-based behavioral therapies" (HHS, 2016, p. 4-26).
- "Unfortunately, despite decades of research, it cannot be concluded that general group counseling is reliably effective in reducing substance use or related problems" (HHS, 2016, p. 4-26).
- "Group counseling is a standard part of most substance use disorder treatments, but should primarily be used only in conjunction with individual counseling or other forms of individual therapy" (HHS, 2016, p. 4-26).
- Personalized care [emphasis added] is not common in the substance use disorder field because many prevention, treatment, and recovery regimens were created as standardized "programs," rather than individualized protocols (HHS, 2016, p. 1-24).

If we are interested in moving our professional practices to the level of personalized care, then, among other topics, we will need to know about the self-empowering approach, which is the primary focus of this article. With even broader knowledge, we can work as generalists; that is, primary care addiction providers who can conduct assessments, treatment planning, and referrals that are not limited to a specific set of services.

Although the Surgeon General's Report is highly authoritative and recent, there have been other authoritative calls to action as well, and not just recently. One of the most significant was "Broadening the Base of Treatment for Alcohol Problems" (IOM, 1990). Unfortunately, many of the changes called for in that document are still needed. The Recovery Bill of Rights (Faces and Voices of Recovery, n.d.) is a more recent and pithier example.

Stanton Peele presents a brilliant analysis of the shortcomings of the Surgeon General's Report, from the perspective of the changes the recovery field ultimately needs to make (2016). From my perspective, the Surgeon General's Report occupies middle ground between how the field operates now and where it ultimately needs to be. I view the Report as a realistic plan for change at present.

### **The Self-Empowering Approach**

"Self-empowering" is a term emphasizing the perspective that the solution to addiction resides *within* individuals, rather than outside of them such as in a higher power, group, or Twelve Step sponsor. The language of the alternative perspective (i.e., powerlessness), is clearly described in AA's first three Steps (Alcoholics Anonymous World Services, 2001, p. 59):

- "We admitted we were powerless over alcohol—that our lives had become unmanageable."
- 2. "We came to believe that a Power greater than ourselves could restore us to sanity."
- 3. "We made a decision to turn our will and our lives over to the care of God as we understood Him."

Another interpretation of "self-empowering" can be gathered from the Serenity Prayer: "God grant me serenity to accept the things I cannot change, courage to

change the things I can, and wisdom to know the difference" ("The origin," 1992).

From this perspective the self-empowering approach is primarily a courage approach, rather than a serenity approach. Clients are encouraged to identify and resolve issues necessary for establishing successful recovery, including

- identifying and maintaining motivations to change
- coping with cravings and other impulses
- identifying and addressing problems (e.g., depression, anxiety, bipolar disorder, etc.) that often establish a foundation on which addiction flourishes
- achieving greater lifestyle balance as way to prevent a recurrence of problems
- improving relationships, as they are ultimately more satisfying than intoxication
- living with meaning and purpose, which is also ultimately more satisfying over time than intoxication

### **Mutual Aid Groups**

The self-empowering approach is available in treatment and in mutual aid groups. The mutual aid groups include SMART Recovery, Women for Sobriety, Lifering Secular Recovery, Refuge Recovery, Secular Organizations for Sobriety, Moderation Management, and HAMS Network (listed here in approximate order of size). Listing these groups together, because they are not powerlessness-based, does not mean to imply that significant differences between them do not exist. However, these differences are beyond the scope of this article.

SMART Recovery, the largest of these groups, has over two thousand meetings worldwide, printed materials in eight languages, and affiliate organizations in the UK and Australia (Horvath & Yeterian, 2012). SMART's tools for recovery would be familiar to anyone familiar with cognitive behavioral and motivational interviewing ideas and techniques. SMART has numerous tools, including ones for identifying and modifying dysfunctional thinking and belief, coping with craving, identifying

motivations to change, breaking large change into small steps, and accepting oneself even while not accepting some past or current behaviors.

I suggest that responsible addiction professionals identify which of these organizations operates in their locality, survey each organization's national or local website, perhaps attend a meeting, and have information about these organizations to provide to clients (such as the website) so that clients can investigate further.

Similarly, responsible professionals should also identify the self-empowering treatment in their own locality. The Self-Empowering Addiction Treatment Association (www.seatainfo.org), along with the websites of the self-empowering groups (which often list treatment resources) are the places to start that search. Unfortunately, treatment may be even less available than these mutual aid groups. If intensive treatment—residential or intensive outpatient—is indicated, it may need to be obtained out of area.

# How to Introduce Multiple Pathways

The introduction of self-empowering mutual aid needs to occur in a larger context. Imagine that willing individuals, perhaps accompanied by family, have come in for an assessment and recommendations for substance problems. We will later consider the same situation if these individuals have been substantially coerced to attend the evaluation and are in "denial."

After the evaluation portion of the interview is completed, the recommendations section might occur as follows:

Thanks. We've discussed what's been problematic for you with your substance use, and your desire to make changes. Now let's consider the options you have, starting with the free and low-cost ones. Then we'll move on to what treatments you might want to access. Treatment, of course, isn't free, so we'll need to consider options that fit your budget. Ideally treatment would be available without budget considerations, but the US hasn't reached that level yet. First we'll discuss mutual aid groups, then treatment, and lastly all of the other

changes you might make in your life, even if you don't get involved with either mutual aid or treatment.

Mutual aid groups are also known as support groups, self-help groups, or mutual help groups. They're free, but donations are requested. They bring together individuals in various phases of the change process. Together they study the recovery approach used by that group. Some individuals, like you, are relatively new. Others may have years or decades of experience.

These groups aren't treatment. Treatment involves working with professionals, establishing a treatment plan, monitoring progress, and often working with your insurance company. The treatment provider may have very specific recommendations for you. Treatment is typically time limited, whereas attendance in mutual aid groups is open-ended and can last a lifetime.

Far and away the most widely available type of mutual aid groups are those based on the Twelve Steps of Alcoholics Anonymous (AA). There are dozens of related organizations such as Narcotics Anonymous (NA) or Cocaine Anonymous (CA). If you find these groups helpful, you get the benefit of having the largest network of meetings available to you. Originally established in 1935, these groups have a long tradition around the world. They are well-known and widely respected. They are so well established that they offer an entire nonusing social world for you to enter, if you wish to do so. In particular the Twelve Step groups offer the option of having a sponsor, a oneto-one relationship with an experienced person in recovery who will assist you in learning the Twelve Step approach. Of course, it's up to you how involved you get with any group.

By the way, if you call your sponsor in the middle of the night because you have a strong craving, your sponsor will probably be glad you called. Your treatment provider may be glad to hear from you then as well, but maybe not, and either way the provider will probably charge you!

### SELF-EMPOWERING RECOVERY

There are other approaches to recovery that are quite different than the Twelve Step approach. Described on the surface, the Twelve Step approach involves accepting the idea that individual will-power will not be sufficient to resolve your problems, whereas the self-empowering groups involve building up, over time, your willpower and personal capacity to recover. The self-empowering groups often go to significant effort to teach you various ideas, techniques, and tools for recovery.

However, this surface description doesn't include the reality that there are as many ways to participate in these groups as there are individuals. We don't yet know how you specifically might make use of these groups, or whether you'll attend at all. How you experience them will be unique to you. Another wrinkle is that you might end up attending multiple mutual aid groups, even if on the surface they seem to have vastly different perspectives. There are as many ways to recover as there are individuals. The job for the two of us, as long as we're working together, and your job ultimately, is to find out what works for you.

I'll give you some additional aspects of these two approaches, but ultimately the best way to assess them is probably to attend one or more meetings of each. We can discuss what you observe if you wish. Typically the self-empowering groups don't have sponsors, don't expect lifetime attendance, have meetings that are more conversational, have a large array of tools and techniques to consider, and may be more flexible about abstinence versus moderation goals. The Twelve Step groups do have sponsors, encourage long-term or lifetime attendance, have meetings that are less interactive, have less emphasis on tools and techniques, and are generally clear that the requirement for membership is a desire to stop.

Another way to describe the differences between these groups is to compare them to two courses of study you might sign up for in school. Imagine one course has no electives. Once you sign up, they tell you what to study; AA is more like that. The self-empowering groups are more like

choosing a broad field of study then choosing one elective after another. Some people like to make one big decision at the beginning, and be closely guided thereafter. Others may be more comfortable making many smaller decisions along the way. SMART Recovery, the largest of the self-empowering groups, has a slogan that emphasizes ongoing decision making: "Discover the power of choice."

All mutual aid groups would benefit from a wide array of groups. When that array is fully available and fully recognized, participants in any group will know they are present by choice, not because that group is the "only option."

However, some individuals don't attend mutual aid groups at all. Although the groups are free, easily accessible, and attendance in them is associated with success, attendance isn't essential for success. There are as many roads to recovery as there are individuals. Similarly, treatment is associated with success, but may not be essential for success. What's most important is for you to be committed to change, and to be persistent even if you have setbacks.

One somewhat unexpected pathway to recovery is the individual who attends both Twelve Step groups and self-empowering groups (Horvath, 2014; White & Kelly, 2014). A common experience they report is, "I do Twelve Step for the fellowship and the other group for the tools." I'll be curious to hear what your experience is if you do that.

