THE NEXUS BETWEEN FOOD & ADDICTION

By Kenneth Blum, Ph.D. and John Giordano, MAC

The INs and OUTs of Depression and Alcohol
By Durum Bozhdaraj, M.D.
Charles B. Nemeroff, M.D., Ph.D.

Meet The Parents Helicopters, Submarines and you
By Dr. Louise Stanger, LCSW

Shame, Stigma And Anonymity
By Karrol-Jo Foster, LMHC, CAP, ACRPS
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Dear Readers,

I welcome you to The Sober World magazine. The Sober World is an informative award winning national magazine that’s designed to help parents and families who have loved ones struggling with addiction. We are a FREE printed publication, as well as an online e-magazine reaching people globally in their search for information about Drug and Alcohol Abuse.

We directly mail our printed magazine each month to whoever has been arrested for drugs or alcohol in Palm Beach County as well as distributing locally to the schools, colleges, drug court, coffee houses, meeting halls, doctor offices and more throughout Palm Beach and Broward County. We also directly mail to treatment centers throughout the country and have a presence at conferences nationally.

Our monthly magazine is available for free on our website at www.thesoberworld.com.

If you would like to receive an E-version monthly of the magazine, please send your e-mail address to patricia@thesoberworld.com.

Drug addiction has reached epidemic proportions throughout the country and is steadily increasing. It is being described as “the biggest man-made epidemic” in the United States. More people are dying from drug overdoses than from any other cause of injury death, including traffic accidents, falls or guns.

Many Petty thefts are drug related, as the addicts need for drugs causes them to take desperate measures in order to have the ability to buy their drugs. The availability of prescription narcotics is overwhelming; as parents our hands are tied.

Purdue Pharma, the company that manufactures Oxycontin generated $3.1 BILLION in revenue in 2010? Scary isn’t it?

Addiction is a disease but there is a terrible stigma attached to it. As family members affected by this disease, we are often too ashamed to speak to anyone about our loved ones addiction, feeling that we will be judged. We try to pass it off as a passing phase in their lives, and some people hide their head in the sand until it becomes very apparent such as through an arrest, getting thrown out of school or even worse an overdose, that we realize the true extent of their addiction.

I know that many of you who are reading this now are frantic that their loved one has been arrested. No parent ever wants to see his or her child arrest or put in jail, but this may be your opportunity to save your child or loved one’s life. They are more apt to listen to you now than they were before, when whatever you said may have fallen on deaf ears. This is the point where you know your loved one needs help, but you don’t know where to begin.

I have compiled this informative magazine to try to take that fear and anxiety away from you and let you know there are many options to choose from.

There are Psychologists and Psychiatrists that specialize in treating people with addictions. There are Education Consultants that will work with you to figure out what your loved ones needs are and come up with the best plan for them. There are Interventionists who will hold an intervention and try to convince your loved one that they need help. There are detox centers that provide medical supervision to help them through the withdrawal process, there are Transport Services that will scoop up your resistant loved one (under the age of 18 yrs. old) and bring them to the facility you have chosen. There are long term Residential Programs (sometimes a year and longer) as well as short term programs (30-90 days), there are Therapeutic Boarding Schools, Wilderness programs, Extended Living and there are Sober Living Housing where they can work, go to meetings and be accountable for staying clean.

Many times a Criminal Attorney will try to work out a deal with the court to allow your child or loved one to seek treatment as an alternative to jail. I know how overwhelming this period can be for you and I urge every parent or relative of an addict to get some help for yourself. There are many groups that can help you. There is Al-Anon, Alateen (for teenagers), Families Anonymous, Nar-Anon and more. This is a disease that affects the whole family, not just the parents.

Addiction knows no race or religion; it affects the wealthy as well as the poor, the highly educated, old, young—IT MAKES NO DIFFERENCE.

This magazine is dedicated to my son Steven who graduated with top honors from University of Central Florida. He graduated with a degree in Psychology, and was going for his Masters in Applied Behavioral Therapy. He was a highly intelligent, sensitive young man who helped many people get their lives on the right course. He could have accomplished whatever he set his mind out to do. Unfortunately, after graduating from college he tried a drug that was offered to him not realizing how addictive it was and the power it would have over him.

My son was 7 months clean when he relapsed and died of a drug overdose. I hope this magazine helps you find the right treatment for your loved one. They have a disease and like all diseases, you try to find the best care suited for their needs. They need help.

Deaths from prescription drug overdose have been called the “silent epidemic” for years. There is approximately one American dying every 17 minutes from an accidental prescription drug overdose. Please don’t allow your loved one to become a statistic. I hope you have found this magazine helpful. You may also visit us on the web at www.thesoberworld.com.

Wishing all the moms out there a Happy Mothers Day!


Sincerely,

Patricia
Publisher
Patricia@TheSoberWorld.com

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We’ve all been sad or experienced downswings in response to life’s struggles, setbacks, or disappointments. Feeling the ups and downs of life from time to time are normal and healthy for emotional development. It is when the feelings of sadness, emptiness, or despair seem to take over your life or that they won’t go away that one should ask themselves “Do I have depression?”

Depression is the leading cause of disability worldwide and a major contributor to the global burden of disease. Recent statistics reveal that approximately 6.9% of adults in the United States have had at least one episode of major depression in the past year. Sadly, only 40% of those diagnosed with a mental illness actually seek out mental health services. Depression is not always a stand-alone illness; rather, it is often seen in combination with substance use and/or alcohol.

Nearly one quarter (24.3%) of alcohol-dependent men and nearly one half (48.5) of alcohol-dependent women have been noted to have a concurrent diagnosis of depression. Researchers have sought to explain the association between alcohol use and depressive symptoms in a variety of ways. First, some studies reveal that the pharmacologic effects of alcohol may produce symptoms of depression more or less directly during periods of intoxication and/or withdrawal. Other studies have shown that depressive symptoms can spontaneously emerge in the context of heavy drinking and abate with abstinence. Chronic drinking and related symptoms may promote depression indirectly as well by contributing to stressful life circumstances (social functioning) that in turn are known to promote depression (poor spousal relationships, unemployment, etc). Lastly, there is a variety of research that supports the idea that individuals with depression are motivated to drink in an effort to cope with the negative affect or decreased mood which may be in turn a potential mechanism for the development of alcohol use disorder. It is also important to note that it is now clearly established that 30-40% of the risk for development of major depression is genetically transmitted. Although these methods have been studied, no single causal or shared risk factor has been identified.

Diagnosis/What is Depression?
Ups and downs or feelings of sadness are common. Often times within social context people will use “depression” to describe isolated and short lived feelings of highs and lows. However, clinical depression is much more severe. Each person’s experience with depression varies, though there are common signs that are important to recognize so that one knows when to seek help. The diagnosis of depression is based on the following criteria: five of the following nine symptoms nearly every day for more than two weeks:

1) Depressed mood or irritability
2) Decreased interest or pleasure in most activities
3) Significant weight change or change in appetite
4) Change in sleep
5) Change in activity
6) Fatigue or loss of energy
7) Feelings of worthlessness or excessive guilt
8) Diminished ability to think or concentrate
9) Thoughts of death or suicide.

Depression is a major risk factor for suicide, the 10th leading cause of death in the United States. The despondent feelings one experiences when depressed, the helplessness and the cognitive distress coupled with an inability to experience pleasure can lead to suicide. Alcohol use concurrent with episodes of depression further increases the occurrence of both suicide attempts and suicide deaths.

Pathophysiology/What’s causing your Depression?
Depression is the result of a complex combination of biological, psychological, and social factors. Three very distinct neurotransmitter systems in the brain related to depression have been studied extensively: serotonin, dopamine, and norepinephrine. An alteration in one or more of these systems is thought to contribute to depressive symptoms. Brain imaging studies have revealed structural and functional alterations in depressed patients. In addition to biological factors, there are the psychological and social factors that contribute to symptoms and episodes of depression. Some of these risk factors or causes include a history of childhood abuse and/or neglect, loneliness, lack of social support, recent stressful life experiences, marital or relationship problems, financial strain, alcohol or drug abuse, unemployment or underemployment, and chronic health problems or pain.

Treatment/ What can you do about it?
Just as the symptoms of depression may differ in different people, the optimal treatment of depression varies from person to person. If you recognize the signs of depression in yourself or a loved one take time to understand the many treatment options available. In many cases the best approach involves a combination that addresses each aspect of the biological, psychological, and social contributing factors.

Feeling helpless and hopeless are cardinal features of depression. The key to recovery is to start by asking for help. Having a strong support system- family, friends, therapists, and/or clergy- will assist your recovery because isolation fuels depression. Let your family and friends know what you’re going through and ask them how they can support you.

You should also consult with a mental health professional to determine the best treatment for your specific symptoms. There are effective treatments for depression, which include certain forms of psychotherapy (eg. Cognitive behavioral therapy or CBT) and antidepressant medication approved by the FDA. Many people have difficulty managing stress and balancing conflicting emotions. This is normal. Psychotherapy may be helpful as it provides skills and insight to prevent future depressive episodes. In other words, learning how to recognize and express your emotions can help you be more resilient and less prone to future depression. Antidepressant medications not only treat depression but prevent relapse. There are a variety of medications that can be used, alone and in combination, and specific regimens can be created to effectively manage and treat depression.

Lastly, if you are drinking to cope with unpleasant feelings or think that you may be depressed, it is imperative that you reach out to an experienced medical professional to seek help and educate yourself about your treatment options. Though it may not seem possible, you can improve your quality of life, without the use of alcohol.

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The family and loved ones of a person in need of recovery, or going through recovery, pay a heavy price that cannot always be measured in dollars and cents.

