Illinois Institute for Addiction Recovery
at Proctor Hospital

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Co-dependency A Silent Killer

PLUS:

Crystal Methamphetamine

Supported Employment

Treating the Triggers

Anabolic Steroids

Libby has often said her work in the field of addiction recovery feels more like a calling than a career, and her enthusiasm for her work can easily be seen by anyone who comes in contact with her.

Libby Zivalich, B.S., C.A.R.S.

When doing trainings and presentations for the Illinois Institute for Addiction Recovery (IIAR), Libby, with tongue firmly in cheek, refers to herself as a "recovering" high school teacher, because that is where her journey to her present position as a Corporate Services Clinician began back in 1988. Libby graduated from Eureka College in Eureka, Illinois with a degree in Mathematics, a minor in Physics and a secondary education-teaching certificate. Many people wonder how she came to work in the field of addiction recovery with a background like that, but to Libby, the transition is really quite logical. One afternoon while grading papers after school, Libby was approached by a student who disclosed she had gotten drunk the night before and intended to end her life by sitting on the railroad tracks until a train came by. Thankfully, the student changed her plans and was reaching out for help. Libby, however, felt at a loss without the proper information or experience needed to truly help this student. That incident shaped Libby's entire career direction from that moment on.

Libby became involved in local drug prevention efforts, volunteering for service groups and developing programs for the community and school where she taught. Shortly after developing the programs, she decided to leave formal teaching to continue her work in drug prevention, addiction treatment and the mental health field. Libby also learned a valuable truth at this time; she thrives on any opportunity to engage people in learning — whether she is facilitating a treatment group or leading trainings. As the saying goes, "You can take the teacher out of the classroom, but you cannot take the classroom out of the teacher," and this has never been more true than in Libby's case.

Since joining the Illinois Institute for Addiction Recovery in November of 2002, Libby has been able to combine her knowledge and experience in the field of addictions with her love of teaching. Libby's responsibilities with IIAR include developing and presenting trainings to audiences of all types, from the classroom to the boardroom, and professionally, she's never been happier. Libby has often said her work in the field of addiction recovery feels more like a calling than a career, and her enthusiasm for her work can easily be seen by anyone who comes in contact with her.

Libby is currently pursuing her Masters Degree at the University of St Francis in Joliet, Illinois and is majoring in Training and Development. Libby plans to continue using her skills, experience and passion to further the mission of the Illinois Institute for Addiction Recovery after she completes her degree. In addition to her work with IIAR, Libby is also on the Board of Directors of the Hult Health Education Center.

Libby has been married to Steve for 4 years, and has a 12-year old stepson, Zach. The family enjoys sports together, particularly basketball. Along with spending time with her family and friends, Libby is a voracious reader, wonderful cook, and loves making beaded jewelry, especially with Zach.▼

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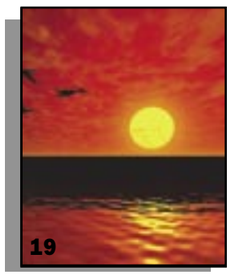

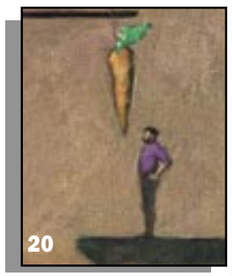

F E A T U R E S

D E P A R T M E N T S

CO-DEPENDENCY

A SILENT KILLER

RELATIONSHIP ADDICTION
RELATIONAL DIFFICULTIES

by Mundie Merrill, B.A., C.A.D.C., MISA I

Co-dependency is a behavior pattern that develops as a result of prolonged exposure to, and the practice of rules that prevents open expression of feelings and direct discussion of issues or conflicts. (1) There are several types of family histories that can produce co-dependency other than addiction history.

VIOLENCE: To do physical, emotional, psychological harm, the use of force.

INCEST: A sexual relationship between persons too close to marry.

TRAUMA: A physical, emotional, psychological injury or shock that has a lasting effect.

RIGIDITY: Unwilling to compromise or consider another's opinion or feelings.

WORK ADDICTION: Self-worth is based on what we do rather than who we are. Work defines our identity.

Co-dependency is a progressive disease in its own right. It has an *onset* (a point at which the person's life is just not working, usually as a result of an addiction). Co-dependency has a *definable course* (the person continues to deteriorate mentally, physically, psychologically and spiritually) and untreated, has a *predictable outcome* (death). (2) Co-dependency is a learned behavior with a set of certain beliefs, feelings, and behaviors that over time become destructive to the person. Co-dependency is not limited to only the interaction within the family; it is also a coping mechanism in the work place and other areas in the person's life.

The co-dependent has a powerful need to take care of others to the point of self-destruction. Rigidity and perfectionism are the two themes that go hand-in-hand with the behavioral style of co-dependency. The co-dependent person finds times of change extremely difficult and experiences the need to control situations and others. Denial and distortion of anger and other intense emotions are usually maintained internally at all cost. The person also has the need to keep secrets, thus giving the false sense of power over other people. Often there is a dependency upon others for approval and the need for acceptance is the prime motivation for the co-dependent's behavior. The co-dependent operates on a sense of internal shame, never feeling good enough and always feeling "broken."

A SILENT KILLER

When a person enters treatment for addiction, it is imperative each family member receives education regarding addiction as a family disease as well as identification of coping skills that over time have been personally destructive. If the family does not engage in the treatment process, it is extremely difficult for the addicted person to continue a solid recovery program. The addiction dramatically affects the entire family and each person deserves their own personal time for education, therapy, and healing.

The consequences for the co-dependent are many. *The progression is:*

Early Stage:
- Denial/excuse-making of the co-dependent's stress.
- Pre-occupation with the dependent person to the point of loss of self.
- Tolerance to inappropriate behavior. Allowing and accepting behavior that is abusive and painful over time without holding the person accountable.
- Taking on another's responsibility that is not yours. Always doing tasks for the other person hoping the person will become responsible.

Late Stage:
- Loss of tolerance to inappropriate behavior. Reserves and energy are exhausted, therefore nothing is tolerated.
- Love Shift: the person takes all of his/her feelings and will focus on something else to avoid emotional pain. A common shift is focusing all energy and attention into work or business or other compulsive behaviors (such as Internet, shopping/spending, sex, food, etc.).
- Medical problems:
- Compromised immune system
- Depression
- Chronic fatigue
- Insomnia/over-sleeping
- Aches, pains, headaches
- Anxiety / Panic Attacks
- Frozen Feelings – Emotionally numb

Because co-dependency impacts the entire family, it is necessary for all members of the family to receive education/therapy. When one member of the family changes, the whole family is in a state of trying to adjust. The whole family experiences the disease of addiction and the whole family can recover.

When co-dependency enters the workplace, there are characteristics that can prevent productivity and a sense of well-being. The following characteristics may identify co-dependency in the work place. (3)

- Compulsive tendencies to prove self-worth and value.
- Assuming the responsibility for meeting the emotional needs of others to the point of the inability to meet personal needs.
- Inability to distinguish healthy boundaries at work with co-workers and supervisors. Fear of threats of separation and abandonment are prime motivators for constant approval and acceptance from others.
- Negative relationships with others suffering from personality or impulsive disorders or self-centeredness are sought out in order to feel needed.
- Denial of self-defeating behavior and the selection of others to re-enforce the behavior.
- Suppression of personal feelings is necessary in order to be viewed as someone to come to for problem resolution and major issues. While appearing fearless, the person is drained of vital, life-giving energy.
- Appearing as depressed and moody, one may act upon these feelings in personal and professional relationships
- Acutely aware of the surroundings and every inflection of voice, behavioral change, and moods of others. The attitude is often negative and highly critical of others.
- High baseline of anxiety and internal feeling of worthlessness.
- Use of alcohol or drugs and/or other addictive behaviors in order to mask the pain of childhood victimization.

It is very important for a clinician to identify these traits and address those issues as a treatment team in order to provide the appropriate plan of therapy. Many suffering from chemical dependency and other addictions suffer from co-dependency as well. This can be a powerful relapse trigger, jeopardizing one's recovery.▼

Because co-dependency impacts the entire family, it is necessary for all members of the family to receive education/therapy.

Additional information on co-dependency is available by calling the Illinois Institute for Addiction Recovery at 1(800) 522-3784 or by visiting the Web site at www.addictionrecov.org.

Mundie Merrill *joined the Illinois Institute for Addiction Recovery (IIAR) in September 2003, but has been in the healthcare industry since 1971. In 1975, she began working in the addiction field at Triangle Center in Springfield, Illinois. She also worked 18 years as an addiction/family counselor at St. John's Hospital, Libertas Program, Springfield, Illinois. Ms. Merrill published a study guide for IAODAPCA (Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc.) regarding family systems and therapy, as well as the text,* Chemically Dependent Older Adults: How Do We Treat Them? *(Hazelden, 1990).*

References

1. Webster's II New Riverside Dictionary Revised Edition, (1996).
2. Schaef, Ann W. *Codependence, Misunderstood, Mistreated.* San Francisco, Harper and Row, (1986).
3. Subby, Robert. *Inside the Chemically Dependency Marriage: Denial and Manipulation — dependency: An Emerging Issue.* Pompano Beach, Fla, Health Communications, (1984).

by Sarah Swanson, M.S., C.R.C., L.S.W., Patrick E. Boyle, M.S.S.A., L.I.S.W., L.I.C.D.C. and Paul Kubek, M.A.

SUPPORTED EMPLOYMENT
the Evidence Based Practice

This service is funded by the Ohio Department of Mental Health, the Substance Abuse and Mental Health Services Administration, and Johnson & Johnson.

Monitoring Job Development to Improve Employment Outcomes

Supported Employment (SE) is a well-defined evidence-based practice (EBP) that helps people with serious mental illness find and keep competitive employment (Becker and Drake, 2003). In experimental studies, 58 percent of mental health clients in evidence-based SE programs found competitive jobs compared to 21 percent of mental health clients in traditional vocational rehabilitation programs (Bond, Drake, Mueser, and Becker, 1997).

The term ***supported employment*** as an ***Evidence Based Practice (EBP)*** is built with seven core principles that distinguishes it from traditional vocational programs (Becker & Bond, 2002; Bond & Jones, 2005). *The principles of SE include the following:*

1. ***Zero Exclusion:*** All clients who want to work are eligible for SE services. People are not excluded based on diagnosis, symptoms, substance use disorders, hospitalization history, nor lack of treatment compliance. Employment specialists help clients find jobs that meet their needs and ask for accommodations, as required.
2. ***Consumer Preferences are Important:*** Preferences in regards to type of work, hours of work, job location, and disclosure of disability are all examples of issues that are important. The employment specialists should consider, as much as possible, the consumer's preferences in order to provide highly individualized services.
3. ***Rapid Job Search:*** Pre-employment programs, vocational evaluation and lengthy vocational counseling are avoided. Instead, clients and employment specialists usually begin applying for jobs within a few weeks of entry into the program.
4. ***Competitive Jobs:*** SE programs help clients find jobs in the community for which anyone may apply. These jobs pay at least minimum wage and are not owned by a social service agency. For example, enclaves (groups of clients working under an agency employed supervisor) are not considered to provide competitive employment even if the work occurs in a community setting.
5. ***Integration of Services:*** Employment specialists are co-located with mental health providers and have frequent contact with case managers. They attend team meetings one or more times each week to share information and problem-solve issues with the mental health providers.
6. ***Time-Unlimited Services:*** Clients are provided follow-along support services for as long as they work at their job. Follow-along services are tailored to the needs of each individual but could include support and encouragement, assistance with symptom management, help understanding workplace expectations, education and support for employers, or on-the-job training. Further, if a consumer loses a job, the employment specialist helps the person think about the job as a learning experience and offers to help with another job search.
7. ***Benefits Planning:*** Clients are offered accurate information about the effects of earned income on their benefits. As people work, the SE program offers assistance with benefits reporting and social security work incentives planning.