As I also said, that distinction between powerlessness and self-empowerment doesn't cover all the relevant aspects of these choices. By making progress in recovery you're going to feel empowered, almost no matter what approach you take. Similarly, even if you don't think of yourself as powerless, you may identify realities that you need to accept rather than fight against. In attending these groups it may be most important to find the groups of people you connect with, whatever the approach of the group is. Building a new social network is very important (Kelly, Stout, Greene, & Slaymaker, 2014).

Now let's move ahead and talk about treatment options.

There is a small but active community of treatment professionals who would largely agree with the phrasing of these paragraphs. Most of them would identify themselves as harm reduction oriented. Although some vociferously oppose even the existence of Twelve Step groups, most are happy to work with the Twelve Step community if cooperation is reciprocated.

# Other Significant Aspects of Self-Empowering Groups Lack of Meetings

A major concern about self-empowering groups is the lack of meetings in most localities. Fortunately, most groups have a substantial online presence, either with meetings or with chat rooms and message boards. Treatment professionals dedicated to the concept of multiple pathways could establish self-empowering groups in their own communities, then assist them in becoming self-sufficient. Such affirmative action may be necessary if these groups are to become sufficiently available. Affirmative action by local, state, and federal governments is also worth considering.

When AA began, it entered a vacuum. Prohibition ended in 1933, AA began in 1935 (Alcoholics Anonymous World Services, 2017). There was very little treatment or any other service available. The oldest self-empowering group on the list began in the 1970s with Women for Sobriety (WFS, 2011). It entered a crowded marketplace, and one often hostile to its presence, hence the need for this article and many others like it. However, all mutual aid groups would benefit from a wide array of groups. When that array is fully available and fully recognized, participants in any group will know they are present by choice, not because that group is the "only option."

### **Court Cards**

Most self-empowering groups sign court cards, but probably would be willing to stop the practice if Twelve Step groups did. A self-empowered approach to recovery is not consistent with coerced attendance.

# Multiple Pathways or Individual Pathways?

The term "multiple pathways" may not adequately convey the complexity of the recovery process across a wide range of people. As Bill White states,

The addiction recovery experience has been sliced and diced in all manner of categories: secular, spiritual, and religious; natural recovery, peerassisted, and treatment-assisted; and abstinence-based, moderation-based, and medication-assisted, to name just a few. Recovery achieved through any of these frameworks is often referred to as a pathway of recovery. The growing consensus that there are multiple pathways of long-term addiction recovery marks an important public and professional milestone within the alcohol and drug problems arena.

Progress has been made by recoveryfocused research scientists on mapping recovery pathways and noting their distinctive and shared qualities. This classification work is important as long as one does not lose sight of the fact that reality is often far messier than such pristine categories would suggest. Or put another way, "the recovery map does not always accurately depict the territory" (2016).

Consequently, addiction professionals need to stay closely attuned to the specific individuals in the recovery process, and not attempt to push them into any previously established recovery path.

### **AA Bashing**

The self-empowering groups have attracted a significant number of individuals who either dislike AA or actively hate it. They are often not shy about expressing their contempt in meetings. Although it is the responsibility of the meeting manager

to end these tirades, not all managers are adept at ending them quickly enough. For now, each mutual aid group, including Twelve Step ones, need to become better at staying focused on what they do, not on other approaches some participants do not like. Ideally each group would say, "No approach works for everyone; let's stay focused on what we do here, then you can make your own decision about how helpful it is."

### The Language of Recovery

The concepts and language used in self-empowering groups may sound foreign to someone with a Twelve Step background. The Surgeon General's Report (HHS, 2016), the DSM-5 (APA, 2013), the Recovery Bill of Rights (Faces and Voices of Recovery, n.d.), and anything written by Bill White provide good examples of contemporary, science-based language about recovery, a term which itself may be outgrown in time.

# What if the "Alcoholic" is in "Denial?"

I previously stated we would return to the situation of people coerced into a substance use evaluation. The "denial" that can occur there is often a result not of denying the facts of what happened, but instead denying the description of the facts or the suggested action steps arising from them. For instance, after a review of the presenting situation, professionals might state, "You need to admit you are an alcoholic, go off to rehab for at least thirty days, never drink again, and attend AA meetings for the rest of your life."

Or these professionals might say,

The two of you disagree about some facts, but do agree that there have been several problems resulting from drinking. Now the question is what, if anything, to do about this situation, and what you [the nondrinker] will do if, from your perspective, sufficient progress doesn't occur. Let me discuss some options for you to consider. Second, we're going to talk about your [the nondrinker's] options if you lose confidence that change isn't happening or isn't happening fast enough, but first we're going to talk about your [the drinker's] options for change.

[Now insert the paragraphs from the section above on how to introduce multiple pathways].

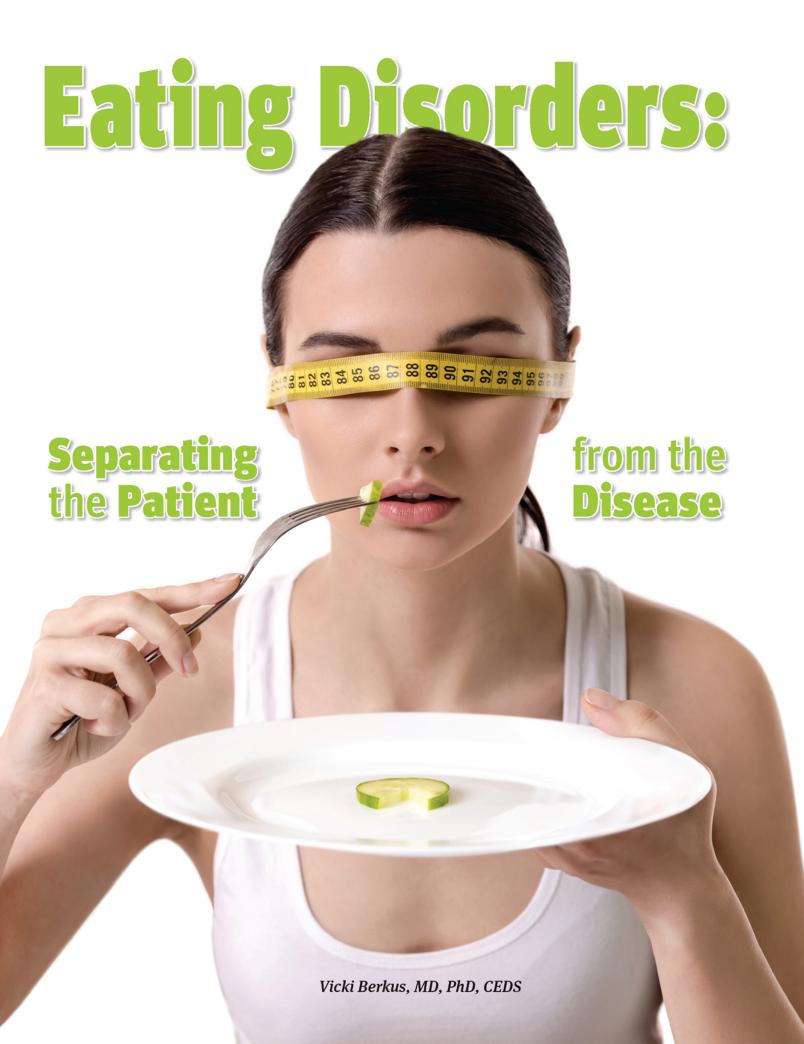
The least irritating language to use is the language of the substance user, and the most likely course of action is the one the user suggests or at least agrees to. The presence of family, which often has substantial capacity to influence the user, means that change (or lack of) can be responded to. As opposed to having an intervention a course of action that has a place in selected instances-many families would benefit from Community Reinforcement and Family Training (CRAFT; Smith & Meyers, 2007), an evidence-based, noncoercive, and highly effective approach for motivating a substance user to enter treatment. Unfortunately, even though CRAFT appears to be substantially more effective than interventions in getting identified patients into treatment, it is not well known, perhaps because it is not dramatic—it typically spans a course of ten to twelve sessions—and does not have its own television show.

### **Conclusions**

Fields change by changing their concepts and their language. These changes involve reasoned discussion, heated debate, or worse. This article aims to be a contribution to reasoned discussion.

If you are ready to practice in the manner the Surgeon General is indicating in his Report, this article has suggested specific language to use and specific actions to take, with particular focus on referring to and cooperating with self-empowering mutual aid groups like SMART Recovery. These groups have been in existence for thirty years and are apparently here to stay. I suggest that it is time for professionals who help others resolve or reduce problematic addictive behavior to learn how to work with self-empowering mutual aid groups, or state openly that their practices are delimited to a specialty area. Individuals seeking comprehensive evaluation and treatment planning can seek these services from primary care addiction generalists, who take on the responsibility of staying abreast of developments in the entire field.

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pists are familiar with and feel comfortable addressing with their clients. I have been giving the information in this article to hundreds of substance abuse therapists, and the common response is, "I had no idea." The comorbidity of substance abuse and eating disorders is common. The difference is that patients will frequently talk about their drug use, but refrain from sharing their eating disorders because of the shame, guilt, and fear associated with anorexia nervosa (anorexia), bulimia nervosa (bulimia), and binge eating disorder (BED) behaviors. This article will help us understand our role in helping patients work towards recovery.