When we are in our active addiction it’s hard to see the world around us the way others do. Our focus is so tuned into our own needs and our addiction, that we usually miss the signs of life around us. Our whole being is tied up in getting to the next hit, or getting the money we need for our drink or drug. We plan our lives around using. Our brains become re-wired and our bodies are affected by this as well. There are actual chemical changes in our brains that guide our thoughts, feelings and actions. There are also physical consequences of our use.

The same is true for the family of a person suffering from a Substance Use Disorder (SUD). The stress and worry of the family re-wires their brains as well. Chronic exposure to the stressors shows up in a variety of ways, including behavioral changes and physical symptoms. They sometimes suffer more physically than the one who is actually using the drugs. While the client has been able to medicate through their feelings and even through physical pain, the family often has no such outlet and no coping skills for their suffering. And, just as an addict can have “triggers” for relapse, so can the family. We see these triggers most often when the client returns home or has communication with the family while away. Simply hearing their voice or receiving a message can send the family into a “relapse” of their own. The body tenses, stress wells up inside, voice and inflection change, fear and anger creep in. This can sometimes lead to a variety of physical symptoms as well – including hives, headaches, digestive system issues, decreased immune response, anxiety attacks and more. These are what we refer to as symptoms of “second-hand use”, meaning that the family didn’t have to use the substance in order to be negatively affected by the use.

As a part of the recovery process the family should be given an opportunity for healing just as robust as what the client in the treatment facility is receiving. If the family’s suffering is not addressed, the client would be exposed to the associated triggers and the chances for the one with the substance use disorder to have lifelong recovery are greatly diminished. Naturally, this in turn continues the cycle for the family as well, and their suffering is prolonged. And, just like the addicted loved one, they need a solution that does more than treat the symptoms. Hypertension, lowered immune systems response, irregular heartbeat, stroke, anxiety, disrupted sleep patterns and loss of interest in sex are all by-products of living with an addicted loved one. But these are only symptoms and treating them alone will not eliminate the problem. Thought process and emotions are typically heavily impacted and appropriate help should be offered. So the answer is not just bloods pressure meds, anti-anxiety meds and immune boosters. We need to treat the root causes that led to the symptoms in the first place.

Certainly, helping the family member with the Substance Use Disorder is a great start to treating the issues within the family as well. By doing this, we can prevent the family members from incurring ongoing exposure to the original source of the problems. But it needs to go further since some damage has likely already been done. Simply removing the exposure won’t be enough. Additionally, there are some situations in which there was existing dysfunction, mental health issues, or other contributing factors prior to the SUD rearing its ugly head. By helping the family learn new coping skills, they are no longer at the mercy of their loved one’s level of engagement in recovery and they no longer need to be at the mercy of their own lingering emotions and thought processes. Instead of failing to the “learned helplessness” of wanting to control the actions of their loved one (who can’t even control their own actions) but having no means to do so, they can learn to regulate their own emotions and responses.

So, how do we treat these issues and regulate the emotions and responses we have been conditioned to? Many of the same treatments received in direct care at the treatment center by their loved one, can be very helpful to the family members as well. Amino Acid Therapy, (Neurotransmitter Replacement Therapies), a process pioneered by world-renowned neurobiology research scientist Dr. Kenneth Blum, is proven to help restore a healthy balance of neurotransmitter activity in the brain, and this treatment can help rebalance and repair the deficiencies. This in turn leads to healthier thoughts, feelings, and actions. Mental clarity, focus, reduced anxiety, and lowered frequency and intensity of depression are all benefits of this approach. Breathing exercises, prayer and meditation practices can reduce stress, anxiety, and the related symptoms. Massage therapy, chiropractic care, auriculotherapy, individual and group counseling can all be very helpful for the family members just as they are for the client in treatment. In situations of trauma, which is often a by-product of the family dealing with SUDs, Eye Movement Desensitization and Reprocessing (EMDR) can be very helpful. Many families can benefit from grief counseling as well.

One area often neglected, but extremely important is learning new communication style and techniques. The whole family could benefit from learning and practicing new ways of expressing themselves in order to avoid falling back into old patterns – which would in turn trigger some of the very symptoms we are attempting to heal. Often times, the individuals involved do not even recognize the unhealthy patterns of communication and a professional counselor should be involved to help with this. One extremely helpful process is known as Structured Family Recovery (SFR). Structured Family Recovery (SFR) is a weekly program designed by Debra Jay that she states, “moves family and friends beyond enabling and frustration, and makes everyone part of a recovery team. Working together creates transparency and accountability in a way that prevents the disease from regaining control.” These approaches and others should be offered by the facility treating the family member with the SUD. It can be done in person or electronically, depending on the families’ ability to attend in-person or not.

Just as the client in treatment needs to have hope for a future in order to sustain change, so does the family. And, unfortunately, sometimes they need to find that hope regardless of the primary client’s successes or struggles in their own treatment.

Family therapy should be a part of any recovery process, not just for the family’s sake, but for the direct client as well. A quality therapist and program should be able to help the family with these processes. If you or a loved one are suffering, either by direct use, or through “second-hand use”, please find a place that offers the help you need.

Lyle Fried graduated Magna Cum Laude with a Psychology degree from Liberty University. He is a Florida Board-Certified Addictions Professional (CAP); Internationally Certified Alcohol & Drug Counselor (ICADC); Board Member, Alliance for Addiction Solutions (AAS); member of the International Substance Abuse & Addiction Coalition (ISAAC); an Approved Training Provider through the Florida Certification Board; and a member of the Florida Association of Drug Court Professionals. He currently works as Co-Founder/CEO of The Shores Treatment & Recovery.
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Ah, comfort foods. There is nothing like a good Danish pastry to start the morning off right. Foods that tend to elevate our mood almost always have a high sugar or other carbohydrate content. Over one-hundred years ago, the average American consumed 12 pounds of sugar a year. Today it’s more like 144 pounds! Sugar is in nearly everything you buy at the grocery store. Any guesses as to why we’re experiencing a tidal wave of obesity and type II diabetes?

We know the damage these foods do to our bodies, but just what are they doing to our brains?! What is it about these delectable morsels that drive us to keep coming back for more when we know they’re not good for us?

Scientists have long suspected that sugar/carbohydrates – our bodies turn carbs into sugar (glucose) and by the way alcohol too – was the nexus between food and addiction; but not until recently are we able to prove it with tangible evidence showing the effects on the brain. New studies are confirming earlier suspicions. What they have discovered is that sugar and carbohydrates stimulate the brain the same way as drugs do and in the same regions.

Dopamine is the primary neurotransmitter of reward and pleasure. It’s one of the feel-good chemicals produced in the brain. Sugar, just like alcohol and drugs, spikes dopamine release in the brain’s reward center giving us a false sense of happiness and being at ease. But what goes up also comes down. When dopamine function begins crashing, we tend to feel cravings for sweet foods or sugary drinks just as an addict craves drugs, although less intense.

Does this mean we are or could become addicted to sugar and/or carbohydrates? Absolutely!

Below you’ll find a much more comprehensive scientific explanation to the connection between sugar/carbohydrates and food addiction. It is not an easy read but very factual and you will walk away with a better understanding of the relationship between sugar/carbohydrates and addiction.

The concept that food and drugs have common neurobiological and neurogenetic mechanisms has been pioneered first by Hoebel (1985) over 25 years ago and introduced into the media and mainstream America by Gold and associates (2013) and Avena’s group (Murray, et al. 2015).

It is so important for the treatment and recovery community to understand why allowing candy at treatment centers may indeed be a trigger for the unwanted transfer of one addiction (e.g. alcohol, opiates, cocaine) for another addiction. We now know that at least 20% of people undergoing lap-band surgery will develop full-blown drug addiction post-surgery. This phenomena of replacing food for drugs has been carefully researched in both human and animal models. It is not so surprising if you consider that similar neurogenetic variants occur across the brain reward circuitry resulting in a low dopamine function and enhance craving for both glucose and alcohol. In 1996 one of us (Blum et al 1996) coined the term “Reward Deficiency Syndrome” (RDS) to help explain the genetically induced commonality of all addictive behaviors drug and non–drug.

In this regard, it is well known that glucose, alcohol, heroin, nicotine, gambling, internet gaming, music and sex all release dopamine at the brain reward site leading to a false or pseudo feeling of well-being. This is especially true in individuals having compromised dopaminergic function through either gene polymorphisms (variants) or environment (epigenetic). This is simple to understand if you adhere to the mathematical formula whereby Phenotype=Genetics +Environment [P=G+E]. So if both certain genes coupled with a bad environment lead to low dopamine function the affected individual will do just about anything to feel good by finding ways to boost up their brain dopamine through both food or drugs or sex.

Research has revealed that obesity causes changes in both behaviors, and brain structures quite similar to the changes observed in drug addiction. However, addiction to food is not the cause of all cases of obesity. Can it be assumed that a large group of individuals no longer eat to survive, but rather survive to eat?

In this context we must consider the importance of the brain’s reward system in food intake the “thrifty gene hypothesis” (survival gene related to famine and fat metabolism) and as such the commonality between food and drug addiction (Speakman, 2006; Prentice, et al. 2008).

Certain overlaps in the brain circuitry activated by food and drug intake suggests that different types of reinforce (natural and artificial) activate a number of the same neural systems (Hoebel, 1985; Hernandez and Hoebel, 1990; Kelley, et al. 2002; Le Magnen, 1988; Volkow and Wise, 2005; Wise, et al. 1989). In fact, there are several regions in the brain involved in the reinforcement of both feeding and drug intake (Kalivas, et al. 2005; Koob and Le Moal, 2005; Mogenson and Yang, 1991; Baldo, et al. 2010), and a number of neurotransmitters, as well as hormones, have been studied in these and related brain areas (Baldo, et al. 2010; Simpson, et al. 2012; Spangler, et al. 2004; Schoffelmeer, et al. 2001; Stein and Belluzzi, 1979).