Fidelity Scale

Fidelity scales have been useful to help assess faithfulness to the implementation of a particular practice model (Bond, 1997; Mowbray, 2003). SE has a fidelity treatment scale with 15 items that measure a service program's adherence to the research-tested design of the model. *Fidelity items, which emanate from the principles identified above, include the following items (Becker and Bond, 2002):*

1. Caseload size
2. Vocational services staff
3. Vocational generalists
4. Integration of rehabilitation treatment with mental health treatment
5. Vocational unit
6. Zero exclusion criteria
7. Ongoing, work-based vocational assessment
8. Rapid job search
9. Individualized job search
10. Diversity of jobs developed
11. Permanence of jobs developed
12. Jobs as transitions
13. Follow-along supports
14. Community-based services
15. Assertive engagement and outreach

There are also 14 items in the general organizational index (GOI). An implementation effort that includes attention to developing those structural components supports the organization's ability to help clients seek and secure employment.

Fidelity and Job Development

The Ohio Supported Employment Coordinating Center of Excellence (Ohio SE CCOE) is a technical-assistance organization that helps organizations and systems implement and sustain SE with high fidelity. It is funded in part by the Substance Abuse and Mental Health Service Administration and a Johnson & Johnson grant administered through the Ohio Department of Mental Health and is a partnership between Mandel School of Applied Social Sciences and the Department of Psychiatry in the Case School of Medicine at Case Western Reserve University. As part of its core services, the SE CCOE conducts baseline and ongoing fidelity reviews at organizations implementing the model. With the results from each fidelity review, the CCOE works in partnership with the organization to enact a fidelity action plan that will enhance or maintain fidelity.

Although the SE treatment scale measures fidelity for some aspects of job development, a fidelity review team is not prompted by the scale to carefully monitor job development. For instance, the scale does not prompt inquiry about the number and quality of employer contacts made by employment specialists, yet the SE CCOE has observed that programs in Ohio are able to impact outcomes positively not only by achieving high fidelity to the model but also by paying careful attention to job development strategies.

In the early phases of SE implementation, many sites continue to use a passive approach to job development. For example, some employment specialists are reluctant to contact employers on behalf of their clients. Instead, these specialists provide job leads to clients, assist them with job applications and teach job-search skills. The employment specialists seldom have contact with employers, and when they do the contact is sparse in content and focuses on asking only about job openings. This practice is in contrast to more sophisticated programs in Ohio where SE specialists contact employers frequently as a way to match job opportunities with the individual needs of each consumer.

Reluctant employment specialists have a variety of concerns about contacting employers. Some have not received training and are unsure of how to approach employers. Others are discouraged by a lack of interest from employers. Another concern for some employment specialists is that they are not absolutely certain how the consumer will perform on the job and are fearful of making "false promises" to both the consumer and the employer. Finally, employment specialists may avoid employer contact because they prefer to provide services from the office rather than in-person in the community.

The advantages to employer contacts are significant. Clients with the most barriers to employment often have great difficulties finding jobs without advocacy from an employment specialist. Many employers hire based on the belief that the employment specialist knows the consumer's strengths and will be able to provide the necessary supports for success.

It should also be noted that some clients are fearful of stigma and request that employment specialists do not contact employers on their behalf. Interestingly, while some Ohio SE programs report that almost all of their clients are comfortable with employer contact, other programs report that almost none of their clients are comfortable with employer contact. It seems likely that clients often reflect the level of comfort (or discomfort) held by employment specialists in regards to employer contact. This has become an area for needed consultation and skill development for these specialists by the CCOE.

It is important that clients have choice about disclosure of disability but it is also important that they understand the possible risks and benefits of disclosure. Further, clients should know that the employment specialist can work with employers without discussing diagnosis, personal information, or in some cases, without even talking about mental health issues.

Training and Consultation

To date, the CCOE has found that a four-pronged approach has been most effective in helping SE programs to improve their job development techniques. The activities include the following: *1) classroom training in job development concepts and techniques, 2) on-the-job training,* 3) *monitoring the number of employer contacts made by each employment specialist,* and *4) coaching from the SE supervisor regarding the quality of employer contacts.*

Classroom training consists of talking to employment specialists about cold calling, networking and other methods of finding job leads. Employment specialists who are not yet comfortable with employer contacts may find it very helpful to receive examples of what they could say to employers and practice identifying strengths for people on their caseloads. Specialists may require very specific information such as how to ask for the hiring manager or how to answer questions about symptoms. The CCOE consultant/trainer places an emphasis on listening to the employer's needs, talking about the consumer's strengths and asking to set up a meeting with the consumer.

The above classroom training prepares employment specialists for on-the-job training. The employment specialist practices job development in the community with the consultant who provides encouragement and feedback until the specialist feels comfortable performing job development independently. This step more likely ensures that information provided in classroom training is adopted into actual practice.

To ensure that new skills are used on an ongoing basis, however, a method for monitoring the behavior must be put in place. A simple method for monitoring the number of employer contacts made by a specialist is to have each person mark contacts in their calendar and report to their supervisor weekly. For example, if the number of jobs found decreases, the SE supervisor may notice a corresponding decrease in the number of employer contacts. If the number of jobs found is low and contacts are plentiful, the supervisor can provide coaching around the quality of job development techniques. Talking to employment specialists about their strategies for approaching employers can provide some helpful information, though shadowing the employment specialist again is a more effective way to pinpoint problems and provide training simultaneously.

Finally, SE supervisors should continue to talk about job development in weekly meetings and encourage the sharing of job development tips and practices. Special attention and ongoing training may be provided for specific issues such as helping people with felonies or asking for job accommodations.

Implementing the SE model based upon the fidelity scale has been demonstrated to improve competitive employment outcomes for persons recovering from serious mental illness. Specific strategies to teach and supervise job development, such as those described by the Ohio SE CCOE, may also have a positive impact on employment outcomes.▼

Sarah Swanson *is currently the Director of Consultation and Training for the Ohio Supported Employment Coordinating Center of Excellence (CCOE) at Case Western Reserve University in Cleveland, Ohio. Sarah received her Bachelor's Degree in Vocational Rehabilitation Counseling and her Master's in Rehabilitation Psychology from the University of Wisconsin-Madison. She has 16 years of experience in community mental health systems, most recently as the Director of Rehabilitation Services at a center in Lorain County, Ohio. For additional information, she may be contacted at the Ohio Supported Employment CCOE c/o NBH 1756 Sagamore Road, Cottage 7, Northfield, Ohio 44067; or by email at sarah.swanson@case.edu.*

Patrick E. Boyle *has been working in the field of human services for thirty years. He now serves the Ohio SAMI and SE CCOEs as Director of Implementation Services, coordinating and providing clinical training and consultation as well as programmatic consultation for programs implementing the New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model in Ohio and nationally and is project coordinator for implementation of the Supported Employment Evidence-Based Practice in Ohio. Mr. Boyle is an adjunct faculty member and doctoral candidate at Mandel School of Applied Social Sciences, Case Western Reserve University, Cleveland, Ohio.*

Paul Kubek *is Director of Communications at the Ohio SAMI CCOE. He is responsible for planning, writing, editing, and coordinating the production of the CCOE's print and electronic communications, including its Web site and newsletter,* SAMI Matters. *He has worked in communications over 20 years. In his work at the CCOE, he collaborates with researchers, practitioners, community partners, and policy makers to translate their expert knowledge and experiences into communications that can be easily understood by diverse audiences.*

References

Becker, D.R., & Drake, R.E. (2003). *A working life for people with severe mental illness.* New York: Oxford Becker, D.R., & Drake, R.E. (2003). A working life for people with severe mental illness. New York: Oxford Press.

Becker, D.R. & Bond, G. R. (Eds.). (2002). *Supported Employment Implementation Resource Kit.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Bond, G.R., Drake, R.E., Mueser, K.T., & Becker, D.R. (1997). An Update on Supported Employment for People With Severe Mental Illness. *Psychiatric Services* 48:335-346.

Bond, G.R. & Jones, A. (2005). Supported Employment. In R.E. Drake & M.R. Merrens & D.W. Lynde (Eds.), Evidence-based Mental Health Practice: A textbook (pp.367-394). New York: WW Norton & Company.

Bond, G.R., Becker, D.R., Drake, R.E., & Vogler, K.M. (1997). A fidelity scale for the individual placement and support model of supported employment. *Rehabilitation Counseling Bulletin,* 40, 265-284.

Mowbray, C., Holter, M.C., Teague, G.B., Bybee, D. (2003). Fidelity Criteria: Development, Measurement, and Validation. *American Journal of Evaluation,* 24 (3), 315-340.

by Martin Masar, M.S.W., L.C.S.W.

The following discusses the impact of an organization's and the therapist's core beliefs. This knowledge is essential if we as therapists are going to provide the types of treatments that are needed by our clients.

Core Beliefs

Intrinsically, every human being and organization has a belief system and core values that direct and control their actions and behaviors. Psychotherapeutically, these core essential elements establish the structure of the system of care, and the priorities for psychotherapeutic practice. They identify what the organization and therapist will and will not tolerate.

To understand the impact of the organization's core beliefs, let's remember Jonathan *(see "You Coming?")* and my commitment, "I was going to successfully treat this young man and give him back the life he wanted me so desperately out of." The emphasis here is on both the "I" and simultaneously on the organization. If I commit to Jonathan (and his parents) with all of my resources and efforts, will my organization commit equally with me?

To understand what drives an organization and, for that matter, an individual, we need to identify with their *vision, mission, scope* and *values*. This knowledge is essential if therapists are going to provide the types of treatments that are needed by their clients. *The following core beliefs are more than just catch phrases:*

- Vision — A vision is what the organization or person intends to become and to achieve at some point in the future. In a vision, it is not the details; it is the direction that counts.

- Mission — A mission statement is an organization or person's enduring purpose. It makes concrete the direction and purpose of the organization or person.

- Scope — The scope is the services that will be provided to meet the vision and mission. *These include:*

  1. *Direct Services (treatment and education)*
  2. *Research (state of the art practice)*
  3. *Consultation and Professional Education (discussion and learning)*
  4. *Advancement (public education)*
  5. *Advocacy (human rights)*

- Values — Values are assumptions, convictions, or beliefs about the manner in which people should behave and the principles that should govern behavior. Values serve as a baseline for actions, decision-making and as guidelines for intentions and interests. A strong value system turns beliefs into standards.

"YOU COMING?"

Jonathan was born to the urban streets of our nation. For the first four years of his life, Jonathan was severely abused and neglected. He was adopted at the age of four. His adoptive parent's first met Jonathan in the Children's Hospital — he was malnourished, had severe bruising throughout his face and body, he had a broken jaw and a fractured arm. He was not potty trained and had difficulty walking.

Despite the loving attempts of Jonathan's adoptive parents, and the many psychiatric hospitalizations, they could not curb his inevitable journey into a life of trouble. Jonathan refused to go to school, refused to follow his parent's requests, committed a variety of different legal offenses, and was extremely aggressive.

I first met Jonathan at age 14 when he was placed in my psychiatric residential treatment facility. In the following months Jonathan argued, fought, stole and defied every rule. He did everything he could to act out and push me away. One day in another of his angry rages he defiantly screamed at me, "I just want to go to jail and serve my time, why don't you get the hell out of my life!" As he left my office, slamming the door behind him, I realized for the first time that Jonathan was actually being honest with his feelings. For the first time he honestly told me how he felt — ("I want" and "you get out of my life" — but, I asked myself — who let me in his life?) From that day forward, I made a silent commitment to Jonathan that somehow I was going to successfully treat this young man and give him back the life he wanted me so desperately out of.