### **Characteristics**

Anorexia is often easier to identify because patients must have been at 85 percent of their normal body weight. They often wear loose clothing to hide themselves and because they have such a skewed perception of their bodies—called "body dysmorphia"—they are not alarmed by the physical changes caused by food restriction. These patients have formed their primary relationship with "ED," their eating disorder. They avoid social interactions with loved ones and will often hide their food or trade it at school. The effects of starvation on the brain have shown that the ability to make good choices is minimal at best (Keys, Brozek, Henschel, Mickelsen, & Taylor, 1950).

If patients come to us for their substance abuse issues, the first thing we should consider is their presentation. Today's social culture worships thinness, and the degree to which it is pursued is based on the consequences of starvation that our patients may or may not share with us. Some of the physical parameters we can look for are the fact that they may be wearing clothing that is heavier than expected based on the temperature. Do they complain of being cold? They may have some psychomotor retardation such as moving slowly or feeling dizzy when they change their position from sitting to standing. They may have difficulty holding on to recent discussions or forget what they told us in previous sessions. They may talk about their depression and anxiety and minimize their extreme fear of gaining weight. They will complain of fatigue and inability to participate in normal physical and cognitive activities—they have used up their store of carbohydrates (glycogen in the liver) and are now relying on fatty acids for energy. They may be eating less than five hundred calories per day and their bodies are used to this decreased amount. If they are open to increasing their food intake, they have to do so with the supervision of a nutritionist

and medical provider. When they are refed too quickly, the heart may not be able to handle the increased metabolic demand and can have serious complications (Bermudez & Beightol, 2004).

When parents ask about changes with starvation, I use the analogy of the ticket books used before the days of the FastPass at Disneyland. The ticket ride coupons were labeled A through E. The E coupons were the best because you could get on the Matterhorn, the main attraction at that time. Kids did not care about the A through C tickets, so I compare the E tickets to the heart and lungs. The body will divert what calories it is receiving to keeping those organs functioning. The D and C tickets are the liver, kidneys, and other important organs that need to function to sustain life. The A and B tickets are the systems that the body will shut down to keep the major organs working: the immune system, the reproductive system, and the endocrine system. Female patients may stop having menstrual cycles (i.e., amenorrhea) and males may have low testosterone levels. They may have more infections due to their compromised immune systems and thyroid function may be low. Muscle mass is lost, energy levels are compromised, and the body slows down the metabolic rate (Andersen & Yager, 2004). These patients may continue to exercise compulsively, causing more muscle wasting and dizziness.

### **How Do We Begin Helping these Patients?**

Patients may be willing to enter into a therapeutic alliance with therapists if we stick to their substance abuse issues and gradually work into learning about what consequences they are experiencing due to the behaviors of their eating disorder. Remember, their perception is they are "fat"; they do not see their bodies the way we see them. They may be rigid in their ideas and we will not win in a battle of wills. These patients need to hear more than "just eat." The fear level is high and it is difficult for non-eating-disorder specialists to understand how difficult it is to even talk about food, let alone eat it. Patients may have only allowed themselves to have half a bagel, a quarter cup of yogurt, and a piece of hard candy as their daily intake and this might have gone on for a year. Can you imagine the control it takes to follow these self-imposed rules? Anyone who has started a diet on Monday realizes that by Wednesday they are struggling to keep it going. The level of control and perseverance around food is extremely hard to challenge. The best treatment for these types of patients—who may also have drug addictions—may be a referral to an eating disorder specialist or a higher level of care. Our job may be to ensure that patients get the medical care needed to ensure they are medically stable.

Patients may have switched from restricting food to becoming bulimic, which means they are using some compensatory behavior to get rid of calories. This may be purging through exercise, vomiting, or laxative use. Bulimic patients may be of normal weight or slightly above. They are at risk for numerous medical complications due to any of these purging behaviors. They may be bingeing and also experiencing a "brain fog," frequently experienced when bingeing on thousands of calories at a time. The difference between BED and bulimia is that bingeing patients do not use any compensatory behaviors to get rid of the ingested calories. Look for an excoriated red area over the index finger (i.e., Russell's sign) caused by rubbing their finger

### **EATING DISORDERS**

against their teeth while trying to induce vomiting (Mehler & Andersen, 2010). Some patients get to the point where they can spontaneously vomit. I have had patients tell me that they can go to a movie, order a large popcorn tub, and purge it without the people sitting next to them having a clue as to what they are doing. Purging can cause a change in serum electrolyte levels (sodium, potassium, chloride, bicarbonate) and can lead to a change in heart rhythm and sudden death. The combination of vomiting alcohol and gastric acid can also lead to erosion of the esophagus, causing them to bleed out (Fairburn & Harrison, 2003).

Compulsive exercising often leads to fainting or severe dehydration. These patients can exercise for hours and ignore pain, weakness, and dizziness. They may even be shaking their leg, sitting on the edge of the chair in your office, to maintain constant motion and burn calories. They would rather exercise than spend time with family or friends, adding to their social isolation.

Laxative abuse can lead to a medical emergency called a "carthartic colon" (Mehler, 1997). When the colon does not function on its own due to the heavy use of laxatives, patients need to get immediate medical care. They may complain of different GI complaints and these need to be taken seriously.

# How Do We Approach Eating Behaviors?

The first thing is to determine if these patients need a higher level of care. Can they refrain at all from the behaviors? How many times per day are they engaged in purging, exercising, or laxative abuse? The need for a medical work-up is first and we may need to insist that patients see their primary physician. Patients can become medically compromised quickly and they lose control by being sent to an emergency room or hospital setting. I tell my patients that this is not the option they want to risk due to their need for control.

Compulsive overeaters may be overweight, and although they are coming to you for their drug addiction, the one rule to help these patients is to understand that they have no control over their bingeing. It may get to the point that they are facing financial complications due to overspending on food. Their increased consumption of carbohydrates may have caused diabetes or metabolic syndrome (i.e., central obesity, hypertension, high serum triglycerides) affecting their ability to lose weight or control their hunger (Kaur, 2014). These patients may be abusing alcohol or marijuana, leading to an increase in food consumption whether it is a side effect of the drug or the environment they chose to continue their addiction.

The patients dealing with these disorders bring their therapeutic challenges to us. If we decide to keep and treat these patients, here are some guidelines to determine where to start.

# Trauma and Co-Occurring Conditions

The common theme of trauma and abuse history in eating disorder patients is like that seen in substance abuse patients (Brewerton, 2007). It can start during the initial session when we take the history. A trauma history is a strong indicator that patients may be dealing with an eating disorder. The addition of other compulsive behaviors such as gambling, sexually acting out, or shopping may also be causing consequences in their lives. What other behaviors are they concerned about? When we take a social history, we may ask about a typical day related to their eating. Do they eat with others? Did they have any "rules" around the kitchen when they were growing up? Could they eat what they wanted any time of the day or were there restrictions? Did they ever get teased about their weight? Who else in the family has disordered eating? These are the questions that may lead to our suspicions being accurate.

### When to Refer

Once there is evidence to support the idea that our patients have a dual diagnosis, this is where some soul searching on our part may help us decide whether to treat or refer patients to a higher level of care. The idea of body image does not just apply to our patients—we need to examine ourselves. Do we have a bias with obese patients? Can we connect with their feelings of hopelessness and fear? What are our issues around our bodies, and can we deal with these in supervision and not let them into the session?

It is at this point that if any answers cause us concern, we should refer

patients for specialized treatment. If they have had their disease for a longer (rather than shorter) period of time, then they may need a team consisting of a psychiatrist, internist or GP, nutritionist, and a therapist specializing in eating disorders. Have we identified any additional comorbidities such as depression, OCD, or anxiety? Do we feel comfortable with their current medications?

### **Levels of Care**

Patients with a single diagnosis of substance abuse are probably starting to look more desirable, but less likely based on the current level of disease seen on an outpatient basis. Patients who had no problem meeting criteria for inpatient or residential care are now struggling with insurance companies and entering lower levels of care based on cost. An intensive outpatient (IOP) program usually consists of twelve hours per week in a program dealing with their eating disorder (Halmi, 2005). If they cannot control their behaviors (e.g., bingeing, purging), they may need a higher level of care such as a partial hospitalization program (PHP). These patients would typically spend five to six days per week in the PHP and go home at night.

An inpatient level of care would be needed for those patients who are medically unstable and need twenty-four-hour supervision and monitoring. They may require GI studies, feeding tubes, daily labs, and cardiac monitoring. If they are suicidal, intoxicated, or in withdrawal, this adds to the level of care they need.

One of the difficult decisions we have as substance abuse therapists is deciding whether patients have anorexia or whether they have become emaciated due to their heroin or drug use. The latter still face the same risks in refeeding as those who meet the criteria for anorexia nervosa. They may still be experiencing the same cognitive difficulties due to malnutrition.