There have been many studies in the scientific literature that unequivocally support these commonality theories as proposed by Avena et al. (2013) and by Blum et al. (1996). In clinical situations, treatment of both food and drug addiction typically appear to present with reciprocal comorbidity and this common comorbidity deserves intensive investigation.

While overeating may have important neurochemical links to drug abuse, less is known about other eating disorders like bulimia (Mann, et al 2014) and anorexia (Jordan, et al. 2003). However, there is increasing evidence that the same gene polymorphisms that can predict both food and drug abuse, the Dopamine D2 receptor A1 form, can also predict eating disorders like anorexia and bulimia and even binge eating disorder.

Many articles have examined research developments and current treatments for obesity, including diet and exercise, psychotherapy, surgical interventions, and pharmacotherapies (Volkow and Baier, 2015; Michaelides, et al. 2012; Blum, et al. 2011). There are, however, some clinical issues that merit attention and provide...
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Anyone who is familiar with 12-Step programs such as AA and NA has at least some basic knowledge of the traditions associated with these programs relative to anonymity. More specifically, the 11th and 12th traditions and the relationship between these two traditions and the spiritual ideals of 12-Step recovery. The intent of these two traditions is rooted in trust and humility and serves to protect the integrity of the 12-Step program. Yet many people, newcomers and old-timers alike, misunderstand these traditions and often take the idea of anonymity to an absurd extreme. I would venture to say there are some reading this article right now who are screaming foul, simply based upon the subtitle alone. For those folks I would suggest considering the notion of contempt prior to investigation and resist your urge to toss this article aside and completely disregard the fact that some misguided ideas do exist relative to anonymity. Furthermore, and this is the hard part, I ask that you merely contemplate the detrimental effect secrecy and silence has on the perpetuation of shame and stigma in substance abuse and addiction (aka ignorance).

Don’t get me wrong, this article is not meant to attack or discredit the idea that anonymity is an important and vital part of 12-Step recovery, especially when it comes to maintaining the vision of its’ founders; Bill Wilson and Dr. Bob. On the contrary, my goal is to examine ways in which anonymity serves a beneficial purpose while also clarifying the ways in which anonymity is often misunderstood. More importantly, it is also my aim to raise conscious awareness by considering when living recovery out loud, non-anonymously, is both appropriate and beneficial to fighting shame and stigma.

Without any prior knowledge of the traditions and the history of AA, one might assume that it is the shame and stigma associated with addiction that warranted the need for anonymity in the first place, and this may ring true and make sense to many people. After all, in 1935 when AA was founded there was certainly a much greater degree of stigma associated with alcoholism and drug addiction than there is now. Yet, shame and stigma still exist and remain significant impediments to lasting recovery. Anonymity as a way of hiding from the judgmental glare of society may have been an initial concern but was not the intent of Bill and Bob in establishing the 11th and 12th traditions. In fact, according to AA history, the intention was that every group member know the full name, address and phone number of all the group members. How else can members be beneficial to each other if they remain anonymous to each other?

Let’s take a look at exactly what the short form of these two traditions says regarding anonymity. Tradition #11 states “Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.” This tradition speaks to AA’s “public relations policy” which means it is specific to personally and publicly promoting AA. Its’ intent is that we should not break personal anonymity in order to promote ourselves as AA representatives or AA as a whole. Tradition #12 states “Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.” As previously mentioned, central to the AA tenet of anonymity are the spiritual principles of trust and humility. As such, AA members should never break the anonymity of another group member outside of the AA program (trust) nor should they break their own personal anonymity for selfish or egotistical gains (humility), yet members may break personal anonymity in the process of trying to help others. And this, my friends, is where both understanding and interpretation can lead to many a heated debate in 12-Step recovery circles. When is breaking personal anonymity beneficial to others and when is it not?

Obviously anonymity is a key aspect of 12-Step recovery programs, and important to those participating in these programs and other recovery treatment programs. Stigma can make public disclosure a dangerous proposition for fear of discrimination on many different levels. Anonymity provides real protection from these concerns, especially early in the recovery process when sobriety is fragile and relapse risk is high. There is also a concern by many who struggle with substance abuse and addiction that they will be judged by friends and family members, perhaps even ostracized by them. These are real struggles and fears experienced by many recovering individuals. This seems illogical, even crazy, if you have any knowledge of addiction and know the facts. Realistically, I would venture to say that every single person on the planet knows someone who is struggling with substance abuse issues or is or has struggled with alcohol and/or drug addiction issues themselves. It’s that pervasive! Unfortunately, people are NOT educated about addiction and, hence, the shame and stigma persists.

So what about the person who has achieved stable recovery and is working an active recovery program? When is it appropriate and beneficial to break personal anonymity? Obviously, it’s a very subjective and individual decision and I’m not here suggesting to make that choice for anyone. I would, however, like to point out the potential benefits of choosing to live recovery out loud. One of the greatest influences of choosing to live recovery out loud is in reducing the negative impact of stigma. Shame is at the emotional core of stigma. It is noted by researchers and clinicians alike as the main barrier to reintegration from treatment, and therefore represents a significant barrier to successful recovery. The more people in recovery who are willing and choose to live their recovery out loud, non-anonymously, are contributing to an environment of lasting recovery for themselves and for those who still struggle.

Now, let’s look at a few important facts:

**Fact #1** – In 1941 interest in the AA Program virtually exploded after an article was published about AA in the Saturday Evening Post.

**Fact #2** – Bill Wilson and Dr. Bob were active promoters of AA through the publication Alcoholics Anonymous (aka The Big Book) which is available for purchase by anyone at local book stores and Amazon.com.

**Fact #3** – It is through the sharing of personal recovery stories that others identify and gain the first glimmer of hope for recovery, whether they are participating in a 12-Step program or not.

**Fact #4** – Bill Wilson and Dr. Bob lived their recovery from addiction out loud!

Continued on page 44
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Defender of Rights, Jeffrey Lynne, Joins newly renamed Beighley, Myrick, Udell & Lynne

-Written by L. Akter

Jeffrey Lynne has said that “only through change can we progress as a society and reach our potential. If you care about something bigger than yourself you can fix it.” Lynne’s work in the Substance Use Disorder Treatment industry has furthered this belief. Having spoken nationally on the topic of Substance Abuse, Jeffrey Lynne has created a name for himself, in this industry, that lands him far beyond the majority of attorneys you will meet. However, his passion for the fair treatment of others did not start in the recovery industry.

From a young age, Lynne knew that he wanted to be a lawyer because he saw how those around him would advocate for what was right; his father, uncle and grandfather all lawyers before him. However, when approached by his family about law school they encouraged him to seek another path, knowing how difficult being on the right side could be, when sometimes the right side didn’t always win. Not surprisingly, Lynne did not let others dissuade him and proceeded to graduate with honors from the University of Miami School of Law.

Upon graduating law school, Lynne became a criminal prosecutor in Miami, then the Assistant City Attorney for Boca Raton, always attempting to fight for what was right for the community by serving the public. Upon realizing that he could better advocate for those who needed support by joining private practice, he turned to the private sector and began to do just that.

Prior to joining Beighley, Myrick, Udell & Lynne, P.A. he had been partner at 2 other exceptional firms. However, in a constant pursuit for change and intellectual growth he has chosen to join Beighley, Myrick, Udell & Lynne, P.A., which has allowed him to not only broaden his practice but also remain true to his ethical belief that centers on building integrated communities.

“There is a reason why I love thy neighbor’ is one of the Ten Commandments. My professional legacy is to ensure that we solve the current problems facing the treatment industry. It’s not about me, it’s about contributing to this community.”

To learn more about Jeffrey Lynne or Beighley, Myrick, Udell & Lynne, P.A. contact him at Tel 561.549.9036 or via email jlynne@bmulaw.com
Recovery from an addiction is truly the most meaningful and beautiful state of life. As someone in long term recovery from an addiction to drugs, I wish I never knew drugs. I wish I never picked up drugs in the first place, but since I did, since I made that mistake, since I nearly destroyed my life, I am forever grateful to be in Recovery.

There is more discussion about Recovery right now than in any time in American history. We are without a doubt in the midst of the greatest public health crisis this country has ever known. We are truly at critical mass, and it is getting even worse, but there are millions of people that are actually rising above their addiction. With drug overdoses and overdose deaths becoming an all too familiar part of our lives, there are some people in recovery deciding to no longer remain anonymous and are speaking out about it. The discussion of Recovery is more commonplace. That’s a good thing. It needs to be talked about even more. We all need to discuss how it can be embraced by everyone as we smash the stigma of addiction. In this higher-than-ever level of Recovery-speak, I see such varied views on this important subject.

In studying and working in this field, and in talking to thousands of people over the past 3 years while filming three documentaries on this issue, I often hear very different views on Recovery. Some people are open-minded about differing views; some are strictly described as the panacea phenomenon for staying clean. Some believe in a life of meetings. Some believe meetings aren’t necessary. Some people in the rooms are against medication assisted treatment and refuse to grant clean-time to those being treated. Others feel that smoking marijuana or taking benzodiazepines can be the remedy for opiate addiction and yet still believe they are in Recovery. It’s a very divisive issue just like addiction itself. For the life of me, I can’t understand why this country is so divided, working in silos to solve our shared drug and alcohol problem. Unfortunately, I find that Recovery is the same way and we should change this. We need to come together for the good of all those still suffering, and embrace recovery no matter which path we each took to get there.

I love to talk and listen to people of differing views, even opposite views. I crave associations with people that are different than me much more so than like-minded people because I can learn more from people with differing views. Ironically, one thing that I have learned is that almost 100% of everyone in Recovery agrees with the Spiritual nature of it. I focus a great deal of time and attention on Recovery and the Recovery movement, not only because I am grateful for it, but because of the importance I feel it presents to all those suffering from addiction. I too understand the spiritual nature of recovery. I believe that those of us in Recovery have a duty, no less an obligation, to talk openly about it so that those that need it can understand how beautiful it is. That is what most reflects our spirit.