A practice I utilized with Jonathan each time he left our therapy sessions was to gently rub his shoulders as I walked him out of the office. Each time I did this he would abruptly pull away. Near the end of his treatment, after one of our (now delightful) therapy sessions, I remained in my chair as Jonathan proceeded towards the door. As he reached for the doorknob, he looked back at me over his shoulder, shrugged, put his hand on his shoulder and smiling said, ***"You coming?"***

On that day I realized that my vision, mission, scope and values for the organization and myself were also a commitment to Jonathan and his parents. I saw before me the success of his treatment. As far as the life he wanted me so desperately out of, I had just received an invitation to come in.

Core Values

Psychotherapists need to appreciate the importance of their own values. Values affect how we view other people and groups, thus influencing interpersonal relationships. Values affect how we perceive situations and solve problems. Values affect how we determine what is and is not ethical behavior. Values affect how we treat and care for others.(Patterson, 1959).

As therapists practicing in the behavioral health field, we too, knowingly or unknowingly, have a vision, mission, scope and values for our practices and ourselves. We all have tolerance levels and internal beliefs. Such recognition will lead therapists to understand their individual beliefs and verify their individual practice perspectives. A good mental health practitioner is one who practices within their resources. The great practitioner is one who recognizes their individual practice perspective and utilizes this awareness to achieve excellence.

Given these definitions of vision, mission, scope and values, from the organization to the individual, we have either a *collision* or *collusion*. In a collision, the treatment I desire to provide for Jonathan will not be tolerated by the organization. However, with collusion, I am off to a positive start in employing all available resources, along with my core beliefs to successfully treat this young man. .

Connecting to a Theory

Theory is the bridge between what we believe (vision, mission and values) and our clinical practice with the individual. Without theory we have no direction or purpose, and without a direction we move aimlessly throughout time with no particular purpose. In essence, our theory becomes a roadmap helping the practitioner with choice points, critical analysis and decision-making. The choice and use of a theory is essential to good clinical practice. The practitioners must be cognizant of their choice of theory and its reflection to their personal values. According to Cecil Patterson, some elements of important consideration in a useful theoretical choice might include the following:

- its relevance to life or real behavior;
- its ability to be understood, and applicability to the client;
- it should give answers and consideration;
- it should be capable of being reduced to practical interventions; and finally, maybe most importantly,
- it should be useful to the practitioner.

Psychotherapeutic Considerations

The following, while certainly not all inclusive, identifies some important considerations in mental health treatment:

Therapeutic Attunement — Although various theoretical approaches tend to emphasize their different principles, the therapeutic relationships which crosses all domains of theory, may be the most curative agent in promoting sustained mental health. Therapeutic attunement is defined as warmth, unconditional positive regard, acceptance, and empathy, with the therapist and individual relationship.

Individual Therapy — Individual therapy could be defined as interventions designed to interrupt, interfere with and/or modify an ongoing process. Interventions become the products of our individual vision, mission, socpe and values; and choice of theory.

Vision — where we are headed with the individual
Mission — what we will do to get there
Scope — what service we provide to achieve our mission
Values — what beliefs we hold as truths about the person
Therory — our roadmap to the future

Family Therapy — Although my work in an adolescent psychiatric residential treatment facility emphasis is with troubled adolescents, I persistently emphasize involvement and participation by parents and family. This is a reflection of my values and ednuring beliefs. Effective family therapy may be the single most valuable therapeutic intervention in changing the lives of troubled adolescents. Numerous research articles continuously demonstrate the effectiveness of family therapy not only to enhance treatment effectiveness and shorten lengths of stays, but also to strengthen the probability of successful and healthy reunification with the family.

Conclusion

Jonathan said, "I just want to go to jail and serve my time, why don't you get the hell out of my life!" I began by assessing and evaluating my core beliefs for Jonathan and his parents to ensure I was committed to the treatment necessary to assist him and his family. Next, I assessed the organizations core beliefs. Would my organization be willing to "go the distance" with Jonathan and me and to endure Jonathan's temper tantrums, anger outbursts, and other disruptive behavior? These questions had to be answered in order for me to proceed with the treatment Jonathan required.

- Vision — Jonathan can have a positive healthy life, without legal difficulties.
- Mission — Jonathan and his family can successfully complete treatment.
- Value — Jonathan and his parents are wonderful people who deserve the best this organization and I can offer. I believe in Jonathan and his parents.
- Scope — Providing all the necessary services, at the level of intensity and frequency, required to work with Jonathan and his parents.

Did I have *collusion* or a *collision*? The organization's answer, *"YES, **we'll go the distance.**"*

From an understanding of the organization's vision, mission, scope and values, to the vision, mission, scope and values of the individual therapist, combined with a healthy environment, neuroscience and psychotherapy we can fully set the course for the kinds and types of treatment centers and individual therapist that will profoundly change lives for generations to come.▼

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Resources

Patterson, C.H. (1959) *Values and Psychotherapy: Counseling and Psychotherapy.* New York: Harper and Row.

Patterson, C.H. (Ed.) (1980). *Theories of Counseling and Psychotherapy.* (3rd ed.). New York: Harper and Row.

by Terrence Daryl Shulman, J.D., C.S.W., A.C.S.W., C.A.C.-I

The Fastest Growing Crime in America

Be honest. Have you ever stolen from work? Took a little "petty cash" here and there? Fudged your time card? Padded an expense report? Ran personal errands on company time? Made copies while looking over your shoulder? What about those extra envelopes, staples, and paper clips you brought home for the kids? If so, you are not alone. The United States Chamber of Commerce estimates nearly 75 percent of employees steal from their workplace and most do so repeatedly. I was one of them.

Last year, Janice Fernworn, 45, was the treasurer of her suburban Detroit church. Over several years, she embezzled in excess of $700,000. She had no history of other addictions. She was married and had five kids. Fernworn said her embezzlement began when she and her husband fell three months behind in their mortgage payment. "I still remember the first time I wrote a check to myself that wasn't legitimate," she said. "My hands shook so badly, I was almost unable to manage the writing. I felt I had exhausted all other possibilities. I don't know when the embezzlement switched from easing the true need to needing the ease but it didn't take long before the hole was so big I couldn't face making it better." She was sentenced to 10 years in prison.

Why Should Mental Health Professionals Care?

The National Association for Shoplifting Prevention estimates 1 out of 11 Americans shoplift. While "shoplifting addiction" has gradually found wider acceptance and understanding, the F.B.I. recently called employee theft "the fastest growing crime in America." Treatment for those struggling with chronic employee theft, and consultations with employers seeking to understand and reduce this phenomenon, has increased.

The American Society of Employers reports that 20 percent of every dollar earned by an American company is lost to employee theft — $53.6 billion per year in the retail industry alone. 55 percent of perpetrators are in the highest-level positions and the average length of time it takes for one to be caught is 18 months. The U.S. Chamber of Commerce estimates one third of all corporate bankruptcies are a direct result of employee theft. And the *Boston Globe* published an article in September 2005 stating U.S. companies lose $759 billion per year in "time theft" by which employees falsify time cards, take long breaks, linger on the Internet or the phone, run personal errands on company time, and even look for new employment while at their current jobs.

What is the Impact on Mental Health Professionals?

Mental health professionals need to work in a healthy and transparent environment. Even in the "touchy feely" world of mental health, the workplace can feel like a toxic fish tank. People come to work with emotional wounds and issues. They play out family dramas, dysfunctions, and authority issues in the workplace. Employee theft may be a cry for help, a call for attention, a sign that something deeper is wrong. But we rarely seek out, much less discover, what that is.

Many therapists, especially those who work with addictions, have known clients who have stolen to support a drug, gambling, or shopping addiction. Too often counselors assume people steal to support an underlying addiction and it will stop when one "gets sober." This is not always true. For many, the stealing *is* or *becomes* the drug. Many remain in denial or are too ashamed to ask for help. Many still think of stealing only in moral, legal, or financial terms. "Just keep working the Steps" is what many have heard and tried. Specialized treatment may be needed but there are few books, few support groups, and few therapists who specialize in treating theft behaviors, including employee theft.

Is it hard to imagine the many complex factors and motivations which can prompt people to steal from work? Job security continues to decline while pressures to work harder, faster and for less compensation increase. Society has created a climate of resentment, mistrust, disloyalty, even harassment. Surveys reveal the top concern of most employees is a lack of appreciation and recognition. "They owe me," is how many feel. Sometimes, as with Janet Fernworn, outside events or issues are the catalyst. Employee theft usually begins a little at a time. Most do not even think of it as stealing. The next thing you know, a star employee is led out in handcuffs.

What is the Impact on the Therapist/Client Relationship?

First, if the therapist is stealing from work, this may affect the professional's life as dramatically as the client's — be it legal issues, loss of employment, a breakdown in relationships, health issues, even suicide. Second, therapists may be less apt to explore, assess, and treat these behaviors if they feel hypocritical, incompetent, or project their own guilt or shame onto the clients. Third, millions of clients with employee theft issues go undetected or untreated who might otherwise be helped. If a client loses his job due to workplace theft, therapy usually comes to a screeching halt. The shame and judgment people face is unimaginable. People with criminal records — especially theft offenses — will face great obstacles in finding decent employment. Those without jobs are without hope: addictions, crime, and self-harm often follow.

Traditionally, most companies simply fire any employee who steals. While this is one option, it does not address the following questions: why are so many people stealing and are there other ways to deter and treat theft? Other factors to consider include: the costs of losing an employee who may not be easily replaced; losing the opportunity to rehabilitate him and engage his assistance in bolstering loss prevention; and passing on the problem to a future employer. Most companies have some sensitivity toward employees with drug, alcohol and gambling problems. You can miss work, lie, do a poor job, even harass a co-worker — but "steal, and you're gone!" Why is theft a sacred cow when so much of it occurs anyhow? "Thou Shalt Not Steal" runs deep.

Our society needs progressive education, prevention, and treatment for employee theft. I encourage better management skills and employee morale strategies. I recommend companies hold periodic meetings-facilitated, ideally, by a neutral, outside consultant-to air grievances, offer apologies, and to express appreciation and gratitude to "keep the tank clean." I suggest confidential counseling be openly offered to any who might have a theft problem. Most employers I have talked to cared less about finding out who is stealing than having it stopped.

In 2004, the Human Resources Director and a head of loss prevention for Cracker Barrel Restaurants told me that Cracker Barrel looks at "the totality of the circumstances" when an employee is found to have stolen from the company. They are ahead of the pack in recognizing that many employees do become addicted to stealing. Often, these employees were put on "internal probation" and placed in counseling. Is the counseling or this novel approach effective? The long-term results of this are not yet in but it is a sign of progressive-minded thinking. Also Cracker Barrel seemed happy to boast one of the lowest employee turnover rates in its industry, thus saving money.

What Do Case Studies Reveal?

A recent client of mine was an assistant manager at a national home furnishings store. He is married, has two young twin daughters, has an MBA, and lives in a nice suburb. He has had a long history of shoplifting, employee theft, and came to see me after having been arrested for breaking into people's cars. If ever there was a person crying for help, he was. I theorized that he stole primarily in reaction to his having been molested as a child and, later, having been traumatized in his early twenties by a hold-up at gunpoint. His boundaries and safety had been violated and he was reliving this experience from the perpetrator's point of view by violating the boundaries of others. His stealing was, in essence, a cry for help.

During our work together he also attended C.A.S.A. (Cleptomaniacs And Shoplifters Anonymous) meetings. Gradually his wife got involved in treatment. As she had become more parent than partner, he rebelled further. He reported feeling taken advantage of at work by his boss and co-workers, which triggered abuse feelings and he embezzled as a way of lashing out. His wife and his former therapist urged him to quit his job immediately. They feared he would get fired or, worse, prosecuted. I shared their concerns but worried my client would have no money and no structure for his time — which spelled trouble, too.