### Where Do We Start?

Now let us say that we decide to work with our patients and need a place to start. One of the easiest ways to approach patients is to ask them what their earliest memory is of being upset with their body. Who else in the family was unhappy with the way they looked? They may come from a family of dieters or compulsive eaters. It

is important to bring them into the here and now. How is their eating disorder taking over their lives? What are the consequences—poor energy, loss of ability to maintain grades, loss of friends, loss of job, increased conflict at home—of the abnormal eating behaviors?

The work starts when we can help them admit that their way is not working and something needs to change. What behaviors are they willing to change? What have they tried and failed to do? Patients suffering from an eating disorder and substance abuse need treatment for both or they will cross from one problem to the other.

Today most of our patients have more complicated needs. I was amazed when I went from inpatient work to private practice and realized it was the same level of acuity of their disease—some just could afford the level of care they so desperately needed. We may have thought we were just dealing with one issue, but being human is difficult and their substance abuse may just be the one problem that gets them into treatment with us.

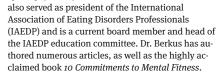
I have heard patients state that they can deal with no longer using a substance, but since they have to face food on a daily basis, they cannot imagine being okay with eating. This is one reason that the level of fear mentioned earlier becomes so important in their treatment. They are living in this fear every time they face food. It is our job to make the fear manageable. This involves working with the family to help them understand the behavior and let them know they have a role, but not as the food police, therapist, physician, or nutritionist. Families need a lot of support and the National Organization for Eating Disorders (NEDA) is a great referral source.

There are some of us whose interests may or may not be in the treatment of these patients. There is now certification offered by the International Association of Eating Disorders Professionals (IAEDP), which can be a great place to reach out to specialists or to obtain more information. Resources can be limited in various geographical locations, so I often tell patients to reach out to any support or Twelve Step group—whether it is AA, OA, CODA (codependency), EA (emotions anonymous)—or somewhere they can share and not feel judged.

I hope the message in this article for everyone reading is what I tell my patients: you do not have to handle these diseases alone. I would never work with patients without an ED team and I hope that the awareness of the need for a team approach is evident based on the behaviors described. We can all be an important part of the team with knowledge and experience in substance abuse. 3

### About the Author

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# Self-Empowering Continued from page 27

As Marcus Aurelius stated, "The world is nothing but change. Our life is only perception" (850/2003). Do you accept self-empowering recovery? •

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Tom Horvath, PhD, is a California-licensed psychologist. He owns and operates Practical Recovery in San Diego. He is a past president of the San Diego Psychological Association, a past president of the Society on



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# Andrea G. Barthwell, MD, DFASAM, & Cherlyne Short Majors, PhD

### **WOMEN IN BEHAVIORAL HEALTH**

hen universal education activist and Nobel Prize laureate Malala Yousafzai addressed the United Nations in 2013, she pointed out that "we cannot all succeed when half of us are held back." Her words resonated with women's rights advocates as she boldly confronted an inequity that still needs to be addressed today, especially in the behavioral health field. Success is a collective, not a zero sum game, and her words invite everyone to participate in this cooperative enterprise of equality.

The relative shortage of female executive leadership in the field presents an urgent challenge to the behavioral health community. Technological, financial, legislative, and other factors are advancing and furthering the industry, so it is critical that gender equality advances along as well. As a group representing half of the targeted treatment population, women should be strategically involved at the highest level in terms of creating new structures, modalities, and paradigms for how treatment is defined, delivered, regulated, and compensated. Women have a unique perspective that is necessary for steering the behavioral health community through these upcoming waves of change and transforming present challenges into opportunities for growth. The statistics on executive leadership in the behavioral health field reveal a major deficit in terms of roles held by women. For example, the National Council for Behavioral Health (NCBH) is comprised of 2,200 member organizations and women hold the CEO position at only eight hundred of them, despite making up a significant 75 percent of the middle management workforce (Rosenberg, 2014). Every one of the NCBH's large corporation partners and 67 percent of their small- to mid-size corporation partners have men as CEOs. Their board is comprised of twenty-five members, yet only seven are women (Rosenberg, 2014).

### **Beyond Behavioral Health**

This shortage of female leadership is not unique to the behavioral health field. According to business advisor Grant Thornton, the percentage of women in senior executive leadership positions has remained stagnant at 20 percent worldwide since 2004 (Williams, 2014). Less than 10 percent of businesses employ a woman as CEO, and statistics show that a majority of female employees are hired to work in finance or human resources (Williams, 2014). While it is true that women own 38 percent of businesses in the United States (American Express Open, 2016), Northwestern University professor and psychologist Alice Eagly, PhD, points out that a large number of these women are running their own small businesses as opposed to holding senior management positions in Fortune 500 companies (APA, 2006). This deficit is neither the result of lesser qualifications nor a lack of advanced education.

### **WOMEN IN BEHAVIORAL HEALTH**

According to the State Street Center for Applied Research, women have earned 37 percent of all MBA degrees, yet hold only 4.6 percent of the S&P 500 CEO positions (Mitchem & McKenna, 2015). This is contradictory to evidence that woman-majority executive committees result in better financial performance, a "41 percent better return on equity and 56 percent better in terms of overall earnings before interest and taxes" (Mitchem & McKenna, 2015). Ongoing research suggests that the underrepresentation of women in senior management is not the result of any evidence-based conclusion, but instead the result of gender biases, system dynamics, organizational hierarchy, communal and agentic behavior dissonance, and other nonsensical rationales.

Adult learning specialists like Robert Kegan and Lisa Laskow Lahey work to look beyond gender gap statistics to the broader societal and organizational obstacles that prevent companies from reaching their full potential. They examine how, in the course of a workday, time and energy is often wasted when employees have to camouflage their weaknesses and play office politics to conceal or justify their inadequacies. In an attempt to correct for this waste of energy, Kegan and Lahey identified new training and development paradigms that may be more appropriate for the modern workplace. These new methods include shifting away from external leadership and development training programs that may be ineffective, costly, and limited to a select number of employees with a mind-set "so valuing the importance of developing people's capabilities that you design a culture that itself immersively sweeps every member of the organization into an ongoing developmental journey in the course of working every day" (Kegan & Lahey, 2016). They point out that conventional incentives for hard work and promotion have changed as well: "Now we're seeing the pursuit of new incomes: personal satisfaction, meaningfulness, and happiness" (Kegan & Lahey, 2016).

The extent to which employers can recognize that men and women both need to experience these new incomes of personal satisfaction, meaningfulness, and happiness will determine how equitably they can embark together on a path that

allows for mutual development, success, fulfillment, and profitability. Though for years employers have allocated sizeable resources to foster diversity and inclusiveness during recruitment, "still in 2015, the workplace shows a slow progression toward a more diverse workforce, particularly in the higher ranks of management and leadership" (Mitchem & McKenna, 2015).

Because the behavioral health sector is "one of the hottest spaces in health care now," it is especially important for women to be taken seriously in the workplace (Miller, 2015). PricewaterhouseCoopers reported a 24 percent increase in deal volume in the behavioral health space between 2013 and 2014, with the upward trend continuing throughout 2015 (Miller, 2015). A number of factors account for this growth. For example, legislation such as the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 mandate that health plans must cover behavioral health services at parity with medical/surgical treatment, which has made treatment centers with stable, consistent revenue streams newly attractive acquisition targets. Medication-assisted treatment (MAT) has become even more appealing to investors than the previously favored high-end residential centers with private pay because of MAT's lower annual costs for insurers and their "more uniform clinical delivery process" (Miller, 2015). In addition, an increasing number of private equity firms are jumping into the addiction market and creating healthy competition, thus providing behavioral health groups with more options as far as infrastructure, portfolio acquisitions, or new ventures. Of note, however, is that these firms are voicing a significant amount of concern about the lack of solid management in the organizations they are interested in purchasing, likely related to the overwhelming absence of women in upper level executive positions.

# How Women Can Make a Difference

The health care field is in a vulnerable, changing state right now and is statistically ready to accept more women into the ranks. Figures from the Bureau of Labor Statistics (2010–2011) show that the

current workforce of the mental health and addiction treatment field is middleaged, with new workers often entering the field later in life as a second career (SAMHSA, 2013). In order to right this imbalance, the Substance Abuse and Mental Health Services Administration (SAMHSA) states in its 2013 "Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues" that it has become essential to recruit students into the field "particularly from underrepresented populations" (SAMHSA, 2013). The health care field needs more female talent in order to sustain the innovation, viability, and quality of its services, as well as its financial success.

Women have the potential to revolutionize the field in a number of different areas. For example, technology is quickly becoming an integral part of the recovery experience. Mobile apps on Android and iPhone smartphones include a wide range of resources for individuals in recovery: abstinence tracking systems, relapse trigger alerts, daily meditations, sobriety calculators, audio recordings of speakers at AA meetings and NA conventions, inspirational quotes, mindfulness meditation aids, social networking platforms for the global recovery community, and even help for travelers to find the nearest AA or NA meeting. Some organizations are creating apps that become a part of their personalized continuing care, enhancing their unique program modalities while promoting their brand. Others are designing apps that guide patients through recovery to prevent relapse. Women with technological and designing experience can offer unique perspectives in terms of shaping the strategic, programmatic, and marketing decisions about how such technological innovations can assist with the integration of behavioral health care into social networks.