The two pillars of that spiritual nature are growth and contribution. Recovery’s permanence is not guaranteed once we arrive at its doorstep. We must grow in our recovery in order to keep it. Growth in life is inevitable if we want to move forward to be successful. Growth in recovery is just as important and doesn’t just stop at any ‘clean-time plateaus’. I believe that Growth is a need of our spirit and without it, Recovery can’t be sustained.

The second pillar of Recovery’s spiritual nature is contribution. Contribution to others is the other need of our spirit. Contribution beyond ourselves — giving back as it is so often referred — is a pillar of recovery. I believe it is actually the cornerstone. It’s often said you can only keep what you have by giving it away. I believe this wholeheartedly. Ironically, it became less and less important in our addiction but it becomes more and more important in our recovery. In fact, it’s more important than anything else. One of my mentors, Zig Ziglar often told us, “You get everything in life you want if you help enough other people to get what they want.” This is so apropos in recovery. Spiritually, our recovery grows when we give it away — and to me — contributing to others is how we can give it away. Service — Service to others, service to community, service to recovery as a whole.

Recovery is a gift, a gift beyond measure, and in some ways I feel Recovery is something I don’t deserve but have to earn. To whom much is given, much is required and service to others is the way I earn my Recovery. Service to others will fuel our growth and Recovery becomes that gift which we earn. Even Scripture stated, “Give unto others and it shall be given unto you.” It’s all an investment and the return on our investment is Long Term Recovery in a life we were destined to live. Watching people give back to their families, to their circles, to their communities inspires me to do more. Service to others enhances my growth, and it becomes not only the pillar of my recovery but the cornerstone of my life.

Michael Deleon, director and producer, of the films “Kids Are Dying” and “An American Epidemic” is expected to release third documentary “Higher Power”. Michael Deleon is the founder of Steered Straight Inc., a motivational outreach program for youth and young adults reaching over two million students nationwide and expanding across 45 states. Stay In Your Lane Media, a division of Steered Straight Inc. is expecting to release the film in early 2016.
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**WHAT AM I MISSING? APPLYING ATTACHMENT THEORY TO TREATMENT AND RECOVERY “A DIFFERENT WAY TO TREAT PEOPLE” (PART 2)**

By David M. Koler, J.D. LCSW

Addiction is an attachment disorder. Human beings, addicts or not, only know and repeat what was modeled for them during childhood. I like to call ages 0-10 healthy narcissism given that the world, as it should, revolves around the child. If the child is not fed, he/she will be hungry; if the child is not given shelter, he/she goes without shelter; and if the child’s diaper is not changed, he/she will be wet. Moreover, if, for example, the child’s parents divorce, who is at fault in the child’s mind? Obviously, given that the world revolves around the child, the child believes he or she is to blame. ‘If I just would have cleaned my plate’, ‘If I would have been a better boy…’ ‘If I just would have kept my room clean.’ These types of messages form the messages or models for future behavior of the child.

Part I of this article (April issue) provided a definition and basic framework for Attachment Theory. Attachment theory provides that most individuals did not grow up with a model for secure attachment; thus, treatment for addiction requires providing a model of secure attachment so that individuals are able to practice healthy behavior in response to pain and discomfort other than acting out in addictive behavior.

Theoretically, Mary Ainsworth PhD (1969) defined secure attachment as developing when a caretaker shows awareness of a child’s emotions and quickly attends to the child when distressed. The child’s perception is that the caretaker is consistent in presence and provision; thus, the child feels safe in exploring their world because of their sense of certainty that their caretakers will be there for them in a nurturing manner if needed. Overall, attachment theory assumes that the experiences of childhood relationships shape adult attachment style; thus, for example, the reason why adults who were physically abused as children have a high propensity for abusing their children. This is the behavior that was modeled and typically the only mode that the adult has for responding to anger.

**The Scientific Link Between Attachment and Addiction:**

Attachment theory posits that an infant learns necessary skills for survival and the development of an Internal Working Model (IWM) whereby the definition of how the person views the world, themselves, and others is defined. “Attachment representations show predictive associations with a wide range of pathological behavior including personality disorder(s), mood disturbance, [substance dependence] and psychopathology” (Caspers, Yucuis, Troutman, & Spinks, 2006). Therefore, the authors conclude that childhood attachment styles (secure or insecure) have a direct impact on the prevalence of Substance Abuse Disorders.

Researchers Kendler and Prescott (2006) reviewed the findings of the Virginia Twin Study of Adolescent Behavioral Development (VTS) for the purpose of exploring the depth of influence between genetics and environment as it relates to addiction and mental health disorders. VTS had a sample size of 2,762 white twins between the age of 8-16 years old and their families. Kendler and Prescott concluded that there are no genes specifically responsible for Substance Use Disorder, but rather, there are genes that an individual can inherit that predisposes them to patterns of behavior closely associated with Substance Use Disorder. Additionally, the authors concluded that if children are brought up in “protective environments”, even though genetically they are predisposed to patterns associated with Substance Abuse Disorder, the environment has a likely potential of being a protective factor against Substance Abuse Disorder.

**The Brain:**

Finally, researchers have directly correlated neurobiology of the human brain and the importance of caregiver attachment relationship during childhood to mental health in adulthood (Miehls, 2011, p. 82). Additionally, the research has indicated that insecure attachments during childhood affects negatively, the development of certain areas of the brain. Moreover, Miehls states “relationships have the capacity to rebuild certain parts of the brain that influence our social and emotional lives.”

The benefit of the connection between neurobiology and attachment is that brain neuroplasticity (the ability of the brain to be re-formed) allows for a corrective experience or secure attachment model during adulthood leading to positive changes in the patient; thus, lessening the need to utilize addictive behavior to deal with abandonment, trauma, abuse and emotional pain etc. Moreover, the implication for treating substance dependence indicates the importance of a secure attachment relationship between the clinician and the patient so as to provide a baseline model or definition.

**Addiction as an Attachment Disorder**

The attachment system of a person is developed as a child in proportion to the relationship between the child and the caregiver; thus, if the attachment process is deficient, the child will have issues related to emotional regulation. Therefore, as an adult, the person is likely to utilize drugs and other substances to regulate emotions as a means of adapting to an inability to regulate emotions learned as a child.

Drugs create an ability for a person to have the illusion of self-esteem, self-confidence, worthiness and “increase feelings of being alive”. An addict attempts to define comfort and security (missing in their vocabulary) through the use of addictive substances or behavior; however, outside sources other than secure modeling will lead to a continued dysfunctional definitions and continued addiciveness.

**Treating Addictiveness and Substance Dependence through Attachment Theory:**

Recent studies have positively confirmed that a direct link exists between insecure attachment and substance dependence.

“Attachment Oriented Therapy” (AOT) has been described as “a way of eliciting, integrating and modifying styles represented within a person’s internal working model” Flores (2004) p. 214). Flores (2001, 2004) goes on to explain that the IWM must be changed or addiction will continue or substitution of one addiction for another will persist. The key point is that when an individual begins to learn (which requires a model) how to self-soothe, thus, learning how to regulate emotions and feelings, they will avoid seeking outside sources as a means of managing these emotions.

The vast majority of individuals in treatment today have been exposed, multiple times, to the treatment experience; Therefore, Continued on page 44
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EXPLORING PEER PRESSURE

“What pressure pushing down on me, Pressing down on you, No man ask for, Under pressure. That burns a building down, Splits a family in two, Puts people on streets.”

~ Queen & David Bowie

We have all experienced a social situation whereby peer pressure has been applied. We may comply with the peer pressure or deny it. In some cases, we may be forced to comply because of familial, societal, or environmental influences. In other cases, we may choose to comply because of a desire to feel acceptance and approval. Either way, peer pressure is a necessary evil in our society, but it’s the recognition of when and when not to comply with peer pressure that sometimes is very difficult for the individual to gauge.

What exactly is peer pressure? Peer pressure is the direct or indirect influence of another, being applied in such a way to create positive or negative influence on one’s own behavioral, perceptual, moral, or ethical guidelines. Peer pressure may also be applied to be a distraction, confrontation, or way with which to compromise the integrity of the individual.

If you have lived any amount of time on this planet, you have most likely experienced some form of peer pressure. In relationship to alcohol and other substances, the peer pressure is often disguised as harmless and possibly beneficial for you, but the reality is, if you are being forced to partake of any substance or alcoholic beverage, then you are in the wrong circle of friends.

“As soon as we begin developing friendships, we start to view our peers as a source of information as well as for approval. Our peers contribute to our sense of belonging and our feelings of self-worth. They also expand our sense of freedom while influencing and reinforcing our views of what constitutes acceptable behavior. At the same time, peer groups create strong expectations for appearance and behavior that can taint the positive rewards associated with peer interaction.”

For some, they have learned to harness the peer pressure, making it an instrument of fuel rather than a source of decay. We live in a society that promotes negative and positive peer pressure, while discouraging individuality. It is individuality that distinguishes us from others. As an individual, we choose to conform to negative or positive peer pressure in order to feel accepted, liked, and loved. Conformity may also include the compliance of another’s ideological views, perceptions, convictions, identities, feelings, and general way of thinking. Ultimately, the individual may “…find themselves conforming to the group’s norms, behaviors, attitudes, speech patterns, and dress code to earn acceptance and approval.”

WHAT CAUSES SOMEONE TO COMPLY WITH PEER PRESSURE?