Instead, I created a contract with him to begin practicing assertiveness at work (and at home) while also taking steps to finally start his own lawn and garden business, which he had put on the back burner. Remarkably, within six months, he had left his job and had more landscaping work than he could handle. His self-esteem and confidence blossomed. His relationship with his wife greatly improved. His journey to well-being continues but he has progressed with the proper treatment and support.

Too often counselors assume people steal to support an underlying addiction and it will stop when one "gets sober." This is not always true. For many, the stealing is or becomes the drug.

Another former client is Director of Accounting at a Retirement Center. She had embezzled $50,000 from her previous employer in the same position, but had managed to secretly pay it back over time before leaving without being confronted. She recently embezzled $40,000 from her current employer, realized she was out of control and sought help. Her husband knew about both thefts and admitted he enabled her the first time by bailing her out with his own money. This time, on the verge of divorce, they knew they needed a different approach. In therapy, we discovered she spent almost all the stolen money on things for her husband. She did not feel worthy of his love and feared he would leave her just as her mother had when she was 3-years old. While significant issues remain, she secretly repaid the money on her own this time and has been learning to value herself without overcompensating at work or in her marriage.

As these case studies show, counseling can address issues of employee theft. This is a new frontier of theory and treatment. Therapists need to be prepared to look at their own dishonest behaviors and explore these issues with clients in a skilled and sensitive manner.▼

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by Steven J. Lee, M.D.

Crystal Methamphetamine

Crystal methamphetamine is a highly addictive stimulant that is experiencing a rapidly escalating epidemic in the United States. Unlike drugs such as heroin or crack cocaine, crystal crosses all social, cultural, and economic lines. Though methamphetamine is an old drug with past waves of increased use, the current epidemic is worse than previous outbreaks because geographic and social barriers that used to keep crystal use more contained no longer exist. Even more worrisome is the association of crystal with the spread of other potentially fatal illnesses, such as HIV and hepatitis B and C. Despite efforts to educate the public, crystal has had a tremendous impact on perpetuating the transmission rates of these and other diseases.

In the current era of rapidly growing technology and information exchange, crystal has become easy to produce or to find, with many Internet sites selling methamphetamine or giving detailed instructions on how to make it. The Internet also provides easy access to sex, which is an activity particularly tied to crystal use, as they both activate the same area of the brain, the mesolimbic pathway. Sex and Internet use can both be compulsive activities, and when they are linked with crystal, the combination creates a triple threat that fuels crystal use and makes it much harder to treat.

Who Uses Crystal?

The U.S. Department of Health and Human Services reported that in 2002, over 12 million people over age 12 reported having tried methamphetamine in their lifetimes. Of those surveyed, almost 600,000 were current users. With a growth rate of about 300,000 new users per year, these numbers are likely much higher now.

The people who use crystal methamphetamine are of all types. The working class in Hawaii, where the current epidemic is believed to have started in the U.S., has been devastated by methamphetamine use. Crystal energizes weary laborers, allowing them to work two or more jobs in order to survive in the high cost of living in Hawaii. Other hard-hit regions include rural areas of the continental U.S., where a fertilizer chemical, one of the key ingredients of methamphetamine, is easily available, and open land protects clandestine production labs. American youth in general are affected. The *2002 National Survey on Drug Use and Health: National Findings* showed that in 1999, 4.7 percent of high school seniors used crystal. In major metropolitan areas, many gay men use methamphetamine, and it has become the drug of choice in gay clubs and circuit parties. This has significantly affected the attempts to stop the spread of HIV in these communities. One Los Angeles clinic reported that in 2005, one out of three gay or bisexual men who tested positive for HIV admitted to using crystal. Methamphetamine is such a powerfully addictive drug that it can affect all people. There are reports of its use even in unexpected communities, such as among the Amish and Mormons.

What Is Crystal Methamphetamine and How Does It Work?

Methamphetamine is a white or yellow crystalline substance that is usually in powder form that can be snorted, smoked, or it can be mixed with water and injected intravenously or squirted in the rectum. The original term "crystal" used to refer to a highly potent form of methamphetamine in larger crystals, but now it is commonly used to refer to any form of the drug. Methamphetamine is a stimulant that works primarily on the neurotransmitter dopamine, as well as norepinephrine. Dopamine is a chemical with activity not just in the brain, but also throughout the entire body, including the heart, lungs, muscles, kidneys, stomach, intestines, and the blood vessels that supply oxygen to all these organs. Dopamine has various functions depending on where in the body it acts. Crystal causes a dramatic increase of dopamine in the brain by inducing brain cells to release their dopamine stores and blocking reuptake transporters that recycle dopamine for later use. The effect is an extremely high accumulation of dopamine, with intense mood and physiological effects.

The chemical structure of crystal is similar to other stimulants, such as amphetamine (Dexedrine and Adderall), methylphenidate (Ritalin, Concerta, Metadate, Focalin), pemoline (Cylert), as well as the hallucinogen methylenedioxymethamphetamine (MDMA, commonly known as ecstasy). Various over-the-counter and herbal remedies, such as caffeine, ephedra (also called *ma huang*), ephedrine, pseudoephedrine, guarana, and ginseng have stimulant properties. Though herbal medicines are touted as "natural remedies," their stimulant effects function in the same way as pharmaceutically produced drugs, and they are not necessarily any safer. Methamphetamine is a particularly potent stimulant because it increases dopamine in the brain much more than any other stimulant: while cocaine increases dopamine transmission in the brain by 400 percent, methamphetamine increases transmission by 1500 percent.

The *nucleus accumbuns*, an area of the brain highly associated with addictive drugs, uses dopamine to communicate with another area called the *ventral tegmentum*. The connection between these two regions is called the mesolimbic pathway, nicknamed the "brain-reward circuit." This circuit is strongly associated with pleasure and can cause compulsive repetition of behavior — in its extreme, compulsive repetition can become out-of-control, leading to addiction. The more directly a drug stimulates this pathway, the more addictive the drug tends to be. Crystal stimulates this pathway more intensely than any other known drug.

The supraphysiologic release of dopamine is associated with the production of free radicals, chemically reactive particles that cause cellular damage. Free radicals cause genetic mutations, cancer, cell death, and aging in the body. In the same way, free radicals produced during crystal use damages brain cells, particularly in the basal ganglia and connections to the prefrontal cortex. These areas affect movement, memory, attention, and even the basic decision-making and impulse control that are needed to stay sober. The structural brain changes that result from crystal use make the tasks of relapse prevention and resisting cravings much more difficult.

What Is It Like to Use Crystal?

Each person's response to crystal may differ: with some feel intense pleasure, while others feel only alertness and anxiety. Some may feel instantly compelled to use the drug again, though the vast majority of crystal users develop an addiction gradually over years, beginning with rare to occasional use, which surreptitiously increases to frequent heavy binges or daily use.

Despite some variability, certain experiences are common and shared by most people using crystal. Crystal often causes an initial rush of euphoria, followed by a strong sense of well-being and boosted self-confidence. Mood is elevated, and if someone is feeling depressed, crystal can bring rapid relief. Senses are heightened, so sights and sounds may seem sharper and more vivid. On the other hand, some people can feel too stimulated and become jittery, anxious, or panicky. In general most people feel a tremendous boost of energy and confidence. Those who are socially withdrawn can become outgoing and charismatic. Thoughts flow more quickly, and grandiosity makes the ideas seem brilliant. Speech can also become more rapid, trying to keep pace with rapid thoughts.

Like other stimulants, methamphetamine helps people to concentrate and even enjoy ordinarily mundane activities. This may seem ideal for the tired worker who has too many things to do but not enough time in the day to do them. In the extreme, people high on crystal become caught in repetitive behavior, whether it is a simple movement, like rocking, grinding teeth, or tapping feet, or more complex activities like cleaning the entire house or dismantling a computer completely into its little components. From the outside the behavior may appear illogical, though the crystal user usually feels a strong sense of purpose.

Like other stimulants, methamphetamine is a powerful anorectic. People lose their appetites, and they may become so focused on an activity that they forget to eat completely. Many chronic crystal users suffer significant weight loss. Crystal also causes dry mouth, tooth grinding, and osteoporosis secondary to malnutrition — a combination that destroys teeth, earning the nickname "meth mouth."

In many people, crystal causes an intense compulsion to have sex. Initially, the combination of sex and crystal were more commonly associated with gay men. In the gay community, crystal was first introduced to the nightclub and circuit party scene, which is a highly sexualized environment. It later spread to sex clubs, sex parties and Internet sex hook-ups. Because of this manner of introduction, crystal is often used in the gay community in sexual contexts. Early studies showed that heterosexual users had different behavior patterns, though recently there have been reports of hypersexual activity among heterosexual users, possibly resulting from the increased visibility of ad campaigns warning gay men of the dangers of sex with crystal. Once a crystal user, whether homosexual or heterosexual, begins to have regular sex with crystal, this becomes an extremely difficult behavior to stop.

Sex while high on crystal is incomparable to "sober sex." The sex drive becomes so strong that some people have continuous sex lasting several hours to days. Pursuit of sexual gratification can become such an overpowering, irresistible compulsion that protection against HIV seems like an annoying hindrance to the much stronger need for sexual gratification. Though the gay community is only a minority of the crystal users in the U.S., they have been the most vocal in addressing crystal addiction because of its effect of perpetuating the transmission of HIV. However, sex with crystal is becoming more prevalent in heterosexuals, as well. For *any person* who pairs crystal with sex, this is a crucial issue to address in addiction treatment and managing triggers for relapsing.

A significant concern about the strong connection between crystal use and hypersexual activity is the effect that crystal has on the spread of HIV, as well as other sexually transmitted diseases, including hepatitis B and C, as well as others. This effect has been documented in numerous studies and anecdotal reports from HIV agencies. In addition, crystal methamphetamine has been shown to impair immune function in both *in vitro* (test tube) and *in vivo* (animal) studies, further weakening the health of crystal users who already have HIV and hepatitis. The simultaneous presence in the brain of crystal and HIV has powerfully synergistic effects on impairment of brain function and possibly on brain damage.

Other effects of crystal to consider include potential dangerous interactions with medications, increased heart rate and blood pressure, insomnia, anorexia, and increased risk of heart attacks, strokes, and seizures. Less common but possible effects include, rhabdomyolysis (severe and life-threatening muscle breakdown), and kidney failure. With prolonged use, crystal can cause paranoid delusions, most commonly with people believing others are following them, talking about them, or spying on them. They may also have other psychotic symptoms such as auditory, visual, or tactile hallucinations, such as bugs crawling on their skin. These people may seem indistinguishable from schizophrenics, though in most cases psychotic symptoms abate over several days after stopping crystal use. With each episode of psychotic symptoms, the risk of psychosis with crystal increases.

Models of Treatment

Treatment of crystal addiction is similar to treatment of other addictions, with some specific tailoring to crystal. A study by a group at UCLA led by addiction researcher Steven Shoptaw showed that people in crystal-focused treatment programs were better able to

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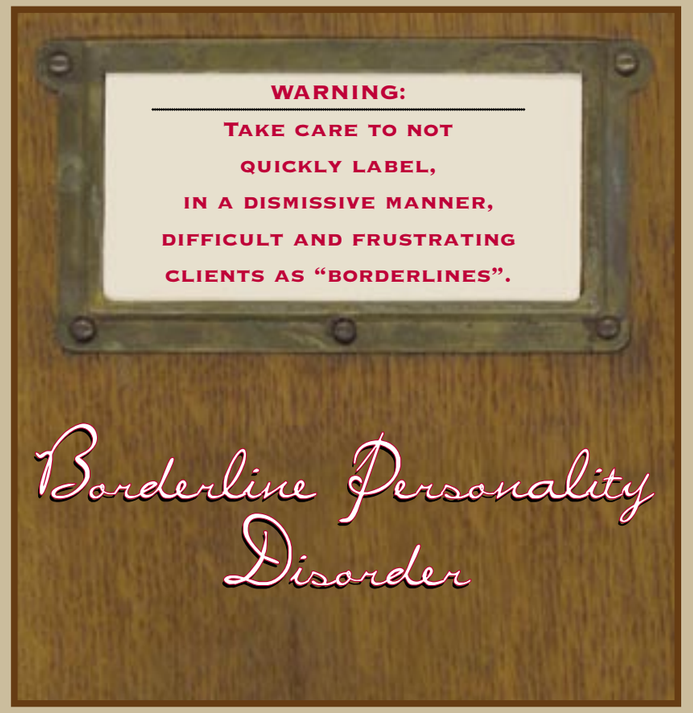

DEALING WITH DEFINITIONS AND CRISES

by David Mee-Lee, M.D.