Women also have a lot to offer in the medical research realm. Advances in the understanding of neurobiology and brain disease along with pharmacological developments have greatly increased the number of options available for MAT and enhancements to traditional approaches to recovery. Women have the opportunity to shift conventional, institutional thinking about addiction

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while building partnerships with the medical community that encourage collaboration and the sharing of ideas.

## **Survey Says**

In a recent survey designed to measure if and how women in the behavioral health profession are moving forward, fifty-four female participants answered questions focused on the following:

- What factors contribute most to your career success?
- What factors are holding you back?
- What do you need to make better progress?

The participants included women primarily from California, with a handful from New York, Pennsylvania, Utah, Idaho, Arizona, Michigan, Nevada, and Colorado, almost 80 percent of whom were either in management or at the executive level.

The survey results suggest that respondents overwhelmingly attribute their success to four factors: relationships, professional expertise and experience, passion for their work, and care for their clients. Building relationships

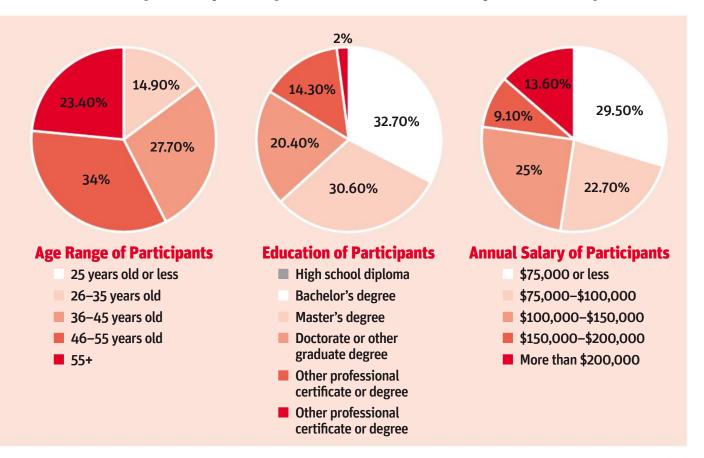
and networking outside their organization has given these women opportunities to share knowledge and strategies, as well as to lend and garner support.

Within their organization, the participants feel that a solid team is crucial to empowerment, efficiency, organization, and support. Expertise, experience, training, tools, and resources are also seen as vital to success, as they enable top performance, fuel self-confidence and professionalism, and shape the skills required to practice at the highest levels. Years of education supported by ongoing training make long-term growth and the ability to initiate new ventures possible. Other important contributors to success are support systems, including supervisors and executives who give feedback and guidance, as well as the innovative and courageous spirit it takes to tackle new projects and concretize a long-range vision.

However, even though many of these women are achieving notable success in the health care field, a large number of them reported that satisfaction is only possible through self-employment or holding the position of CEO and having the freedom to create their own

opportunities. These responses suggest that there is work to be done within organizational culture to make employees' experiences at a company more satisfying, as Kegan and Lahey explored (2016). Partnering with employees in a safe and supportive environment to identify where they need more training and development, or to help them find more meaning and satisfaction in their positions, might help behavioral health organizations retain professionals who are more satisfied and productive, and consequently, able to contribute more to the company's success. Since it may take a while for the behavioral health industry to transition to the employee training and development paradigm that Kegan and Lahey, among others, advocate, women might benefit in the meantime from learning new strategies and techniques that help them better navigate current organizational obstacles in order to stay with and benefit from working at their companies for a greater amount of their career.

When asked about the factors holding them back from achieving satisfaction in their career, the women largely reported the following:



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- Dominance of men in senior management (or as owners) where women are sometimes marginalized
- No room for growth or inability to advance because titles and roles are not clearly defined, or leadership does not share control of the organization
- Lack of advanced education and training to take on new risks and responsibilities
- Lack of strategic mentoring and coaching to advance within or beyond organizations

Women who are not in senior executive positions in their organizations often experience fallout from gender disparity in leadership. Gender hierarchy studies have shown that men tend to dominate the C-Suite, and in the behavioral health field in particular, these men often do not even have the specialized training that women within their organizations have. What men do tend to have, however, are financial resources or relationships with financial institutions. Therefore, while male senior executives focus on financial issues, especially in the current hot venture capital market, women are tasked with running the organization, often without the senior executive support, vision, and leadership they need to be effective. Furthermore, not enough women are given a voice in the senior management decisions that affect both day-to-day management and long-term planning.

Other women report feeling stuck in their current positions because the path to a more satisfying role is either not clear or not available to them. This frustration does not occur as frequently in large organizations where there may be more opportunities or in startup environments where there is often more fluidity. To navigate around the obstacles blocking their advancement, these women express a desire for more education, training, and coaching. They want to be savvier about how and where to move on while developing strategies that will give them more control and options.

Because they recognize the increasing role that the financial industry is playing in behavioral health today and how business models are changing, many

women identify the need to develop an understanding of venture capital and business development while nurturing entrepreneurial instincts. They want to be able to negotiate more effectively, learn how to strategize, and/or make executive decisions. While they credit relationships for their professional success, they still place a great deal of importance on the need to network more, to develop more strategic connections, and to gain access to greater opportunities. When asked about their long-term (i.e., two- to five-year) goals, the majority of women put education and training at the top of their list-from BA to PhD as well as specialized training in fields such as organizational development.

Women's presence on executive teams and in boardrooms is a critical source of knowledge and experience needed to confront today's challenges.

A common theme throughout the survey was "a need to know what I do not know," suggesting that there are not only gaps in knowledge, but also insecurities about taking on risks without having specialized training in areas that traditional degree programs may not have covered, expertise such as raising capital, mergers and acquisitions, or even billing practices and insurance. Developing leadership skills is also high on the list as a way to facilitate advancement, growth, and entrepreneurial development.

Many women have advanced theoretical skills, but have not learned how to apply them effectively in real-time environments or need help knowing how to adapt their skills to work more productively in an industry whose priorities and infrastructure are shifting rapidly. While the majority of participants believe that new skills and training maintain relevancy, sustain high levels of professionalism, and

improve their chances for promotion, others emphasize that knowing how to apply skills and training is even more important. Operating and managing a business is just one of many subjects that are often not taught in an academic environment or certification program but need to be mastered.

Companies often value deliverables more than skill competency for promotion, so skills must be proven by measurable actions and initiatives. When asked about participating in programs that could improve their day-to-day experience, more than half respond favorably. One participant pointed out that executives are often more concerned with the macro, whereas the micro is where an organization lives in the dayto-day; another respondent felt that women need a program that teaches macro-focused thinking to help them compete in the male-dominated entrepreneurial space.

Coaching, as well as building selfawareness and new skills, are attractive solutions to career stagnation for many women because of the focus on their particular roadblocks to promotion. Once equipped and empowered, a frequent response for those coached is to coach others. The byproduct of advancement is clear: the desire to continue growing and learning, strategizing next steps, and mentoring and advancing staff as well as others. Success and satisfaction tend to trickle down. The most desired topics for one-on-one mentoring and coaching are entrepreneurial and strategic decision-making skills, suggesting that women who are thinking about next steps for starting or growing a business or moving up in an organization prefer to focus on the macro level.

Though statistically women behavioral health professionals are being excluded from senior management positions, the women from this sample survey are nonetheless ambitiously striving to better their services, grow in their expertise, build their businesses, open new businesses, and continue to get the education and training they need to stay on top of the latest practices and trends. They express a desire to become more involved in state policy, to oversee competency training for frontline

techs, to educate and modernize the industry, to gain equity in their companies, and participate in strategic merger and acquisition decisions, along with a multiplicity of other initiatives. In other words, they remain undaunted in their quest to improve and grow the field while making themselves, their clients, and their organization or practice successful. They display the leadership, drive, and vision necessary to forge the partnerships and set the standards as new alliances are forged out of private equity and technology innovation.

It is also important to these women to have a strong moral compass, helping to keep their values and ethics at the forefront of their business. These are all solid ingredients for a management dream team, the kind of collaborative and eminently qualified executives with whom private equity firms are eager to do business but are often unable to find.

## **Conclusion**

In short, the underrepresentation of women in leadership positions within behavioral health organizations can be diminished with programs that support and empower women. Women's presence on executive teams and in boardrooms is a critical source of knowledge and experience needed to confront today's challenges. Their leadership is crucial to help guide the industry's choices about how clients are treated, how businesses are structured and operated to comply with legislative policy, how organizations remain healthy fiscally, and how the economical delivery of quality services can remain sustainable. Mentoring, coaching, and other immersive training courses, in partnership with organizations, would help women build on what they have learned in degree and certificate programs and what they are good at (e.g., building teams, networking, operational excellence, delivering quality services) while adding to their skill sets the entrepreneurial, management, and financial wherewithal to take their organizations and practices into the future. Their long-term goals are also in alignment with where the industry is headed; with innovation and funding heading the agenda of the top behavioral health organizations today, training and revenue are priorities. **©** 

### About the Authors

Andrea G. Barthwell, MD, DFASAM, is an internationally renowned physician who has been a pioneer in the field of addiction medicine within the American Addiction Society of Medicine (ASAM) and a contributor to the



field of alcoholism and addiction treatment. Dr. Barthwell currently serves as the CMO of Treatment Management Behavioral Health and the founder and CEO of the Two Dreams facilities.