For those who perceptively give into, or comply with peer pressure, the nature of the compliance may vary. “(For instance), the adolescent brain is often likened to a car with a fully functioning gas pedal (the reward system) but weak brakes (the prefrontal cortex). Teenagers are highly motivated to pursue pleasurable rewards and avoid pain, but their judgment and decision-making skills are still limited.” Whereas for an adult, the need for peer acceptance, the pursuit of pleasures, and the avoidance of pain should have lessened within time. While the ability to make rational decisions and having good judgement should have increased with maturation. It is not to say that the psychological makeup of every adult is impenetrable to peer pressure, or the desires of pleasure seeking, or the avoidance of pain, rather with the process of maturity an adult’s comprehension and ability to make good judgment should have increased.

Moreover, for teenagers and young adults, the ability to make levelheaded decisions is lessened with a number of factors including biopsychosocial, maturation, hormonal, and environmental. Nevertheless, we have all known physically mature adults who make irrational and poor decisions. While we may have also known young teens who make concrete and healthy decisions. Yet, “the teenage years are a critical window of vulnerability to substance use disorders (and peer pressure), because the brain is still developing and malleable (a property known as neurolplasticity), and some brain areas are less mature than others. This affects their ability to weigh risks accurately and make sound decisions, including decisions about using drugs.”

STRATEGIES FOR RESISTING PEER PRESSURE

“I’m not in this world to live up to your expectations and you’re not in this world to live up to mine.”

~ Bruce Lee

Peer pressure is a norm within life. The longer we live within society, the greater likelihood we will encounter peer pressure. Peer pressure can be beneficial or it may prove limiting. The following are a few skills for resisting peer pressure:

- Develop relationships that reinforce your personal self-worth and self-esteem.
- Avoid relationships that are pressuring you to engage in illegal or inappropriate acts.
- Recognize that it is never wrong to say “no” or deny someone’s offer of an illegal or legal substance.
- In some cases, it may be prudent to inform others how you may feel.
- Kindly remove yourself from environments that make you feel uncomfortable or unsafe.
- Avoid relationships that are not personally uplifting and positive.
- Develop relationships that reinforce your personal self-worth and self-esteem.
- “Despite popular belief, willpower alone is often insufficient to overcome an addiction. Drug use has compromised the very parts of the brain that make it possible to ‘say no.”

FOR CHILDREN AND TEENS

Parents have a vital role in curtailing unhealthy forms of peer pressure. Peer pressure can be beneficial for encouraging children to be adventurous, ambitious, and setting healthy goals. However, when a child is in an environment that is reinforcing negative acts, attitudes, or behavior; the parent has an obligation to teach their child strategies for coping with such peer pressure. The following are a few key strategies for managing peer pressure:

- Always encourage open and healthy forms of communication. “Let kids know they can come to you if they’re feeling pressure to do things that seem wrong or risky.”
- Never belittle a child for making mistakes or making poor choices.
- “Help your child develop self-confidence.” Self-confidence is developed through an unconditional acceptance, love, and approval of thyself. “Kids who feel good about themselves are less vulnerable to peer pressure.”
- As a parent, help develop your child’s self-esteem and confidence by creating an environment of acceptance and love.
- Frequently remind your child that they are loved, acceptable and worthy.
- Create a safe and inviting environment to discuss feelings and emotions.

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WE ACCEPT THESE MAJOR INSURANCE CARRIERS
In the 1969 best-selling book titled “Between Parent and Teenager”, Dr. Hiam Ginott coined the term helicopter parent when he was describing a teen complaining that his “mother hovers over me like a helicopter.” Since that fateful day, scholars and the popular press have made the noun a common term used in our lexicon. The hit TV show Portlandia has even immortalized helicopter parents with a clip that has garnered over 200,000 hits on YouTube.

It’s important to note that nobody sets out to be overly involved in their child’s life or to create a young adult that is incapable of launching him or herself into the world. Culture, norms, and mores play a large role. Parents, rather, start out wanting a better life for their offspring. In their zeal to be helpful and protective, they over-insert themselves into their children’s lives, scheduling play dates and activities, doing homework, making their beds, cleaning their rooms, choosing which courses they take, and bailing them out with money. “Over-parenting took off in the 90s’ and manifested itself as a combination of excessive anxiety, unrealistic achievement goals, and old fashioned spoiling” says Cristen Conger, author of The Five Signs of Overparenting. As the helicopter parenting builds, the parent gets further involved in their child’s life and it can turn into a condition of being hyper protective. In this instance, when the child falls down, the parent is so overly involved that they shield the child from experiencing pain. The same goes for emotional pain when everyone wins a medal.

The five red flags of modern over-parenting will help you better understand the impact of this style of parenting.

1. With the advent of modern technology, children as young as nine now have cellphones and parents can track almost every movement. In my professional experience, I have helped families with young adults who are experiencing a substance abuse disorder. I’ve found parents thereof feel a false sense of security when they pay for their young adult child to have a cellphone because the parent believes they are keeping an electronic leash on their child. In reality, often times the phones are used to further their substance abuse disorder as they may speed dial their drug dealer.

2. Somewhere along the line folks have forgotten the value of free time and creative play. For example, a University of Maryland study found a 25% drop in kids free playtime from 1981-1987 and an increase in homework. Think about the children and parents you know in your daily life. More often than not they are being toled around to after school and enrichment activities, sports, or glued to a digital device. What happened to looking at the sky, doodling, cardboard boxes, or simply using the imagination?

3. Let’s face it – not everyone deserves a trophy. In our over-parenting world, our desire to boost our child’s self-esteem has made ribbons and trophies big business. The psychology goes like this: if I am always terrific – worthy of a medal – then when I mess up, it’s hard to know who I am. A landmark study in 2007 from Columbia University found that “kids [who are] continually told they are smart tend to avoid activities where they don’t excel”, missing out on experimentation and opportunities to try new things. This is the key to sports – children learn that missing the ball or losing the game is fundamental to life and the important thing is to learn from the mistake and bravely move forward.

4. Have you witnessed parents turn and go on rants against teachers, coaches, and other children? When parents find themselves fighting with principals, nannies and friends, they may have crossed the line into armed warfare and taught their child the lesson that their parent will always save them. Another issue is that a parent yelling at another adult undermines their authority. Experts, however, say that parents should allow their kids to resolve peer conflicts and not immediately intervene to diffuse situations. This way adolescent children can learn how to problem solve on their own. While it’s understandable that parents do not relish in seeing their children in disagreements or disappointments, it is also not their job to serve as defense attorneys for their kids’ behalf.

5. Today, approximately 3.4 million young adult children are dubbed ‘boomerang children’ – they went out into the world and then boomeranged back home after college. While this may be partially attributed to the economic collapse in 2008 and several years of fallout after, we also know that many young adults do not know how to venture out on their own. Leaving home is considered a rite of passage in the United States, and I remember as a mother of a young college graduate I did everything to communicate to my daughter she needed to leave and be self-supporting. I even used Feng Shui in a manner that suggested it was time to leave the nest.

Parents of all ages can relate to the experiences I described above. The truth of the matter is it is no easy task rearing a child and seeing him or her off into adulthood. The key is to strike a balance, set healthy boundaries and to communicate unconditional love to a child. A few suggestions to avoid helicopter parent pitfalls include:

1. Turn away from hovering over your child by letting them do activities on their own. For example, give them age appropriate household chores. Children as early as age four can pick their own clothes, make a sandwich, sort socks, fold towels, help set the table, put clothes in the laundry basket, put toys away etc...

2. Allow your child to feel their feelings. It’s not about putting worry on your child’s back, rather, it’s giving them the opportunity to feel and react to their emotions. To help them further understand their feelings, buy a Feeling Chart and explore with your child the various emotions – happy, sad, angry, baffled, confused, etc.

3. Allow yourself and your child to live their life. If you orbit around your soccer star son and he does not make the team, you may unconsciously make him feel even worse as he may feel like a disappointment to you. Live your life and let him or her experience many different things.

4. It is a good thing to congratulate your child when they do well, and to reprimand them when they do bad, but avoid specific labels for your child because it can set up a self-fulfilling prophecy that you do not want. For example, if your child did something good in school, he or she deserves compliments. However, if he or she messes up, that does not mean she is terminally "bad".

Continued on page 46
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When a family member gets addicted to alcohol or drugs every member of the family gets hurt. Families struggle to function normally while trying to hide the shame, pain and problems caused by the family’s addiction. Yes, addiction is a family disease and if your family has it you are in for the duration.

The family needs to come together and find the best experts available to beat the addiction. If the family gives it less than their full effort, the disease will damage every family member and perhaps destroy the very core of love history that has held the family together. The bottom line is this: the family either recognizes and treats the addiction or the family goes into denial and the addiction destroys the family.

Many families join together in a united front to hide the addiction. They mistakenly believe that if they could just act normal --- if they could just hide the “family problem” and appear “normal” like other families everything will be fine.

Trying to hide the addiction is not a good problem-solving strategy. It is like lighting the fuse on a stick of dynamite and putting it out of sight in your pocket as you sit down for family dinner. The strategy works great, right up to the point where the dynamite explodes.

The dynamite won’t go away just because you don’t want it to be there. Neither will the addiction of a family member. The addiction may seem to come and go. On some days the problems aren’t very bad and then all of a sudden it’s intolerable. Why is this?

This is because addiction is chronic (long-term), progressive (it keeps causing more severe problems), and eventually fatal. All true stories of addiction end in one of two ways: recovery or death. And recovery isn’t easy. There are things you need to do every day to stay away from alcohol and drugs.

Without a family program addiction will eventually turn the family from a safe and loving place that promotes healthy sobriety slowly into a torture chamber. The addiction must be addressed to try to avoid this.

Healthy functional families have many of the systems built into normal family structure that keeps the family together through difficult times and helps them to heal and rebuild after serious pain, problems, and loss.