Not every client who frustrates a therapist and splits the team is a "borderline".

What Do You Mean by "Borderline"?

It is easy in behavioral health to stick a diagnostic label on someone. But before a therapist starts throwing those sticky labels around, it is worth being a little cautious. Not every client who frustrates a therapist and splits the team is a "borderline". Not every client who has several diagnoses, a thick medical record and cutting behavior has Borderline Personality Disorder (BPD). BPD is one of those Diagnostic and Statistical Manual (DSM) categories that clinicians like to use as a dumping ground for any client who seems to stir up strong feelings and frustrations for the therapist or treatment team. Antisocial and Narcissistic Personality Disorders are other personality disorder categories that elicit similar reactions. Another current fad seems to be to call anyone with mood swings Bipolar Disorder. But there are specific dimensions of personality function that define BPD, so "borderline" should be used carefully.

Different Approaches to Defining Borderline Personality Disorder

The Revised Diagnostic Interview for Borderlines (DIB-R) model (Zanarini, Gunderson, Frankenburg & Chauncey, 1989) uses a cluster of dimensions that defines BPD more specifically:

- Dysphoric affect — such as depression, helplessness, loneliness, emptiness, anxiety
- Disturbed cognition — depersonalization, derealization, hallucinations etc.
- Impulsive behaviors — verbal outbursts, assault, cutting behavior, substance abuse
- Troubled relationships — very dependent, entitled or manipulative behavior, masochistic etc.

Symptoms in each of these four domains must be present at the same time to qualify for BPD in this more restrictive cluster of symptoms, which results in a somewhat smaller and more homogeneous group of people than if using the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM-IV). DSM-IV notes a pervasive pattern of the following areas that begins by early adulthood and is present in a variety of contexts:

- Instability of interpersonal relationships
- Instability of self-image
- Instability of affects
- Marked impulsivity

Dr. Larry Siever, Director of the Special Evaluation Program for Mood and Personality Disorders at Mt. Sinai School of Medicine in New York, outlines the dimensions of BPD in a similar yet different way:

- Consequences of traumatic stress — people who may have a predisposition to be more emotionally vulnerable are negatively affected by trauma in their early years
- Affective dysregulation — difficulty controlling anger or feelings of loneliness and depression
- Impulsivity — cutting behavior, substance abuse, abrupt termination of therapy
- Dissociation/self injurious behavior (SIB) — lost time; suicidal behavior.

No Need to Feel Hopeless About People with BPD

Dr. Mary Zanarini, Director of the Laboratory for the Study of Adult Development at McLean Hospital in Belmont, Massachusetts, tracked the ten-year course of 290 former inpatients (Zanarini, Frankenburg, Hennen & Silk, 2003). All the patients were carefully diagnosed with BPD and were interviewed every two years to assess their symptomatic and functional status. Over 93 percent of the surviving patients were reinterviewed at all five follow-up sessions. Almost 90 percent of clients experienced a remission of their BPD; and almost 80 percent of clients with BPD attained good psychosocial functioning.

In the study, a "remission" was defined as no longer meeting criteria for BPD for two years. A "recurrence" was defined as meeting criteria for BPD for two years, after meeting the criteria for remission in a previous follow-up period.

Dr. Zanarini highlighted two hopeful findings that expanded on the work of her original study:

- *Remissions* were common and they increased over the course of the ten years - 88 percent experienced at least one two-year period when they met no criteria for BPD. But a tenacious 12 percent did not experience even one remission.

- *Recurrences* of BPD were relatively rare among the patients who experienced a remission of BPD — only 17.6 percent had a recurrence; almost 80 percent of patients with BPD attained good psychosocial functioning over the course of the ten years.

"Psychosocial functioning" was specific and defined as at least one emotionally sustaining relationship with a friend or romantic partner **and** both a good vocational performance and a sustained vocational history. The "bottom line" is that the prognosis for most, but not all patients with BPD is better than previously recognized.

Levels of Borderline Personality Disorder That Translate Into Stages of Treatment

Dr. Marsha Linehan, founder of Dialectical Behavior Therapy (DBT), has focused on BPD for over thirty years. Her work grew out of developing services for highly suicidal clients with BPD. *She outlines four levels of BPD and the corresponding stage of treatment goal for each level (Linehan, 1993):*

- ***Level 1:*** severe behavioral dyscontrol — ***Stage 1*** treatment goal: behavior control
- ***Level 2:*** quiet desperation — ***Stage 2*** treatment goal: nontraumatic emotional experiencing
- ***Level 3:*** problems in living — ***Stage 3*** treatment goal: ordinary happiness and unhappiness
- ***Level 4:*** incompleteness — ***Stage 4*** treatment goal: freedom and capacity for joy

For many who work with people with BPD issues, Stage 1 treatment is what often consumes a lot of clinical effort and energy. In order to move from severe behavior dyscontrol to behavioral control, there are behaviors to **decrease** and skills to **increase**.

Decrease:
- Life threatening behaviors
- Therapy-interfering behaviors
- Quality-of-life interfering behaviors

Increase:
- Mindfulness
- Interpersonal effectiveness
- Emotion regulation
- Distress tolerance
- Self-management

Treatment for people with BPD can become overwhelming as both client and clinicians' "buttons" can so easily be pushed. Having some structure of levels of BPD and the related stages of treatment provide a sense of direction and hope.

Dealing with Crises and the Role of Inpatient and Residential Treatment

Twenty-four hour treatment settings have certain benefits in the midst of crises. But they can also present liabilities for certain people with BPD and other personality vulnerabilities. A safe place to sleep and eat away from the stress of the outside world can also re-create a psychological "womb." For people with longstanding needs for nurturance, theses longings are aroused with such 24-hour care and can precipitate regression. Equally longstanding are fears of abandonment and mistrust as to whether anyone will really be there for them. Total care settings spark off powerful, conflicted dynamics in the client. On the one hand the person is starved for nurturance, while at the same time the client has strong urges to control the expected rejection and abandonment. It is as if the client is saying: "This safe and secure setting is so fulfilling and I have wanted this nurturance all my life. But if I can't count on this

BPD is one of those Diagnostic and Statistical Manual (DSM) categories that clinicians like to use as a dumping ground for any client who seems to stir up strong feelings and frustrations for the therapist or treatment team.

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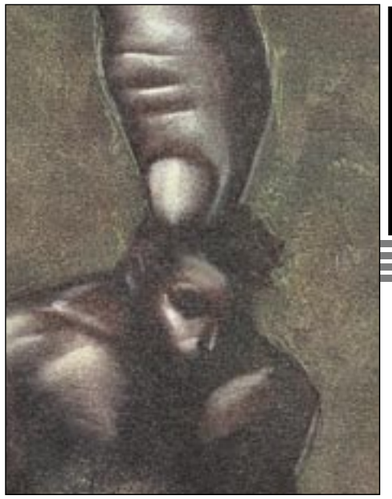

ANABOLIC STEROIDS

by Michael S. Bahrke, Ph.D. and Charles E. Yesalis, M.P.H., Sc.D.

High School Steroid Use May Lead to Drug Testing
Fox News Channel 4/30/2004

Report: School Steroid Use Silent, Rampant
Associated Press 2/6/2005

More Girls Try Taking Steroids to Tone Up
Associated Press 4/25/2005

It is no wonder, over the past few years, according to results from the most recent 2005 Monitoring the Future Study, among high school students, there have been significant decreases in the perceived risks and disapproval of steroid use while at the same time availability of steroids has remained high, leading to the above headlines.

Anabolic-androgenic steroids (steroids), taken orally or by injection, are synthetic derivatives of the primary male hormone, testosterone. Athletes use steroids for many different reasons. Originally, athletes used steroids to improve performance. Football players wanted to increase muscle size and strength. Track athletes and other runners hoped to be able to perform frequent, high intensity, and long duration workouts without physical breakdown. Field athletes wanted to put the shot, or throw the hammer, discus or javelin farther than their competitors or holders of previous records. Weightlifters desired to lift the maximum amount of weight possible and bodybuilders desired more lean muscle and less fat.

However, in recent years, steroid use by non-athletes has also become more prevalent and now an increasing number of steroid users simply want to "look good" — which to many people means being big and muscular. It is not unusual for male and female actors and models to use steroids to enhance appearance.

Prevalence and Incidence

According to results from a recent survey conducted by the Centers for Disease Control and Prevention, nearly 7 percent of high school male students and over 5 percent of high school female students have used steroids at some point in their lives. Based on recent U.S. Census estimates of high school students, these prevalence rates translate to well over three-quarters of a million young people in the United States who have used steroids at least once during their lifetime.

It should also be pointed out that use of steroids by adolescents is not limited only to the United States. Surveys conducted in other countries have reported similar, overall prevalence rates for high school-aged students. In addition, several surveys of college, Olympic, and professional athletes suggest high levels of steroid use among male and female athletes in a wide variety of sports from baseball to wrestling.

Signs of Steroid Use

Possible indicators of steroid use include rapid and disproportionate increases in muscle size or strength (or other measures of athletic performance) that are well beyond what is expected with ordinary training. In addition, obsessive focus with weightlifting and diet, preoccupation with body image, increased appetite, and mood swings are frequently observed in those abusing steroids.

Adverse Physiological Effects of Steroids

Side effects accompany the use of virtually every drug and steroids are no exception. The best-documented adverse physiological effects of steroids are those on the liver and the cardiovascular and reproductive systems.

Cardiovascular side effects of steroids may include increased blood pressure, heart size, and risk of heart attack and stroke, among others. Unfortunately, some of these effects may result in death. In addition, jaundice and tumor growth, and liver toxicity are some of the adverse effects on the liver. Normal liver function generally returns following cessation of steroid use.

Changes in libido and fertility, including testicular shrinkage; reduced levels of testosterone, sperm production, and sperm count motility; alterations in sperm structure, impotence, breast growth, and enlargement of the prostate are the primary side effects of steroids on the male reproductive system. When steroid use is stopped, the testes resume sperm production and sperm quality usually recovers spontaneously within a few months.

In females, steroid use has been associated with a number of adverse effects, some of which are not reversible upon discontinuation. These include menstrual abnormalities; deepening of the voice; shrinkage of the breasts; male-pattern baldness; and an increase in sex drive, acne, body hair, and clitoris size.

Although premature stunting of growth and early puberty in younger male and female steroids users has not been fully studied, such effects have been described for many years.

Adverse Psychological and Behavioral Effects of Steroids

Mood swings, irritability, increased aggression and violent behavior ("roid rage"), mania, psychosis, dependence, and depression upon withdrawal are the prominent adverse psychological and behavioral effects most often associated with steroid use and discontinuation. Symptoms of withdrawal from steroids include depressed mood, fatigue, muscle and joint pain, restlessness, anorexia, insomnia, decreased libido, headache, and a craving to use steroids again.

The most life-threatening complication of withdrawal from steroids is suicidal depression. The depressive withdrawal syndrome usually begins within the first week of steroid discontinuation and can last for several months. Treatment generally consists of supportive therapy with or without pharmacotherapy.