Cherlyne Short Majors, PhD, has held senior executive level positions for numerous internationally recognized behavioral health care treatment providers including the Betty Ford Center, Cirque Lodge, and most recently Constellation Behavioral Health.



Dr. Majors's experience in the fields of child/maternal health and behavioral health spans thirty years in a variety of settings, including treatment of SUDs in children and adults. Dr. Majors is a founder of The Women's CEO Global Alliance in Behavioral Health and WILLOW Institute, which provides leadership training for emerging women leaders in behavioral health.

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## **Author's Note**

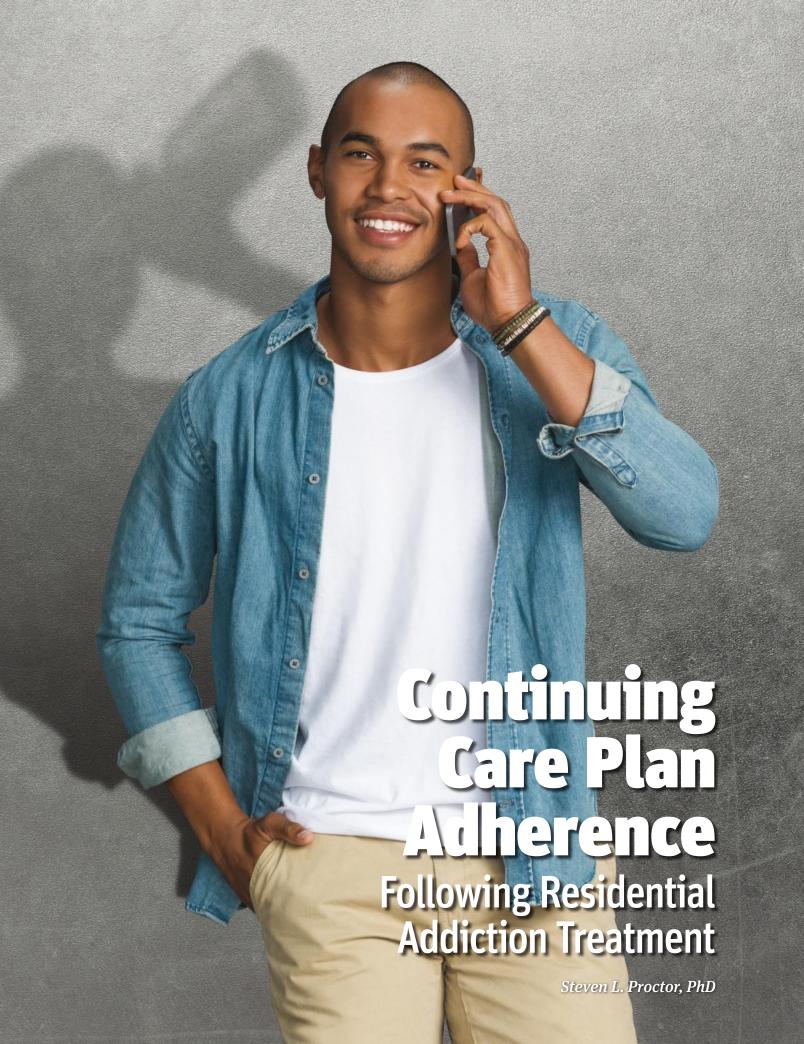
## **Cherlyne Short Majors, PhD**

Being the only woman at the executive conference table has been more the rule than the exception in my thirty-year career in behavioral health. Even after earning a place at that table, deep-seated gender inequities and discriminatory attitudes and practices have often turned the executive suite into a random game of musical chairs in which male-favored power dynamics and structures controlled how, when, and for whom the music stopped.

Like many women, it was critical for me to begin working according to my own convictions and passions, developing my strengths and talents, and collaborating with like-minded colleagues. Currently, this path to personal and professional empowerment for women aspiring to be in the C-Suite is still fraught with many obstacles.

As in every field today, political, economic, and technological disruptions are both challenging and revolutionizing behavioral health. We need 100 percent of our professionals, men and women, engaged in, committed to, and rewarded by efforts to deliver the most equitable and effective treatment solutions possible for those who are struggling. We need training to make this happen as well as advocacy to build awareness of where change needs to occur and how it can be supported at an institutional and organizational level.

Women in our field want to be leaders, and they have the talent and the drive. By creating opportunities for learning and collaboration and offering mentorship, we can help them aspire to and assume power-sharing roles that will make the field of behavioral health thrive.



ommon sense suggests that greater patient adherence to substance use disorder (SUD) treatment recommendations is associated with better outcomes. Surprisingly, however, there is limited previous research systematically investigating the adherence-outcome relationship in the context of SUD treatment.

A sizeable knowledge base, primarily from the medical treatment literature, supports a link between the extent to which patients' behaviors (e.g., taking medication, executing lifestyle changes) coincides with favorable treatment outcomes (DiMatteo, Giordani, Lepper, & Croghan, 2002; Simpson et al., 2006). The treatment of SUDs is increasingly being contextualized within a disease management framework, much like that of other chronic medical conditions such as hypertension, diabetes, and asthma (IOM, 2006; McLellan, Lewis, O'Brien, & Kleber, 2000). Accordingly, there has been a shift in focus in recent years from the primary to secondary (or continuing care) phase of treatment. The continuing care phase involves providing some form of less-intensive, tapered care such as standard outpatient treatment or community-based self-help and/or support groups. The overarching goal of any continuing care plan is to sustain treatment gains attained in the primary phase in an effort to manage SUDs and ultimately achieve remission.

According to the US Surgeon General's recent landmark "Report on Alcohol, Drugs, and Health" (HHS, 2016), there are a number of evidence-based interventions for the treatment of SUDs with demonstrated effectiveness. Considerable work also supports the widely held belief that the provision of lower intensity continuing care services delivered on an outpatient treatment basis after the primary treatment phase (e.g., residential/inpatient) is associated with favorable long-term clinical outcomes. As described by McKay (2009), however, individual patients differ significantly in their response to continuing care interventions, which can be influenced by a number of patient-level and program-level factors. One patient-level factor of particular interest is adherence—given that poor adherence often leads to patient dropout, which in turn has been shown to be associated with unfavorable long-term outcomes (Simpson, Joe, & Brown, 1997). Although participation in continuing care activities—like community-based self-help groups and/or formal outpatient aftercare programming—is a reliable predictor of positive longterm functioning (McKay, 2009; Proctor & Herschman, 2014), research suggests that few patients are adherent in that many participate in little to no continuing care (Etheridge, Hubbard, Anderson, Craddock, & Flynn, 1997), and even fewer receive continuing care for any meaningful length of time.

Considering that SUD is increasingly being recognized as a chronic, relapsing condition requiring protracted disease management comparable to other chronic medical conditions (e.g., hypertension, diabetes, asthma), studies investigating the impact of patient adherence to continuing care plans and its impact on recovery are of paramount importance (McLellan, McKay,

Forman, Cacciola, & Kemp, 2005). Several reviews of the vast SUD treatment literature suggest that long-term care strategies have the potential to produce lasting benefits for individuals with SUDs (McKay, 2009; McLellan et al., 2000; Proctor & Herschman, 2014). However, the presence of evidence-based continuing care treatment options in the absence of patient adherence presumably renders such options of limited clinical value.

The SUD treatment adherence research has largely focused on adherence to medication-assisted treatment (MAT) regimens involving the use of methadone, buprenorphine-based formulations (Suboxone), or naltrexone (Vivitrol). For such pharmacological interventions, the measurement of adherence is relatively easy and involves simply whether or not patients took their prescribed medication as directed. Conversely, the measurement of adherence for psychosocial interventions is understandably more challenging given the variability in treatment regimens and complexity of quantifying adherence. As a result, much of the current research support for the adherence-outcome relationship in SUD literature has failed to consider the multifaceted, psychosocial, continuing care phase of SUD treatment. The use of strict inclusionary criteria in studies demonstrating the strongest support to date linking adherence to psychosocial treatment with long-term outcomes (Mattson et al., 1998) also necessitates further work with a naturalistic (i.e., "real world") treatment population. Thus, in light of the surprisingly limited empirical evidence to date, it remains unclear to what extent patient adherence to multicomponent continuing care plans is associated with long-term recovery.

## **Study Aim**

The main objective of the study was to determine whether patient adherence to multicomponent, psychosocial continuing care plans during the initial twelve-month period following discharge from residential treatment predicted a number of successful long-term clinical outcomes using data from a naturalistic treatment sample.

## **Study Design and Sample**

The study described herein was a secondary analysis of a subset of data from a previously published study evaluating the effectiveness of a protracted, telephone-based care plan management intervention (Proctor, Wainwright, Herschman, & Kopak, 2017). Data for the current study were derived from existing patient records using the management information system of a large behavioral health care management services provider. Patients were studied through retrospective electronic record review for twelve months following discharge from primary residential addiction treatment. Residential treatment included a combination of group and individual therapy using Twelve Step, mindfulness meditation, and cognitive behavioral techniques, and the average length of stay (LOS) for the sample was about twenty-eight days (SD = 8.58). Upon admission to treatment, all patients participated in a comprehensive biopsychosocial assessment and diagnostic evaluation. Diagnostic determinations were made by trained clinical staff as per the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994), and were subsequently verified by the treatment provider's staff psychiatrist.