As these systems are destroyed by the addiction, all the family members begin to suffer and with the suffering come horrible changes.

Not all family members are damaged in the same way. Some family members will be better at hiding the pain than others, but make no mistake- all family members will be impacted by the addiction. They will become experts at both hiding their addiction while using, and the growing pain will disrupt the family. Many families buckle under the strain and break apart, damaging all family members in the process.

As a result, it is easy to look at a family that is affected by addiction, notice the serious problems the family is having, and not even notice that alcohol/drug addiction is causing the problem. This is because we have trained ourselves not to notice.

There are several reasons why this happens.

1. Addicted people are often in denial. They don’t believe their drinking/drugging is causing the problems. They are also experts at shifting the blame to other members of the family.

2. Many of the problems in the addictive family do not appear to be directly caused by alcohol/drugs. The car gets dented! Money goes missing. People get into arguments and fights. You lose your wallet --- again. The family is being destroyed by serious problems. It is obvious that something is going wrong, but the causal link to the alcohol/drug addiction is not obvious. This is especially true where the family culture allows social drinking, the sharing of prescription drugs, or the use of marijuana and other illegal drugs.

3. It seems that in addicted families there is a never ending flow of problems and problem solving. Most families trapped by addiction blame the problem on everything except the true cause of the problem --- the addiction. This dysfunctional approach to communication and problem solving keeps the core problem hidden while keeping family members buried in an endless barrage of problems.

4. As more family members start to see that the addiction is at the core of almost every family problem, they can then start learning about addiction as a family disease and get the information they need so they can all begin to start healing.

Without professional help, active addiction can destroy families and cause harmful effects that can last a lifetime.

Terence T. Gorski is the Founder and President of The CENAPS Corporation. He is an internationally recognized expert on substance abuse, mental health, violence, and crime. He is best known for his contributions to relapse prevention, managing chemically dependent offenders and developing community-based teams for managing the problems of alcohol, drugs, violence, and crime. He is a prolific author and has published numerous books and articles. Terence is the Director of The National Certification School for Relapse Prevention Specialists.

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WHY EXTENDING THE CONTINUUM OF CARE IS A MATTER OF LIFE OR DEATH
FOR THE ADDICTION TREATMENT CLIENT AND PROVIDER

By Jacob Levenson

In the 1970’s, the United States Air Force established its addiction treatment program. Because individuals did not have to be reassigned if they were away from duty for 30 days or less, it was decided that their standard of addiction treatment would be 28 to 30 days of in-patient care which meant the reassignment process could be avoided. The decision was based on bureaucratic reasons. Across the nation, other treatment facilities followed suit and insurers adopted the standard of reimbursing 28 to 30 days of in-patient care. This treatment template was never based on medical evidence, no data indicated 30 days of treatment would be effective.

Today, addiction experts understand that there is no ‘magic number’ and successful treatment approaches are not ‘one-size-fits-all’. In fact, over the years, research has indicated that 30 days of addiction treatment is not enough. There have been a number of published studies which report that longer durations of treatment effectively reduces the chances of relapse. In 1999, The National Institute on Drug Abuse reported in one study that of 1,605 cocaine users, 35% of people who received treatment for less than 90 days reported drug use the following year compared with 17% of people who received treatment for 90 days or more. Studies of youth also reflect the connection between longer care and a greater chance of recovery. In 2001, a UCLA study of 1,167 adolescents receiving substance-abuse treatment found that those in treatment for 90 days or more had significantly lower relapse rates than teens in programs of 21 days. Some of the earliest evidence emerged from high success rates in the treatment of health professionals. The Federation of State Physician Health Programs has long recommended 90-day treatments and continued follow-up care for physicians who abuse drugs.

Longer treatment durations reflect the fact that addiction is a chronic disease of the brain and relapse is common. It is generally agreed, but not widely reported, that addiction treatment facility alumni retention rates range from 5% to 8% at six or more months, meaning treatment facilities lose contact with more than 95% of their discharged patients. While retention rates are not the same as success rates or disease remission rates, they can be used as indicators as to whether or not facilities maintain relationships with, and extend the continuum of care for discharged patients. We have learned that addiction, like other chronic diseases, requires extended care in order to be effective over the long term.

At MAP Health Management, our clients have been collecting, tracking and demonstrating addiction treatment outcomes data on discharged patients for over five years. We have several million entries into our data repository. With over five years of data, we have begun to recognize specific patterns and trends with individuals who completed treatment for addiction and participated in a program based on extending the continuum of care for 12 months or longer.

Maintaining a connection with a recently discharged patient is a key component to successfully extending the continuum of care. Our data shows that, one month following in-patient treatment, 90% of these individuals remained in contact with a recovery support professional, 68% remained in contact at 90 days, and 53% remained in contact at six months following in-patient treatment.

The results are promising as these addiction treatment providers seek to extend the continuum of care for their discharged patients in order to, (1) provide extended care and support during the tenuous first year of recovery and, (2) collect outcomes data which effectively demonstrates the efficacy of their treatment. Although participant attrition was evident, 35% of individuals remained in contact at the one-year mark, which meant they had a minimum of one telephone conversation or telehealth session each week. This type of extended care with this number of connections for individuals early in recovery is unique and we believe it to be a strong indicator that extending the continuum of care to discharged patients is possible and key to the maintenance of disease remission and long-term recovery.

Furthermore, our data shows that 33% of the total number of individuals who participated in the extended care program and reported to have experienced a use event, completed 12 continuous months of contact. The data regarding individuals remaining in contact after a use event is compelling. Individuals who experience use events often find it difficult to remain in contact with a healthcare professional. This is due to a variety of factors including feelings of shame, guilt, and the isolation that often accompanies them. These results indicate that it is possible to continue the process of recovery after a use event and extending the continuum of care works to improve long-term recovery for those who might have otherwise been lost to follow-up and ultimately to relapse.

Each year, more Americans die from overdose than the year before and the public is demanding a change in addiction treatment. Most providers understand that addiction is not likely to be effectively treated in 30 days and have adapted their programs and services accordingly. As the field continues to evolve with science supported discoveries about the nature of addiction and recovery, quality providers will need to once again adapt.

Extending the continuum of care for patients with substance use disorders is now recognized as best practice as it is with other chronic diseases. The U.S. healthcare system is the costliest in the world, accounting for 17% of the gross domestic product. Efforts to improve the system have been summarized recently as ‘The Triple Aim’, which refers to the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The addiction treatment field must respond to the demands inherent in The Triple Aim if it is to remain a relevant part of our health care system.

Furthermore, as the addiction treatment field transitions to pay-for-value reimbursements, providers who routinely extend the continuum of care for discharged patients will have the distinct advantage of being able to demonstrate outcomes data and provide treatment success rates to potential patients and health insurance payers. We know the current model of treatment needs improvement and data has begun to point to the critical importance of extending the continuum of care to every individual treated for addiction. Ultimately, by extending the continuum of care providers will see an increase in the effectiveness of treatment and the need for re-treatment will decrease along with those associated costs.

Jacob Levenson founded Austin-based MAP Health Management, LLC in 2011, and serves as Chief Executive Officer. MAP has established itself as the nation’s leader in the provision of a comprehensive, accessible technology platform specifically developed to improve treatment outcomes for individuals treated for addictions and other behavioral health illnesses. Levenson’s teams of research analysts, clinical directors, recovery advocates, technology professionals and billing experts are dedicated to improving outcomes, empowering treatment providers with data, reducing costs and driving facility revenue. Levenson is a frequent contributor to leading addiction and population management publications.
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Joseph Campbell identified a pattern in all great myths and stories. He called it the *Hero’s Journey*. In these stories, the protagonist receives a call to adventure into the unknown. Commonly, the hero is reluctant to heed the call. At times, they are thrust into their adventure by calamity or crisis. They are no longer able to stay in the known, but have to move into the unknown in order to survive: in either scenario, accepting the call is something “they cannot not do.” The unknown is frightening and staring into a dark threshold feels like certain annihilation.

In my work with adolescents and young adults struggling with addiction, the above pattern resonates. They must leave some things behind and they will acquire some new traits and attributes. They walk into meetings. They walk into a therapist’s office. Parents walk into rooms that they hoped they would never have to enter: Al Anon, family therapy, emergency rooms. As with the forests in Campbell’s paradigm, these rooms are metaphors for the unexamined self. The dark recesses of our minds terrify us. Clients often express a fear that if they start to feel their pain and their shame that they will never be able to turn it off.

As therapists, we invite our clients to look inward, to feel the unfelt, and to stare their shame in the eyes. Confronting them or tearing down the walls that have up to this point been a critical means for survival may injure the clients: attraction, not promotion. We learn to hold them with gentleness, kindness and non-judgment because we know that we too need that same patience. We know this because we have gone into the dark corners of our own psyches and recognize that our demons share so much with the ones we see in others. When they find themselves in the company of such a container (i.e., a counselor or an old-timer they meet at an A.A. meeting) they eventually take the risk to show up honestly and authentically. When their story is met with loving and accepting eyes rather than disgust, fear or pity, they begin to consider something new about themselves. They begin to consider that they are lovable. This healing has dramatic effects and the need for self-medication to mask their shame retreats just a little.

I have been working in and running a wilderness therapy program for over 20 years. I have been a witness to clients and their families as they *literally walk into the woods*. But more impressively, I’ve seen clients and families courageously explore their own stories. They come into contact with the pain and their shame and learn to let it go in the company of others. They sit in rooms or in the high desert of Utah and tell their stories and listen to others’ stories considering the possibility that the truth they had previously accepted might not be “The Truth.” The only way we can observe our context is by being in a new one. Sometimes fish are the last to discover water because they have never known the “not water.” Sitting in a room or a circle with an empathic Other allows us to challenge our assumptions.