Treatment and Recovery

Treatment for steroid use should address any physical or psychiatric complications the steroids have caused.

In addition to a comprehensive medical history, physical and mental status examinations, laboratory examination should include liver function tests, cholesterol profile, endocrine tests, and complete blood count. Urine testing for steroids is recommended. Laboratory tests are important in assessing steroid use and in providing useful feedback about possible harmful effects.

Cessation of steroid use should result in the elimination of most complications, and abstinence should be the goal of any treatment. During initial abstinence, attention should be directed toward withdrawal. Suicidal thoughts must be monitored and hospitalization may be required in some cases.

Supportive therapy, including reassurance, education, and counseling is the mainstay of withdrawal treatment. Antidepressants may be used when withdrawal is complicated by major depression. Nonsteroidal anti-inflammatory medications may be used to help alleviate musculoskeletal discomfort.

When withdrawal symptoms and medical complications have been addressed, treatment should focus on maintaining abstinence and on psychosocial factors that may influence further use.

Steroid users may experience both internal and external pressures to resume use. These urges require identification and understanding and alternative responses to steroid use should be explored. Many steroid users manifest an over reliance on physical attributes to maintain self-esteem. Some users may continue to feel small no matter how big they are. For these users, therapy may be needed to help develop a balance of physical and nonphysical pursuits that can foster feelings of competence.

It is also important to reassure former users, especially those who have not used for several years that adverse health effects at this point are quite unlikely given the transient effects of steroids.

Education and Prevention

Anabolic steroid education and prevention programs have been available for many years. However, changing a behavior (using steroids) that has resulted in major benefits to the user, such as improved appearance and athletic performance, presents a very difficult challenge.

Traditional education approaches to tobacco, alcohol, and drug abuse prevention have not been effective. Fortunately, a few programs are demonstrating some success, such as Adolescents Training and Learning to Avoid Steroids (ATLAS) Program and Athletes Targeting Healthy Exercise and Nutrition Alternatives (ATHENA) Program, which focus on positive educational initiatives related to nutrition and strength training. However, while these programs that educate steroid users about the health risks and ethical issues associated with anabolic steroid use can help reduce use, these programs are not a panacea. Consequently, drug testing of adolescents needs to be seriously considered as another potential weapon in the fight against steroid abuse.

Although use of steroids is illegal in most countries of the world, and their use is banned by virtually every sport governing body, surveys and drug-testing data indicate continued use by competitive athletes worldwide and at all levels. The fact that the level of steroid use appears to have increased significantly over the past three decades among adolescents, women, and recreational athletes is also of growing concern.

The use of steroids presents an interesting public health challenge. While these drugs are associated with deleterious physical and psychological outcomes, they are also being used to achieve what many consider socially desirable ends: being physically attractive and being a winner.▼

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References

Bahrke, M.S., & Yesalis, C.E. (2002). *Performance-Enhancing Substances in Sport and Exercise.* Champaign, IL: Human Kinetics.

Centers for Disease Control and Prevention. (2005). Youth Risk Behavior Surveillance System. www.cdc.gov/nccdphp/dash/yrbs

Elliot, D.L., et al. (2004). Preventing Substance Use and Disordered Eating: Initial Outcomes of the ATHENA (Athletes Targeting Healthy Exercise and Nutrition Alternatives) Program. *Archives of Pediatrics and Adolescent Medicine,* 158: 1043-1049.

Goldberg, L., et al. (1996). The Adolescents Training and Learning to Avoid Steroids (ATLAS) Prevention Program: Background and Results of a Model Intervention. *Archives of Pediatrics and Adolescent Medicine,* 150:713-721.

Monitoring the Future Study (2005). http://www.monitoringthefuture.org/

Yesalis, C.E. (2000). *Anabolic Steroids in Sport and Exercise.* Champaign, IL: Human Kinetics.

Yesalis, C.E., & Cowart, V.S. (1998). *The Steroids Game: An Expert's Inside Look at Anabolic Steroid Use in Sports.* Champaign, IL: Human Kinetics.

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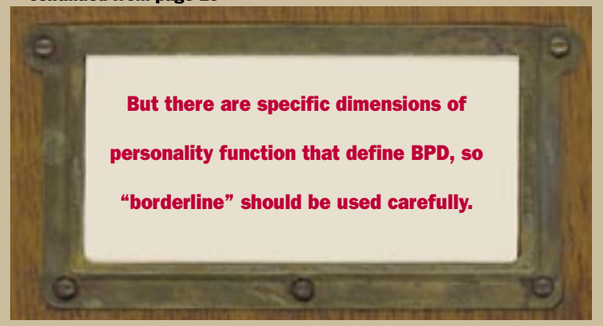

continuing and I will be emotionally abandoned anyway, I at least want to be in control of the rejection."

The sudden fluctuations in mood, interactions and the alliance with such BPD clients partly arise from these conflicted dynamics. *To balance the strong need for nurturance with the fear of abandonment or rejection, here are some clinical implications:*

- Keep the inpatient or residential stay as brief as possible to limit the degree of regression.
- Focus the inpatient stay on preparing the client for return as soon as possible to the real world.
- Use the safe, supportive milieu to practice cognitive and behavioral strategies that increase the confidence of the client and family that he or she is safe enough to continue recovery in the community e.g., what can you think about and do differently next time there is a crisis and you have an impulse to cut yourself?

You might say: *"This brief stay in the inpatient unit or residential program is to practice some ways to cope with a crisis without hurting yourself or others. We won't be working on all the things that are important to talk about. Most of that can happen when you continue care in an outpatient setting. This will not be a stay to get a total emotional makeover; nor to understand and solve all the issues and concerns of your life to be happy. But we will hang in with you to think and do whatever it takes to help you cope in the community as soon as possible. That is where the real ongoing work will be done, not here. So let's think about and practice what you could do differently to cope with another crisis like this one."*

The emphasis is on active responsibility to practice and learn how to get ready for coping in the community, not on passive nurturance and care. The message is: you can cope, but we will be here at your side to work with you and support you in that growth process.

Be Careful About Reinforcing Suicidal Behavior

Imagine if every time a person becomes suicidal the response is to move them from a stressful home environment into a safe, caring treatment environment. The client quickly learns to see him or herself as unable to cope in the community — that they can only be safe by having others take control of them and their environment. So the next time a similar crisis arises, guess where the person first thinks to go to feel safe and get relief?

Most clients know that if they have run out of money and want to get off the streets; or get relief from the stresses at home or the street, the surest way to get to a 24 hour setting is to present depressed and suicidal. That is not to say that everyone who presents suicidal is not really in crisis; nor that we should never hospitalize people who are suicidal. But when hospitalization and intensive treatment is always the first option, it reinforces the patient's dependence on a 24-hour setting as the main coping and relief mechanism.

Marsha Linehan suggests that in a Dialectical Behavior Therapy approach, the message is that hospitalization and intense treatment is the last option if at all, but certainly not the first option. Compared with treatment-as-usual, DBT reduces the prevalence and medical severity of parasuicidal episodes, therapy dropout, and inpatient psychiatric days.

You might say: *"I really understand that life feels hopeless and depressing right now and that it seems that death is the best and only option. But I am glad you are here talking to me because that tells me a part of you might be open to other alternatives. So let's work on how to explore all the options, not just the death one. I will hang in with you in that process. There is no magic in an inpatient stay. It will not solve all the problems right now; and it may even delay solutions and make things worse. So let's think together on what we can do to focus on active functioning in the community. Let's work with the part of you that found life worth living and brought you to reach out for help. You wouldn't have called me if you wanted to die, as you know I don't help people die. But you do know I want to be here for you to help you live. Thank you for reaching out to me for help. Now let's get on with focusing on helping you to live."*

Working with people with BPD is not easy. But they also are not hopeless. Learning to balance nurturance with expecting responsibility can enhance success in the treatment of BPD. It may also spare a therapist years of frustration as they deal with conflicts and crises.▼

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References

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) Washington, DC, American Psychiatric Association.

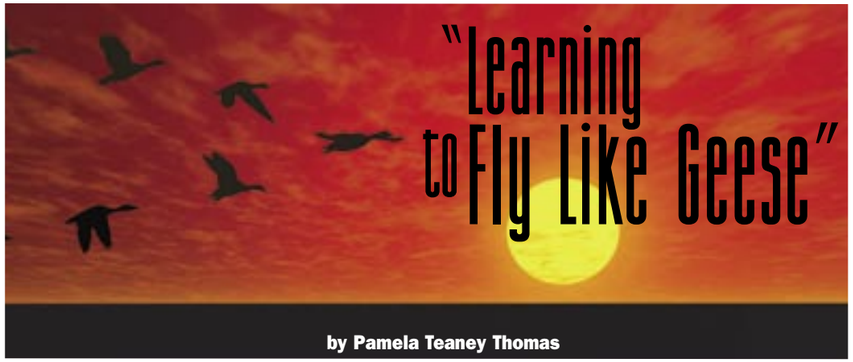
Linehan, M.M. (1993). "Cognitive-Behavioral Treatment of Borderline Personality Disorder." New York, Guilford Press.

Linehan, M.M. (1993). "Skills Training Manual for Treating Borderline Personality Disorder." New York, Guilford Press.

Linehan, M.M., Tutek, D.A., Heard, H.L. & Armstrong, H.E. (1994). "Interpersonal Outcome of Cognitive Behavioral Treatment for Chronically Suicidal Borderline Patients." *American Journal of Psychiatry.* 151:1771-1776.

Zanarini, M.C., Gunderson, J.G., Frankenburg, F.R. & Chauncey, D.L. (1989). "The Revised Diagnostic Interview for Borderlines: Discriminating BPD from Other Axis II Disorders." *Journal of Personal Disorders.* 3:10-18.

Zanarini, M.C., Frankenburg, F.R., Hennen, J. & Silk, K.R. (2003). "The Longitudinal Course of Borderline Psychopathology; 6-Year Prospective Follow-Up of the Phenomenology of Borderline Personality Disorder." *American Journal of Psychiatry.* 160:274-283.



"Learning to Fly Like Geese"

by Pamela Teaney Thomas

Living in South Dakota one gets to mark the changing seasons by looking up into the sky in the spring and again in the fall, to see the famous "flying V" of the Canadian geese.

One fall day as I stepped outside on to my deck, I noticed the sound of the geese was much louder than usual. Instead of flying high in a V formation, a small group of geese were flying low to the ground, circling round and round. As they continued this pattern of circling, more and more geese joined in, honking and flapping ever so ungracefully. The geese steadily rose higher and higher in what appeared to be a chaotic motion with no clear leader, yet working together without colliding. This process finally reached a magical height turning into the amazing "V" flight formation.

This process is similar to what happens when humans form a committee or coalition. If one understands this natural development of a team, the better chance there is for success in reaching goals faster and easier, and ensuring a group's longevity.

First Step — FORM
Form begins with taking an idea, and discussing with others to gather support for a common direction or goal.

Second Step — NORM
Setting up a social structure begins with the team working together on reaching goals. Who will do each duty? Who will take the lead? This process may appear chaotic; however, it is necessary. If one takes off with the idea prematurely thinking others will follow, they may find themselves alone, tired and discouraged. Height, distance or magnitude will not be reached if time is not taken for the team to invest in the same ideas and direction.

Third Step — STORM
People may get upset, not supporting the current norms or direction of the group. It may feel like the team is falling apart, and it will if the storm is not recognized. This stage is a natural process in the team development process to move the group to renorm.

Fourth Step — RENORM
Renorming is a process of clarifying goals, looking at a vision, revisiting objectives, tasks, position responsibilities and deadlines. Renorming may also include social rules. Once members can support the revised norms, there should be a sense of strong commitment and drive. The group is now ready for performing the flight.