## **Participants**

The study sample consisted of 271 patients (59 percent male) with an average age of 40.43 years (SD = 13.99) who were discharged from a single residential addiction treatment program located in the southwestern United States between 2013 and 2015. All patients agreed to receive telephone-based protracted care plan management postdischarge. The racial composition of the sample was predominately white (92 percent). Slightly more than half (55 percent) of patients were unemployed, and approximately twothirds (68 percent) paid for treatment out-of-pocket (i.e., were self-pay). Nearly half (44 percent) were single at the time of admission to treatment, while a similar proportion (44 percent) indicated that they were either married or in a romantic relationship.

In terms of the clinical characteristics of the sample, the most prevalent primary SUD diagnosis involved alcohol with two-thirds (66 percent) of patients meeting criteria for a DSM-IV alcohol use disorder (AUD). The second most prevalent SUD involved opioids (i.e., heroin or prescription pain relievers) with 18 percent receiving an opioid use disorder (OUD) diagnosis, followed by stimulants (i.e., cocaine, methamphetamine, or amphetamines) at 10 percent. The majority of patients also received a co-occurring psychiatric disorder diagnosis with 61 percent of patients meeting criteria for a non-SUD mental health condition. Among those with a co-occurring disorder, major depressive disorder (31 percent) was the most common comorbid condition, followed by an anxiety disorder (22 percent) and posttraumatic stress disorder (15 percent).

## Measures

Before being discharged from residential treatment, all patients and their multidisciplinary treatment team collaboratively created a multicomponent continuing care discharge plan, which included a detailed list of goals and expectations regarding continuing care. Although continuing care plans may have been variable—given they were personalized to the patients' unique needs—all plans included regular attendance at community-based self-help groups (e.g., AA/NA meetings) as well as standard

outpatient treatment with a local provider in their home community, beginning within seven days of discharge. All patients received protracted, telephone-based care plan management by master's level, licensed telehealth specialists for twelve months, and patients answered an average of 23.92 (SD = 0.99) telephone calls. Telephone contacts included a standardized set of questions asking patients about their recent use of alcohol or drugs as well as their perceived quality of life and adherence to continuing care plans.

It is important to note that telephone contacts did not involve counseling per se, but rather care plan management with a focus on whether patients were adherent to their personalized discharge plan. One of three possible adherence ratings was assigned by telehealth specialists based on the extent to which patients followed their continuing care plan. During each telephone contact, patients were asked a series of "yes" or "no" questions corresponding directly to their continuing care plan. The values for each continuing care plan element response were added and divided by the total number of care plan elements. For example, telehealth specialists may have asked patients whether they attended a Twelve Step meeting, attended outpatient individual therapy with their local counselor, attended their medication management appointment, and took their prescribed medication as directed. If patients responded "yes" to all continuing care discharge plan elements, then the telehealth specialists would assign a "fully adherent" rating. If patients responded "yes" to 50 percent or more, but less than all of their continuing care plan elements, telehealth specialists would assign a "partially adherent"

rating. Completing less than 50 percent of continuing care plan elements resulted in a "nonadherent" rating.

## **Outcomes**

Primary outcomes included:

- Past thirty-day abstinence at twelve months
- Continuous abstinence through the entire twelve-month period following residential treatment discharge

Secondary outcomes included:

- Readmission to any residential level of care through twelve months
- Perceived quality of life at twelve months

## Results

Comparisons involving level of patient adherence to continuing care discharge plans with study outcomes at twelve months revealed several notable findings (see Table 1). Fully adherent patients demonstrated significantly better results on all but one study outcome at twelve months compared to patients who were partially adherent or nonadherent. Specifically, fully adherent patients evidenced significantly higher rates of continuous abstinence, past thirty-day abstinence, and a positive quality of life at twelve months compared to nonadherent patients. Fully adherent patients also demonstrated significantly higher rates of continuous abstinence and past thirty-day abstinence at twelve months compared to partially adherent patients. Finally, partially adherent patients evidenced significantly higher rates of continuous abstinence, past thirty-day abstinence, and a positive quality of life compared to nonadherent patients.

Table 1. Associations between Patient Adherence and Outcomes at 12 Months

|                                | Continuing Care Plan Adherence |                            |                    |
|--------------------------------|--------------------------------|----------------------------|--------------------|
| 12-Month Outcome               | Non<br>(n = 47)                | Partially ( <i>n</i> = 73) | Fully<br>(n = 151) |
| Past 30-day Abstinence a, b, c | 51%                            | 92%                        | 99%                |
| Continuous Abstinence a, b, c  | 23%                            | 58%                        | 88%                |
| Readmission                    | 13%                            | 4%                         | 8%                 |
| Quality of Life a, c           | 72%                            | 93%                        | 97%                |

- a. Non- and partially adherent groups significantly differed at p < .01.
- b. Partially and fully adherent groups significantly differed at p < .01.
- c. Non- and fully adherent groups significantly differed at p < .01.

 $\textbf{Note:} \ \ \text{The mean scores are the means of number of mistakes made by subjects.}$ 

Findings from logistic regression also revealed that patient adherence was a significant predictor of continuous abstinence through the entire twelve-month postdischarge period after controlling for the effect of relevant demographic variables (i.e., age, sex, marital status, and employment status). Patients who were fully adherent to their continuing care discharge plans through twelve months were nearly ten times more likely to be continuously abstinent through the initial twelve months postdischarge from residential treatment compared to patients who were nonadherent or partially adherent to their care plans. Patient adherence was also a significant independent predictor of a positive quality of life, such that fully adherent patients were nearly eight times more likely to report positive quality of life at twelve months relative to patients who were not fully adherent to their continuing care discharge plans.

## **Recommendations for Practice**

As the SUD treatment field's apparent paradigm shift from the primary phase to the secondary (or continuing care) phase moves onward, there is a clear need for studies to systematically research the role of relevant variables that may influence continuing care outcomes. One such understudied variable is patient adherence to continuing care plan recommendations. Consistent with previous research (Mattson et al., 1998), the current study found that greater adherence was associated with better long-term outcomes. However, the current study extends previous work regarding the adherence-outcome relationship through the use of a naturalistic treatment sample, less restrictive inclusionary criteria, and a more sophisticated measure of patient adherence. The current findings provide empirical evidence to support the widely-held belief that greater patient adherence to psychosocial continuing care options is linked to favorable treatment response. Although, theoretically, the assumed positive correlation between adherence to continuing care plans and outcomes among SUD patients is a reasonable notion, surprisingly very few studies have tested the effect of adherence in SUD treatment outcomes beyond MAT evaluations.

The reported findings contribute to the current knowledge base and provide

insight into realistic outcomes expectations for patients who are adherent to their multicomponent continuing care discharge plans. In the context of the current study, several noteworthy findings were found with respect to abstinence, which is arguably the most important outcome for patients receiving SUD treatment. Patients who were adherent to all elements of their continuing care discharge plans through twelve months were significantly more likely to demonstrate both continuous and past thirty-day abstinence at twelve months compared to patients who were not adherent. Remarkably, patients who received a fully adherent rating through twelve months were nearly ten times more likely to be continuously abstinent through the entire twelve-month period following residential treatment discharge relative to patients in the nonadherent or partially adherent groups. Therefore, providing psychoeducation to patients before they leave residential treatment during discharge planning sessions on the findings reported here and the apparent long-term benefits of following all continuing care plan elements may address one of the most commonly cited traditional barriers to adherence (e.g., failure on the patient's part to understand the importance of adherence) and possibly lead to increased motivation and successful long-term outcomes.

It is also important to highlight that adherence was associated with additional long-term benefits beyond abstinence. Although abstinence—or more specifically, remission—is the gold standard of SUD outcomes, it alone is insufficient to fully capture the broader construct of recovery (Betty Ford Institute Consensus Panel, 2007). As such, the use of measures of quality of life is becoming an increasingly more common practice to demonstrate evidence of therapeutic benefit in SUD treatment outcomes research (Donovan. Mattson, Cisler, Longabaugh, & Zweben, 2005). This study found that patients who were fully adherent to their continuing care discharge plans were nearly eight times more likely to report a positive quality of life at twelve months compared to patients who were not fully adherent. This suggests that adherence may impact additional indicators of postresidential treatment functioning. Although the achievement of abstinence was presumably a result

of greater adherence to continuing care plans—which in turn likely contributed to patients' perception of a positive quality of life—testing for the mediating role of abstinence on quality of life was beyond the scope of the current study.