Our version of wilderness therapy is a nomadic primitive living model, with 3-4 field guides and group sizes of 6-10. The beauty of wilderness therapy is that doing and experiencing is more important than saying. Simply, we provide the basic necessities in the beauty of nature and teach people how to feel. Without the medicators and the distractions of the virtual world we live in, feeling is inevitable. All the unwanted feelings surround you as you lay at night in your sleeping bag 20 miles from any city with only yourself as company.

Several years ago, I remember greeting a new client as he exited the truck and entered his wilderness. I asked him about himself, his story and his recent treatment experiences. His narrative was laced with 12-step slogans and therapeutic jargon. Yet, as the next few weeks were to show, both to him and me, none of it was “in him.” Surrender, humility, and serenity eluded him. He was at war with the elements, himself, his peers, me and his parents as he tried to prove that this time he would take his recovery seriously. I observed many times, “I hear your recovery, but I don’t see it.”

Experiential therapies have some advantage over talk therapy in that they value doing over saying. Accessing our wounds through talk therapy may not be as effective because we don’t know what we don’t know. Experiential therapies (Equine therapy, play therapy, psychodrama or wilderness therapy) provide the therapist with information that even the client is not aware of. Experiential therapy bypasses conscious resistance since it does not walk through the front door and announce itself. Even in traditional talk therapy settings, it is the experience of therapy that makes the change, not merely the information that is exchanged.

It is important to remember the walls and defenses are earned. They should be honored rather than attacked. When we try to break down defenses, the person behind them is compelled to reinforce them rather than surrender. When we merely call people on their crap, I call it “doing psychology on people” rather than doing “therapy.” Sometimes treatment professionals evoke resistance and when the client fails to make progress and wash their hands with sanctimonious impurity and note, “Addiction is an insidious disease. Some addicts aren’t ready for change.” The insidiousness of addiction should not exclude self-examination of the treatment approach or the treatment professional.

In the end, no matter one’s approach, some will die, some will run, some will refuse the call to adventure that Campbell talks about. And if we as treatment professionals are willing, we will continue to explore the unexamined parts of ourselves. My therapist told me some time ago, many people die long before they are dead. They have learned everything there is to know and are not open to new thoughts or ideas. Recently, at a parenting intensive, a parent whose child was in treatment for addiction, shared that when she started this journey a most frightening thing happened. She discovered that something she had long assumed to be a foundational truth for her wasn’t true anymore and with this thought, she had the realization that all of her assumptions were up for grabs. The experience was both terrifying and liberating.

It is my honor to sit and listen to the stories of addicts and their families. It requires me to stay on my own journey—walk into rooms, into the woods, both literally and metaphorically, that frighten me. I learn as much or more in providing treatment to others as they learn from me. So we wander in the wilderness together and we learn that no matter the story, the heroic journey is always inward.

*Brad Reedy, Ph.D. is the Owner and Clinical Director of Evoke Therapy Programs. He is also the author of The Journey of the Heroic Parent: Your Child’s Struggle and the Road Home*
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MENTAL HEALTH IN THE WORKPLACE

By Tom Murphy

We are reminded almost daily of the consequences of a mentally ill person being allowed to work in a profession in which they place others at risk, in addition to themselves. Some examples are police, military, aviation, and even school-bus drivers. This sometimes-fatal combination reminds us of the ongoing argument about the employee’s privacy vs. the employer’s right to know. How can companies assist those who need help without intruding on their employees’ private lives?

According to the World Health Organization, in 2014, approximately 27% of adults in Europe (83 million people) suffered from disorders such as depression, substance abuse, and anxiety. The percentages are similar in the United States. Unfortunately, both employers and employees have incentives to prevent discussions about mental illness from entering the workplace. Employees do not want the stigma attached to mental illness or the possibility of losing their job. Employers fear the potential liability claims and lawsuits that are prevalent in our society today.

In the United States, we have established laws such as the Americans with Disabilities Act (ADA) that prevents employers from asking job applicants about their health, which includes both physical and mental health. Applicants’ and employees’ health can be evaluated further, but only once a job offer has been extended or once they become an employee. Certain forms of employment are held to a higher standard, including the ones mentioned earlier. These industries can use certain regulations and professional licensing standards to require additional health information prior to the employment or offer.

More employers need to recognize the risks associated with untreated mental illnesses and many in the mental-health arena, as well as business associations, are trying to lessen the communication barriers and stigmas associated with these illnesses. We are starting to see these changes in industries such as construction, utilities, and aviation due to the costs associated with a catastrophic event. Employers are beginning to realize that reaching out to employees they suspect are in crisis is worth the risk of a future employer liability lawsuit if it can prevent tragedy.

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As a Level 4 facility Sunset House is appropriate for persons who have completed other levels of residential treatment, particularly levels 2 and 3. This includes clients who have demonstrated problems in applying recovery skills, a lack of personal responsibility, or a lack of connection to the world of work, education, or family life. Although clinical services are provided, the main emphasis is on services that are low-intensity and typically emphasize a supportive environment. This would include services that would focus on recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the world of work, education, and family life.

In conjunction with DCF, Sunset House also maintains The American Society of Addiction Medicine or ASAM criteria. This professional society aims to promote the appropriate role of a facility or physician in the care of patients with a substance use disorder. ASAM was created in 1988 and is an approved and accepted model by The American Medical Association and looks to monitor placement criteria so that patients are not placed in a level of care that does not meet the needs of their specific diagnosis, in essence protecting the patients with the sole ethical aim to do no harm.
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A SURGEON’S STORY OF ADDICTION
By Steven B. Heird, MD

I was pleasantly surprised at how I felt this morning. My mind seemed clearer to me than it had been in many years. This was my fourth day in this place. While sitting comfortably on the back porch patio, I was very puzzled about how I had gotten on the path that brought me here. I was a prestigious vascular surgeon with a successful practice. I was the chief of the department of vascular surgery at a large community hospital. I had a beautiful wife, and four healthy children. I owned a large house and drove a BMW.

What did I learn in rehab? I learned that I had the disease of alcoholism and addiction which is chronic, progressive and fatal if left untreated. I learned that telling the truth, and being honest with myself and others, set me free from the bondage of my secret world of addiction. I learned that I had to change everything if I was going to have a healthy recovery. This meant changing people, places and things, but more importantly, changing myself. I am ultimately responsible for the choices I make and the consequences, good or bad, which result from those choices. I learned it was okay to take care of me first, in order to take care of those I love. I have learned that a sober life is taking life one day at a time.

So what did I learn in rehab? I learned that I had the disease of alcoholism and addiction which is chronic, progressive and fatal if left untreated. I learned that telling the truth, and being honest with myself and others, set me free from the bondage of my secret world of addiction. I learned that I had to change everything if I was going to have a healthy recovery. This meant changing people, places and things, but more importantly, changing myself. I am ultimately responsible for the choices I make and the consequences, good or bad, which result from those choices.

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Steven B. Heird, MD practices vascular surgery in York Pennsylvania. He is the bestselling author of To Hell and Back, A Surgeon’s Story of Addiction. Dr. Heird is currently focused on developing and implementing programs which support recovery and wellness for all individuals suffering from addictions.
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Methamphetamine, also known as meth or crystal, is back with a vengeance. And due to higher purity and cheaper prices, it is more dangerous and addictive than ever before. Throughout its long history, meth has been used to instill feelings of confidence and strength, from individuals seeking to bolster their self-esteem to soldiers in World War II battles.

But chronic meth use today brings personal devastation and a host of physical consequences. However, we now have a much better understanding of the drug and how to treat it. The impact of meth and a comprehensive guide to treatment are described in my book “Lust, Men, and Meth: A Gay Man’s Guide to Sex and Recovery,” which draws from thirteen years of patient sessions and personal research. I will share some key points of the book here.

In the United States there are dual meth epidemics: rural and urban. In states like West Virginia, Kentucky, Arkansas, and Montana, the drug appeals to men and women seeking to numb uncomfortable emotions related to poverty, unemployment, and feelings of hopelessness. In urban areas meth use is concentrated among gay men who have discovered the drug’s ability to heighten sexual desire. This results in high-risk sexual behavior often accompanied by high rates of HIV, hepatitis, and other sexually-transmitted infections.

Unlike cocaine, meth is a synthetic amphetamine; it is manufactured from acetone, pseudoephedrine, lithium, iodine, and other toxic chemicals. Meth therefore has particularly destructive properties; it flushes dopamine out of neurons while blocking receptors, resulting in a flood of euphoric feelings that instantly eliminate self-doubt, sadness, and unworthiness. It impacts the dopamine receptors for much longer than cocaine, resulting in a “high” that can last eight to ten hours. Because it is neurotoxic, meth literally destroys the dopamine transport system with chronic use, creating long-term brain impairment that requires up to 18 months to heal. While the brain “rewires” the dopamine transport system, a person can totally abstain from the drug but continue to experience muddled thinking, hopeless moods and, consequently, frequent relapses.

Meth can be smoked, snorted, inserted rectally, or injected or “slammed”. Usage quickly increases heart rate, blood pressure, respiration, energy, and sensory acuity. Psychologically, meth increases confidence and sex drive while decreasing boredom and timidity. When consistently used to enhance sex, meth commandeers sexual desire and ultimately results in arousal being only achieved by using the drug. Once a meth user is in recovery, this nonetheless creates persistent sexual dysfunction that is a contributing factor to relapse.

Through chronic use, meth users experience tremors, dry mouth, weight loss, sinus infections and skin problems, as well as confusion, insomnia, depression, irritability, paranoia, and even full-blown psychosis. Users quickly spiral downward into a devastating addiction. Partners, friends, and families distance themselves because of erratic behavior. Consequently, most users ultimately find their support system limited to their dealer and the men with whom they hook up for sex. Narcotics Anonymous and Crystal Meth Anonymous provide a safe harbor for those seeking help, although the physical and sexual effects of meth create a difficult recovery marked by frequent relapses. This dynamic has resulted in the erroneous belief that meth recovery is impossible. This is false. People recover from methamphetamine but it is a long process that requires support groups combined with in-depth psychological reflection that may require professional assistance.