Fifth Step — PERFORM
Researchers discovered that a flock of 25 birds flying in V formations and coasting on the wake of the bird just ahead, can fly 70 percent farther than a single bird using the same amount of energy because the birds:

• Share common direction and sense of community
People who share a common direction and sense of community can get where they are going quicker and easier because they are traveling on the thrust of one another.

• Feel drag and resistance going alone
When a goose falls out of formation, it suddenly feels the drag and resistance of flying alone. It quickly moves back into formation to take advantage of the lifting power of the bird immediately in front. If people have as much sense as geese, they must be willing to head in the same direction and be willing to accept and give help to others.

• Take turns doing hard jobs and sharing the lead
When the lead goose tires, it rotates back into the formation, and another goose flies to the point position. It pays to take turns doing the hard tasks and sharing leadership. As with geese, people are interdependent on others' skills, capabilities, and unique gifts, talents, or resources.

• Encourage those in front to keep going
There are numerous theories about the honking. It could be about letting others know where they are so no midair collisions occur; however, many believe the honking is about creating an environment of success and mutual encouragement. Humans need to make sure their honking is encouraging to make production much greater.

• Stand by each other
When a goose is sick, wounded, or shot down, two geese drop out of formation and follow it down to help and protect it. They stay until it dies or is able to fly again. Then they launch out with another formation or catch up with the flock. People need to stand by each other in high and difficult times.

Understanding these stages of team development helped to create two community coalitions plus a PTA and maintain their continued success. **Humans, like geese, were created to work together and to support one another.** When we encourage each other and support our leaders we can accomplish amazing things — better than working alone.▼

Pamela Teaney Thomas *is currently the Youth Development Coordinator for the Rapid City Area Schools and Project Director of A.S.A.P. INC/Drug Free Communities in South Dakota. She is an award-winning presenter, national motivational speaker, educator, and counselor. She may be contacted at pamtt@rushmore.com.*

Treating the Triggers

Kill the Craving

by Robert DeLetis, C.A.D.C.

Pouring a drink-in order to stop drinking. Rolling a joint-to kick a pot habit. Laying out a few lines of cocaine-to overcome the desire to snort it. These are not oxymorons or acts of a fool. They are examples of a new form of therapy for chemical addiction called Exposure Response Prevention (ERP).

What is Exposure Response Prevention Treatment?

ERP is based on principles of operant and respondent learning. Respondent learning takes place when one associates a new stimulus with one that already has an effect on us. For example, we experience respondent learning when we associate the name of a new restaurant with the already familiar experience of having a delicious meal.

Operant learning takes place when we associate rewards, punishments, success, and failure with individual patterns of behavior. Everyday we experience operant learning. It is the primary way in which we learn new behaviors and strengthen or weaken existing behaviors. When we meet a new person we use conversation that was rewarded in the past. When we learn to serve a tennis ball we undergo an intense operant learning experience that will eventually (we hope) lead to a more effective serve.

Conventional Approaches

Conventional wisdom advises people recovering from chemical addiction to avoid the people, places, and things they previously associated with their drug and alcohol abuse. This advice is based on the fact that the addict associates, through respondent learning, people places, and things with the preparation and use of their addicted substances. Respondent learning gives these stimuli the power to trigger strong desires to use drugs or alcohol. For example, if a recovering addict meets a friend with whom they snorted cocaine in the past the addict will get the urge or impulse to use cocaine because of the respondent connection between their friend and cocaine use. Because of this connection conventional treatment advises that the recovering person avoid these stimuli completely.

Unfortunately, it is virtually impossible to avoid all former stimuli connected with drug and alcohol abuse (Chiauzzi & Liljegren, 1993). This fact partially explains why the relapse rate for recovering addicts is about 75 percent within one year. Dr. Joe Santoro, co-founder of SLS Health, a residential facility in New York explains, "We realized that the conventional advice just didn't work for most addicted people. We needed to find a way to teach them how to cope with stimuli connected to their former addictions to give them a better chance of staying clean." Dr. Santoro went on to say, "So we applied exposure response prevention techniques to the problem. If we could simulate exposure to the most powerful forms of stimuli associated with chemical use, we could show the patient that after repeated therapeutic exposure to these stimuli their impulse to use would completely extinguish" (Santoro, DeLetis, & Bergman, 2004, 49-50).

Studies completed by Dawe et al. (1993) and Powell et al. (1993) provide research data that supports the effectiveness of ERP for the treatment of opiate addiction. Blakely & Baker (1980) and Hodgson & Rankin (1982) documented the effectiveness of exposure therapy for alcohol use stimuli.

The Craving Wave

The impulse to use rises upon exposure to a triggering stimulus. If the person does not use, their craving will peak and then decline to zero.

ERP Kits

SLS Health uses ERP kits made up of simulated drugs, drug use paraphernalia, music and photographs that the user associates with their chemical abuse. Each of these objects has the power to trigger a strong level of craving in an addicted individual. They have no effect on a non-addicted person. SLS also developed a photo card form of ERP for self-administered therapy. Each card set depicts a hierarchical sequence of drug preparation and use scenes by substance. There are card sets available for crack, cocaine, alcohol, heroin and marijuana.

SLS Health's developed the format for an ERP therapy session in a specially designed room for the therapy session that is decorated to remind the patient of their chemical use. Patients need to learn that they can ride their craving wave without giving into a desire to use. Through repeated ERP therapy sessions the impulse to use triggered by the ERP stimuli becomes weaker and weaker. Eventually, the patient feels virtually no desire to use at all. It is at that point that the patient feels they have really accomplished something special.

An ERP Therapy Session

A typical ERP session starts with about five minutes of relaxation exercises. After relaxing the patient is asked to rate their craving level before being exposed to their triggering stimuli. They use a 10 point scale to do this where 10 represents a desire to use immediately. The patient's pulse is also measured (pulse rate generally increases as a patient's craving level rises). Once baseline ratings are secured exposure to the first level of stimulus begins. After looking, touching and smelling the objects and answering a few questions, the patient is again asked to rate their craving level. Their pulse is taken again as well. Generally, their craving level is up as is their pulse. If they have become over stimulated then the ERP stimuli are put away and they return to doing relaxation exercises. Otherwise, they continue to look at the objects while repeating their cognitive scripts. Cognitive scripts are motivating statements designed by therapist and patient. They are associated with the triggering stimulus and the impulse to use. *Typical cognitive scripts include:*

"Remember the pain and hurt I caused myself and my family."

"I will be able to feel better about myself if I walk away."

"Remember the physical pain and consequences of withdrawal."

The patient makes a respondent connection between these scripts and stimuli formerly associated with chemical abuse. So not only does the patient break the drink or drug connection with the triggering stimuli, he also connects the stimuli with his cognitive scripts. This new connection will help him to walk away from a tempting situation.

Once a patient has completed the first level of stimulus exposure he proceeds to the next level and repeats all of the steps. An ERP therapy session continues until the patient has completed all of the stimulus exposure levels or the session has to be stopped because of over stimulation.

The typical patient requires at least 30 ERP sessions to complete the entire stimulus hierarchy without experiencing any significant levels of cravings (as measured by the rating scale and pulse rate). Once a patient can view the ERP stimuli without experiencing an impulse to use they can end this part of their treatment.

ERP helps the patient to confront their worst fear: accidental exposure to a substance abuse triggers. ERP treats these triggers. It prepares them to handle these situations without making them cocky. After ERP therapy they will not experience an unmanageable level of craving if they are triggered by a situation. Instead the situation will trigger their cognitive scripts that will help them to think and talk their way out of the situation without using.

Real World ERP

For some patients simulated ERP therapy is not sufficient. They need to experience ERP in real world situations. Some patients go to a bar (with their therapist) where they can experience triggers to drink and learn to cope with them without using. This step can only be taken after a patient has successfully completed simulated ERP sessions.

For example, one patient treated at SLS Health had a serious addiction to crack cocaine. Every two weeks on the day he got paid he would go on a several day crack binge. The patient responded well to office based ERP and wanted to handle his most difficult real world trigger: payday. His therapist described how they did real world ERP as follows: "Joseph and I went to pick up his paycheck together. I remember the first time very well. He was very nervous. He was sweating and twitching. He really wanted to get high. I helped him get through his cravings and after about five 'paycheck' sessions he was able to get his check on his own without being triggered to use." Real world ERP sessions can be very helpful when a patient must confront situations in his daily life. When avoidance is not possible, ERP can save the day.

ERP is a Tool, Not a Cure

ERP therapy should never be used as the sole treatment for substance abuse problems. ERP is a new therapy that treats the triggers and can help people recover from drug and alcohol abuse when intelligently combined with other forms of treatment. A comprehensive treatment approach should include group therapy, community based support meetings, individual psychotherapy to handle concurrent psychological problems and medication where appropriate to assist in the treatment of psychological disorders such as depression, anxiety, and mood swings.▼

Robert DeLetis, *Director of ERP Therapy at SLS Health Inc. for the past 15 years, is an international and nationally certified alcohol and drug counselor (CADC). He is also the co-author of* Kill the Craving, *a book that introduces Exposure Response Prevention (ERP) to professionals and their clients. As the creator of ERP nearly 12 years ago, he has developed training seminars, in-service trainings, as well as created a full professional ERP kits for counselors, psychologist, and doctors to learn this new approach to substance abuse treatment. More information about ERP therapy is available at 1(888) 8-CARE-4U and the Web site at www.erptherapy.com. Mr. DeLetis may be contacted at Rdeletis@slshealth.com.*

References

Blakely, R., & Baker, R. (1980). "An exposure approach to alcohol abuse." *Behaviour Research and Therapy*, 18, 319-325.

Chiauzzi, E. J., & Liljegren, S. (1993). "Taboo topics in addiction treatment: An empirical review of clinical folklore." *Journal of Substance Abuse Treatment*, 10, 303-316.

Dawe, S., Powell, J., Richards, D., Gossop, M., Marks, I., Strang, J., & Gray, J. (1993). "Does post-withdrawal cue exposure improve outcome in opiate addiction: A controlled trial." *Addiction*, 88, 1233-1245.

Hodgson, R.J., & Rankin, H.J. (1982). "Cue exposure and relapse prevention." In W.M. Hay & P.E. Nathan (Eds.). *Clinical case studies in the behavioral treatment of alcoholism*, (pp. 207-226). New York: Plenum.

Powell, J.H., Bradley, B., & Gray, J.A. (1993). "Subjective craving for opiates: evaluations of a cue exposure protocol for use with detoxified opiate addicts." *British Journal of Clinical Psychology*, 32, 39-53.

Santoro, J., DeLetis, R. & Bergman, B. (2004). *Kill The Craving*, (pp.49-50). SLS Health Press.

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achieve and maintain abstinence compared to subjects treated in general addiction programs (Peck et al). Ideally the best treatment for crystal addiction is complete abstinence because the drug is physiologically so addictive. However, if a crystal user with poor insight is firmly opposed to stopping, then an abstinence – only approach may drive that person away from seeking assistance.

If crystal has only mild negative consequences and the addict is not motivated to stop using, a harm reduction approach is appropriate, remaining client-focused and identifying the treatment goals of the crystal user — what aspects of crystal use does the crystal user feel are important to address? Most want to learn more about crystal and how to use it safely. Harm reduction educates people about drugs or other behaviors so that they can make logical decisions about their use. It also clarifies all of a person's general goals in life outside of drugs e.g., increasing income, furthering a career, improving self-esteem, completing school, improving personal relationships, etc. This type of treatment monitors people's ability to use crystal safely, watches for any loss of control, and points out when crystal use becomes an obstacle to achieving other life goals. In this way, harm reduction strives to cultivate an internal motivation to change. Harm reduction has a vital role in helping crystal addicts who are not yet ready to stop completely, but are willing to receive education about their drug use. It also acclimates them to the concept of drug treatment.