## **Study Limitations**

This study included a number of limitations that suggest the need for additional work in this area. First, the context of the current study was a previous evaluation of a protracted, telephone-based care plan management intervention in which all patients received regular contact over the course of an entire year following discharge. As such, the findings reported here may not generalize to all patients discharged from residential treatment given the disparate practices and treatment philosophies that often accompany different programs. Second, the sample was predominately white, and approximately two-thirds paid for their own treatment care out-of-pocket, which warrants caution in generalizing the findings to innetwork programs or those serving more racially diverse patients. The overrepresentation of white patients in the current sample is especially salient considering that recent national data indicate that over one-third of national SUD treatment admissions are a member of a racial/ethnic minority group (SAMHSA, 2016). Third, the current study sample was comprised primarily of patients who had successfully completed residential treatment, which may be indicative of higher levels of motivation and readiness to change, and may not be representative of all patients. Additional research is necessary to determine if continuing care plan adherence predicts long-term outcomes among patients who are prematurely discharged from residential care. Finally, closer examination of the role of other relevant factors and/or barriers likely to impact patient adherence (e.g., employment, transportation, child care) is warranted and requires further investigation.

## **Conclusion**

Despite the study limitations, one can assert the following important conclusion: If patients and providers aspire to positive long-term outcomes following discharge from the primary residential treatment episode, adherence to multicomponent

continuing care plans is a requisite—a notion supported by the current study's reported findings. ©

## About the Author

Steven L. Proctor, PhD, is the founder and principal at PRO Health Group. He specializes in the evaluation of behavioral health care treatment systems with a particular focus on addiction treatment outcomes and he has published extensively in



this area. He is committed to evaluating and improving the effectiveness of SUD treatment services, and frequently provides research, training, and program evaluation consultation to various treatment agencies.

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## CCAPP Continued from page 7

counseling sessions with open-ended questions and using more reflective statements than questions can help establish and increase rapport, as can demonstrating patience, respect, and an awareness of clients' cultures.

Subject matter may influence the success of cross-cultural interviewing. Certain subjects may not be acceptable to clients for discussion, such as those not typically shared with an unfamiliar person. Personal or family affairs, questions about family or spouses, and "personal" concerns such as alcohol or drug use may be considered private matters. If so, counselors might need to explain why it is necessary to ask certain questions. Or, counselors can say to clients, "Please tell me any time you do not want to answer a question."

Culturally sensitive counselors will need to learn how to overcome language barriers posed by clients who use English as a second language, especially how to use interpreters effectively with non-English-speaking clients (US Department of Agriculture, 1986). A final consideration in crosscultural counseling is to identify the expectations of clients. One example might be that clients with high adherence to their cultural values may strive to maintain a role in counseling that protects the family honor. Another example could be clients who expect immediate symptom relief from a goaloriented, authoritative counselor (Kim, Atkinson, & Umemoto, 2001).

In conclusion, multicultural counseling is possible with cultural sensitivity combined with client-centered addiction counselors. This means we

need well-trained counselors who see compassion, collaboration, and meeting clients where they are—plus cultural sensitivity—as the necessary ingredients for cross-cultural or multicultural counseling. It is culturally sensitive for us all to remember that we will never know everything about a culture, including the one with which we identify.

## **About the Author**

Pete Nielsen, CADC-II, is the CEO of the California Consortium of Addiction Programs and Professionals (CCAPP). Mr. Nielsen has worked in education as a campus director, academic dean, and an instructor. He has also



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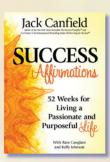
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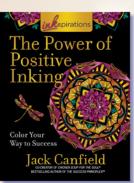
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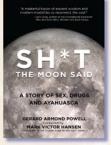
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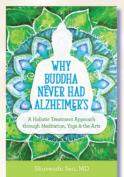
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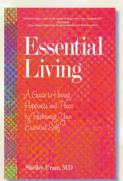
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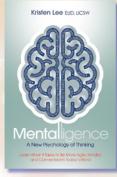
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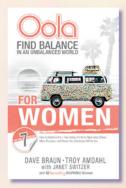
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## **CE QUIZ**

## **Do You Accept Self-Empowering Recovery?**

- 1. All of these were listed as areas the Surgeon General's "Report on Alcohol, Drugs, and Health" addressed, except:
  - (A) Medication-assisted treatment
  - B Reducing harm
  - © Mutual aid groups
  - (D) None of the above, these are all valid areas
- True or False. According to the Surgeon General's Report, research shows that medication-assisted treatment leads to better outcomes than behavioral treatments alone.
  - (A) True
  - (B) False
- 3. Which is not a mutual aid group that employs a selfempowering approach?
  - (A) Moderation Management
  - **B** Women for Sobriety
  - © Alcoholics Anonymous
  - None of the above, these are all valid groups
- 4. True or False. SMART Recovery is the largest mutual aid group the author listed that utilizes a self-empowering approach.
  - (A) True
  - (B) False
- Additional aspects of self-empowering mutual aid groups include all of the following, except:
  - A Signing court cards
  - (B) A lack of meetings
  - © Severe dislike for AA
  - (D) None of the above, these are all valid aspects

## **Eating Disorders: Separating the Patient from the Disease**

- True or False. Anorexia is easier than other eating disorders to identify because patients must be at 75 percent of their normal body weight.
  - (A) True
  - (B) False
- All of the following are symptoms of eating disorders counselors should look for when making an assessment, except:
  - A Feeling cold and dizzy
  - B Psychomotor retardation and forgetfulness
  - © Fatigue and wearing baggy clothing
  - D None, these are all valid symptoms
- 3. Which of the following is not a way bulimic patients may purge food?
  - (A) Exercise
  - (B) Vomiting
  - © Severe reduction in caloric intake
  - D Laxative use
- True or False. The combination of vomiting alcohol and gastric acid may lead to erosion of the esophagus, causing patients to bleed out.
  - (A) True
  - False
- 5. Metabolic syndrome is a risk for patients suffering from which eating disorders?
  - A Binge eating disorder
  - Anorexia nervosa
  - © Bulimia nervosa
  - D Both B and C

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## **Continuing Care Plan Adherence Following Residential Addiction Treatment**

- 1. In the sample of study participants, what was the second most prevalent substance used?
  - (A) Alcohol
  - (B) Stimulants
  - © Opioids
  - None of the above
- 2. Which of the following is where substance abuse treatment adherence research has been focused most often?
  - (A) Medication-assisted therapy
  - Mutual aid groups
  - © Both A and B
  - (D) None of the above
- 3. True or False. A significant knowledge base supports the notion that the extent of a patient's behavior (e.g., taking medication and going to therapy) affects treatment outcomes.
  - (A) True
  - (B) False
- 4. Participants in the study were examined following discharge from what level of treatment?
  - (A) Outpatient
  - (B) Intensive outpatient
  - © Residential
  - (D) All of the above
- 5. True or False. The current study found that greater adherence was not associated with better long-term outcomes.
  - (A) True
  - (B) False

## **Learning Objectives**

## Do You Accept Self-Empowering Recovery?

- 1. Explain the Surgeon General's "Report on Alcohol, Drugs, and Health" and its areas
- 2. Describe the terms "self-empowering" and "powerlessness" as related to recovery
- 3. List the different mutual aid groups that use a self-empowering approach
- 4. Analyze therapist dialogue to determine if it offers multiple pathways for clients

## **Eating Disorders: Separating the Patient from the Disease**

- 1. Describe the characteristics of patients presenting with an eating disorder
- 2. List various physical and mental health consequences and co-occurring issues that are related to eating disorders
- 3. Expound on situations that might require referral to higher levels of care
- 4. Present eating disorder resources for patients and counselors

## Continuing Care Plan Adherence Following Residential Addiction Treatment

- 1. Analyze previous research on continuing care plan adherence
- 2. Describe the current study and its aims
- 3. Evaluate the results of the study
- 4. List implications for counselors' and treatment centers' continuing care plans

## **Counselor Magazine Evaluation Quiz**

Scale: 1 = strongly disagree, 5 = strongly agree

- 1. After completing this course, I am able to
  - a. Learn outcome 1
    - (1) (2) (3) (4) (5)
  - b. Learn outcome 2
    - 1 2 3 4

- c. Learn outcome 3
  - (1) (2) (3) (4) (5)

- 2. The course/session material was appropriate to my education, experience, and/or licensure level
  - (1) (2) (3) (4) (5)
- 3. The course/session material was relevant to my practice
  - 1 2 3 4 5
- 4. The course/session material was current
  - (1) (2) (3) (4) (5)
- 5. The course/session material presented the content effectively
  - 1 2 3 4 5
- 6. The handouts and teaching aids enhanced the content of the course/session
  - (1) (2) (3) (4) (5)
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  - (1) (2) (3) (4) (5)
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- (1) (2) (3) (4) (5)
- b. My questions or concerns were addressed effectively
  - 1 2 3 4 5
- c. My questions or concerns were addressed in a timely manner

- (1) (2) (3) (4) (5)
- 9. The technology was user friendly
- - 1 2 3 4 5
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- (1) (2) (3) (4) (5)

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ATLANTA (DoubleTree by Hilton Atlanta-Buckhead), GA

Hosted by







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## Our mission is simple.

Providing the Best Treatment for a Better Life.

Together, we help you **uncover** your story, **discover** the real you, and **recover** your life!



## We know you want the best for your teen. So do we.

What changes do you want to see in your child's life so you can trust that they're on the right path?

All of us at Newport Academy have been in your shoes, and we found the path to healing. Call us. Let's eliminate your fears and change your child's life for the better, starting now.





Empowering Teens. Restoring Families.

MENTAL HEALTH ♦ EATING DISORDERS ♦ SUBSTANCE ABUSE

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