Unlike for other drugs, harm-reduction treatment for crystal addiction needs to be more aggressive in alerting people about the high risk of developing addiction and to educate them about the specific neurophysiologic activity of crystal and the structural changes in the brain it causes. Crystal users should hear from the beginning that ultimately abstinence is the safest way to avoid addiction. The longer that a person continues to use crystal, the more structural changes in the brain occur that intensify the compulsion to use crystal and weakens the ability to make appropriate judgments. The principle of harm reduction rests on the assumption that the drug user is making rational decisions about drugs, but with prolonged crystal use, the ability to make rational choices is physiologically impaired.

Abstinence-based programs include traditional relapse-prevention therapy, teaching newer, more adaptive coping skills that will replace crystal, addressing individual issues that make crystal so appealing, and teaching specific ways to deal with cravings. Group therapy is an excellent treatment modality in which people share their experiences, both good and bad, about their addiction and support each other in their struggles to stay sober. In particular, 12-step groups, such as Crystal Meth Anonymous (CMA) or even Alcoholics Anonymous (AA), are extremely helpful. Talking about drug use with peers rather than with healthcare providers can be much more powerful because of a respect for the shared understanding that other addicts have. Becoming a sponsor and teaching sobriety skills to another person helps addicts to internalize relapse-prevention concepts. Longitudinal studies have shown that people who participate in 12-step groups are twice as likely to remain sober compared to those not involved in 12-step programs. Interestingly, improvement was not related to the level of motivation of participants.

The above-mentioned abstinence-based treatments are used at all levels of treatment intensity, from weekly outpatient treatment to intensive day treatment to inpatient rehabilitation. Guidelines for the intensity of treatment are the same as for other drugs: if an addict continues to relapse during routine outpatient treatment, then intensive outpatient treatment is necessary. If the addict still continues to relapse, is unable to stay sober unless in a protected environment, or is in medical or psychiatric danger, then inpatient treatment is necessary.

Issues specific to crystal must be addressed at any level of treatment. For example, the specific use that crystal has for each individual (e.g., to increase work performance, to improve self-esteem, to alleviate depression, or to remove sexual inhibitions in a conflicted gay person with internalized homophobia) should be explored in depth, and more adaptive coping mechanisms should be frankly discussed. For many this includes a specific focus on relearning how to have sober sex and mourning the loss of sex on crystal. Information about addiction and the physiology of crystal in the brain should be clearly explained so that addicts understand the reasons for their strong compulsions.

Another treatment to consider for crystal addiction is medication. Currently detoxification regimens are being investigated that ameliorate the difficult crash of crystal. These regimens include medications that decrease intense dysphoria, increase dopamine levels, and restore normal sleeping patterns. While crystal withdrawal itself is not deadly, intense depression can be fatal when it leads to suicidal ideation. In addition, the concept of detoxification — using pills to modulate a person's mood — is congruent with the crystal addict's coping style, and he or she may be more willing to enter a treatment that includes this familiar coping *mechanism*. Offering detoxification attracts more people into treatment who would otherwise avoid drug-treatment facilities.

Also under investigation are medications to help maintain abstinence. These include medications working on GABA (gamma-aminobutyric acid) receptors, calcium channels, and glutamate receptors. Some medications under investigation include topiramate (Topamax), gabapentin (Neurontin) and modafinil (Provigil), which have shown preliminary success in the treatment of cocaine addiction.▼

Dr. Steven J. Lee *is an Assistant Clinical Professor of Psychiatry at Columbia University. He is a diplomate of the American Academy of Addiction Psychiatrists (AAAP) and a member of the American Society of Addiction Medicine (ASAM). He is a board member of the Gay and Lesbian Medical Association (GLMA) and a member of the advisory committee on crystal methamphetamine addiction. Dr. Lee is an active member of the American Psychiatric Association (APA) and has sat on two of its national committees. He lectures regularly at national conferences of the APA and ASAM on topics of addiction, and he speaks often in New York City for various mental health organizations. Dr. Lee has published several articles in psychiatric and addiction journals. Currently, he is conducting a clinical trial on crystal methamphetamine treatment and his book* Overcoming Crystal Methamphetamine Addiction *is in press. You may contact Dr. Lee by writing to 130 West 15th St., Suite 9G, New York, NY 10011.*

References

Buchacz, K. et al. Amphetamine use is associated with increased HIV incidence among men who have sex with men in San Francisco. *AIDS.* 2005 Sep 2;19(13):1423-4.

Chapman, D.E., Hanson, G.R., Kesner, R.P. & Keefe, K.A. Long-term changes in basal ganglia function after a neurotoxic regimen of methamphetamine. *Journal of Pharmacol Exp Ther.* 2001 Feb; 296(2):520-7.

Halkitis, P.N., Green, K.A. & Mourgues, P. Longitudinal Investigation of Methamphetmaine Use Among Gay and Bisexual Men in New York City: Findings from Project BUPMS. *Journal of Urban Health.* 2005 Mar:82(1 Suppl 1):i18-i25. Epub 2005 Feb 28.

Kita, T., Wagner, G.C. & Nakashima, T. Current research on methamphetamine-induced neurotoxicity: animal models of monoamine disruption. *Journal of Pharmacology and Science.* Jul;92(3):178-95.

Larimer, M.E., Palmer, R.S. & Marlatt, G.A. Relapse Prevention: an overview of Marlatt's Cognitive-Behavioral Model. *Alcohol Research and Health.* 1999; 23(2):151-160.

Margos, W.F. et al. Human immunodeficiency virus-1 Tat protein and methamphetamine interact synergistically to impail striatal dopaminergic function. *Journal of Neurochemistry.* 2002 Nov; 83(4):955-63.

Peck, J.A. et al. Sustained reductions in drug use and depression symptoms from treatment for drug abuse in methamphetamine-dependent gay and bisexual men. *J Urban Health.* 2005 Mar;82(1 Suppl 1):i100-8.

Results from the 2002 National Survey on Drug Use and Health: National Findings, September 2003. www.samhsa.gov/oas/nhsda/2k2nsduh/2k2sofw.pdf.

Timko, C., Moos, R.H., Finney, J.W. & Lesar, M.D. Long-term outcomes of alcohol use disorders. Comparing untreated individuals with those in Alcoholics Anonymous and formal treatment. *Journal of Studies on Alcohol.* 2000 63:529-540.

ILLINOIS INSTITUTE FOR ADDICTION RECOVERY 2006 TRAINING AND WORKSHOP SCHEDULE

April 28th – 29th; July 28th – 29th

Intervention Training

Randee McGraw, CSADC, CAS, CEAP, MISA-II and Phil Scherer, CSADC, PCGC, MISA-II

Workshop cost: $200.00 (*must attend both days* – 14 CEU's)

Utilizing didactic lecture, video case vignettes, role-plays, and interactive group discussion, *this workshop will*:

- Describe the underlying philosophy and principles of the Family Meeting Approach to Intervention and how to utilize this approach to assist families in addressing issues related to addiction and other problems impacting upon the family system
- Review the Johnson, Systemic and the ARISE Models of Family Interventions
- Increase familiarity for coaching "Concerned Other" through the process of developing a support system in order to facilitate the Intervention
- Provide practical information in order to implement Intervention techniques within a clinician's practice
- Educate participants on becoming certified as an Interventionist
- Address how to determine what Intervention approach or Model to use
- Learn how to assess for "Safety Issues"

About the speakers: Mr. Randee McGraw is currently the Administrative Director of the Illinois Institute for Addiction Recovery at Proctor Hospital in Peoria, Illinois, BroMenn Regional Medical Center in Normal, Illinois, and Springfield, Illinois, where he has been employed since 1979. McGraw developed and implemented: the first comprehensive treatment program for Pathological Gambling in Illinois; a consultation service to implement treatment for Pathological Gambling in other agencies and hospitals; a treatment program for family members or concerned persons of people diagnosed with addiction; a treatment program for Adult Children of Addicts and survivors of childhood trauma; a comprehensive treatment program for all process addictions; a gambling counselor training program.

Phil Scherer is the Clinical Coordinator for the Illinois Institute for Addiction Recovery at Proctor Hospital. Scherer oversees the day-to-day clinical direction of the Illinois Institute's Proctor facility located in Peoria Illinois. Mr. Scherer is certified through the Illinois Alcohol and Other Drug Abuse Professional Certification Association at the supervisor level. Mr. Scherer is a certified Problem and Compulsive Gambling Counselor as well as a Mental Illness and Substance Abuse II professional. He is also certified through the American Compulsive Gambling Counselor Certification Board and the National Council on Problem Gambling as a counselor of problem gamblers.

June 15th

Clinical Supervision: Skills for the Future

David Powell, PhD

Workshop cost: $100.00 (6.5 CEU's)

This course provides a foundation of supervision and management of personnel. Based on "The Blended Model of Clinical Supervision" published in *Clinical Supervision in Alcohol and Drug Abuse Counseling,* by David Powell, it fulfills the training requirements for certification in clinical supervision of the International Certification and reciprocity Consortium. The material includes supervising those treating co-occurring disorder, working in an outcome-driven, managed care environment and the latest legal and ethical concerns. This course is recommended for present and future supervisors. It is ideal for agencies to train their management staff.

About the speaker: In addition to Dr. David Powell's thirty-six years of clinical experience and his academic degrees in counseling and psychology, he also holds a master's degrees in medical ethics from Yale University. He has trained throughout the world in the areas of clinical supervision, management and ethics. He is the author of a self-study course published by Hazelden on ethics and clinical practice.

August 18th

Not for Women Only: Recognizing and Treating Eating Disorders in Men

Cynthia Power, CSC, CAS, CCGC, CPCGC, ICGC

Workshop cost: $100.00 (6.5 CEU's)

The goals of this workshop, therefore, include increasing the treating clinician's awareness of male eating disorders and related conditions, identifying gender-specific differences between male and female eating disordered clients, and learning effective treatment tools for helping males suffering from a variety of eating disorders and related problems of size, appearance, sexuality and compulsive exercise.

August 25th

A Lady or a Tramp? Recognizing and Understanding the Female Sex Addict

Cynthia Power, CSC, CAS, CCGC, CPCGC, ICGC

Workshop cost: $100.00 (6.5 CEU's)

Twenty years ago, a question was slowly becoming more and more common, "Just what is a sex addict and what does he look like?" The past few years have seen a significant shift in focus, with the question becoming, "Do women ever struggle with sex addiction too?" The answer is a resounding YES. The goals of this workshop are to identify the characteristics of the female sex addict, elucidate her core beliefs, provide methods for assessing the female sex addict as well as the cybersex woman, and indicate tools for her recovery. Information on helping husbands, family and friends of female sex addicts will additionally be offered.

About the speaker: Cynthia (Cindy) Power is co-founder and co-owner of Life Enrichment Services, Inc., a private practice in Wheaton, Illinois. She has worked with a variety of couples, families and groups in the greater Chicago area for over thirty years. Cindy received her M.A. degree in Clinical Psychology from Indiana State University in Terre Haute, Indiana and is a Licensed Clinical Professional Counselor in the State of Illinois. She is a trainer and consultant to a number of Regional Programs and Agencies. For the last twenty-five years she has been actively presenting nationally and in Canada.

Above trainings will be held in Classroom III, in the Proctor Professional Bldg., Peoria, IL. from 8:30am – 4:30pm unless otherwise noted. For registration and lodging information, call 1 (800) 522-3784 or visit the Web site www.addictionrecov.org. Refreshments will be provided, but lunch will be on your own for all workshops.

If you have questions regarding addictions, please call 1 (800) 522-3784, or write to Eric Zehr at Proctor Hospital, 5409 N. Knoxville Ave., Peoria, IL 61614. On the Internet, contact: Eric.Zehr@Proctor.org. For more answers, visit our interactive Web site at http://www.addictionrecov.org.


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