When used for sex, methamphetamine quickly fuses with sexual desire, resulting in high-risk behavior indistinguishable from sex and porn addiction. There is a preoccupation with sexual hookups involving “PNP” (party and play – a desire to use drugs and sex), a gay male social trend facilitated by phone apps. Sex-drug episodes usually last several days and typically involve sexual contact with a number of individuals as well as the use of meth and other drugs such as GHB (gamma hydroxybutyric acid). These long drug runs are followed by days dominated by extreme depression and hopelessness (“Suicide Tuesdays” resulting from the depletion of dopamine.

Because of the long period of brain recovery, meth users may not achieve full benefit from traditional inpatient programs. Although the drug doesn’t have the acute physical detox of opioids, meth users experience tremors, temperature fluctuations, and persistent low mood. Meth has other unique properties, as well. For example, it increases visual memory while impairing verbal memory. This means that meth users become highly sensitive to visual images which can trigger drug cravings. Inadvertently seeing images of meth or a syringe, or simply walking into a CMA meeting and seeing other users, can be extremely triggering.

On the other hand, meth impairs verbal memory, resulting in limited abstract thoughts and comprehension. Because of this, concepts as straightforward as the Twelve-Step recovery program may be confusing and frustrating. Poor verbal memory has important implications for cognitive behavioral therapy (CBT), one of the standard modalities of psychotherapy. CBT teaches individuals to control feelings through awareness of one’s thoughts. Negative emotions can be limited by consciously changing intervening negative thoughts to those that are more positive and conducive to healthy emotions. With their limited attention span, however, meth users can find traditional CBT problematic. Many clinicians treating meth users adapt CBT materials to shorter, more concise exercises, casually referred to “CBT Lite.”

Impaired concentration by users has led to the development of best-practice models for methamphetamine recovery that accommodate these limitations. For example, treatment programs with brief, daily groups taking place over a very long period of time are highly effective, especially when combined with motivational interventions and support groups such as NA or CMA.

Recovery from meth’s damage to sexual functioning is more complicated; it requires a gradual process of eliminating compulsive use of sex or pornography, coupled with the development of a healthy sense of self. These become the foundation for both healthy sex and intimacy. This process for reclaiming health sexuality in sobriety is fully explained in my book.

The return of meth has created serious havoc in the lives of many Americans. Because of its unique characteristics, meth treatment and recovery require special knowledge and sensitivity. With a greater understanding, we can assist meth users along the path of recovery. As witnessed by thousands of case studies among men and women, there is indeed life after meth.

David Fawcett is a psychotherapist and sex therapist in Fort Lauderdale. He is the author of “Lust, Men, and Meth: A Gay Man’s Guide to Sex and Recovery” and is a highly-acclaimed trainer on addictions, mental health, and co-occurring HIV and mental health. For more information, visit www.david-fawcett.com
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CALCULATING THE PRICE OF HAPPINESS
By Maxim W. Furek, MA, CADC, ICADC

Many of us fantasize about having vast sums of wealth. Thoughts of winning the lottery are a prime example. We have all dreamed about spending that multi-million dollar jackpot, believing that such a prize would be transformational, providing us with mansions, cars and boats and a means to attain genuine and lasting happiness.

Materialistic happiness is a popular philosophy and Dan Price has become a recent convert to that theory.

Price, the founder of Gravity Payments, surprised his staff by announcing that he planned over the next three years to raise the salary of even the lowest-paid clerk, customer service representative and salesman to a minimum of $70,000. He planned to increase the salaries of his 70 employees, with 30 ultimately doubling their salaries. The average salary at Gravity is $48,000 per year. Price, who founded the Seattle-based credit-card payment-processing firm in 2004, vowed to cut his own salary of nearly $1 million to $70,000.

There continues to be a large void between the rich and poor, more in evidence in poorer countries but an issue that American politicians have been driving home for a long time. The Middle Class is shrinking and the disparity between rich and poor is growing larger. The attainment of happiness is ultimately a discussion about class and this needs to be the leading edge of the conversation. Those suffering the effects of poverty are unable to experience materialistic pleasures that appear to make so many others happy.

While Dan Price’s fortunate few believe $70,000 to be the Holy Grail, others hope for a modest salary increase of $15 per hour?

Recently, lawmakers in California voted to increase the minimum wage to $15.00 an hour for large businesses in 2022, while New York officials negotiated to bring the $15-an-hour minimum to New York City by 2019 and the rest of the state in subsequent years.

Not everyone believes that this will be a good thing. Interviewed by the Washington Times, Donald Boudreaux, professor of economics at George Mason University, said virtually no economists deny that raising the cost of labor makes labor less attractive to employers. Boudreaux said the laws will hurt the very people they purport to protect: society’s least advantaged.

“A particularly pernicious effect of the minimum wage is that the worst consequences, the people who are most likely to be harmed by it, are the people who can least afford to be harmed by it,” Mr. Boudreaux said. “Not just teenagers, not just unskilled workers, but the least advantaged teenagers, who went to bad schools, who are from broken homes, so they don’t have any social connections at all, or the single mom without transportation of her own, those are the workers who are least likely to be employed under the minimum wage.”

Attempts to secure financial equality and class warfare have become political themes debated by both Republicans and Democrats. During the current presidential campaign, candidates are increasingly discussing the shrinking middle class, lack of manufacturing jobs and wage stagnation. The mood of the electorate appears to be one of frustration and anger, in large measure shaping the tone of the election.

Price’s Gravity Experiment speaks to the disparity between the salaries of chief executives and their employees. The United States has one of the world’s largest pay gaps, with chief executives earning nearly 300 times what the average worker makes, according to some economists’ estimates.

Still, that corporate excess does not always equate to a better life and, in numerous instances, has proved to be a detriment.

In his article “The Madness of Materialism,” Steve Taylor explains that material goods and wealth do not lead to happiness. Taylor writes, “Study after study by psychologists has shown that there is no correlation between wealth and happiness. The only exception is in cases of real poverty, when extra income does relieve suffering and brings security. But once our basic material needs are satisfied, our level of income makes little difference to our level of happiness.”

Taylor argues further that extreme wealth may be more problematic than most realize. He says, “Research has shown, for example, that extremely rich people such as billionaires are not significantly happier than people with an average income, and suffer from higher levels of depression.”

Magic Number

If happiness can be relegated to a numerical equation, then Jeff Hayden may have discovered that proverbial magic number. Hayden has concluded that, combined with altruism, the number is 100. Hayden says, “One of the most counterintuitive pieces of advice I found is that to make yourself feel happier, you should help others. In fact, 100 hours per year (or two hours per week) is the optimal time we should dedicate to helping others in order to enrich our lives.”

Max Lucado has also calculated a number, although smaller than the aforementioned one. In his “Today I Will Make a Difference,” Lucado suggests, “I will spend time with those I love - My spouse, my children, my family. A man can own the world but be poor for the lack of love. A man can own nothing and yet be wealthy in relationships. Today I will spend at least five minutes with the significant people in my world. I will spend five quality minutes talking or hugging or thanking or listening; five undiluted minutes with my mate, children, and friends. Today I will make a difference.”

So what is it? $70,000 annually? $15.00 per hour? 100 hours per year? Five minutes a day?

Not everyone agrees with those mathematical equations and not everyone believes that materialism is the answer. As Steve Taylor has suggested, philosophers, poets, and scientists all agree that happiness can’t be attained through money, prestige, or power. The good news is that we already have the currency needed to be happy. It’s inside us just waiting to be discovered. Happiness is more about discovering who you are and finding what you really want to do. That truth, once realized, is priceless.

Maxim W. Furek, MA, CADC, ICADC is passionately researching aspects of happiness. His rich background includes aspects of psychology, addictions, mental health and music journalism. His book Sheppton: The Myth, Miracle & Music explores the miracle and optimism that saved the lives of two entombed Pennsylvania miners. Learn more at sheptonmyth.com

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There is a common saying which is floating through the recovery community as of that, which is that the opposite of “addiction” is not “sobriety,” but rather “community.” And science is continuing to support the notion that connectivity amongst human beings is a stronger buffer against relapse from Substance Use Disorder than abstinence and counseling (and perhaps Medication Assisted Treatment) alone.

Continuing in this line of thought, the Delray Beach Drug Task Force (www.dbdrugtaskforce.org) and its visionary leader, Executive Director Suzanne Spencer, has continued to push this concept forward by holding the first ever “SUD [Substance Use Disorder] Talks” (www.sudtalks.org) in Delray Beach, Florida, on Thursday, February 11, 2016, at the historic Crest Theater in downtown Delray Beach. Attended by the “Who’s Who” of the recovery community, coupled with progressive law enforcement, educators, civic leaders, business owners, and interested citizens, the SUD Talks was modeled after the ever-popular “TED Talks” but with a subject focused upon how each individual in society is responsible for being their own “Agent of Change.”

Fulfilling its name as being the “Village by the Sea,” the City of Delray Beach itself was a major sponsor of the event, alongside “Visionary Sponsor” Michael S. Weiner, Esq., of the Weiner & Thompson law firm; “Idea Sponsor” Advanced Recovery Systems; “Thinker and Doer Sponsor” the Fred & Gladys Alpert Jewish Family & Children’s Services; along with The Hanley Foundation and The Home Depot.

Moving, motivational, and inspiring, are just a few of the words repeated throughout the night, as the various speakers made presentations ranging from 8 to 45 minutes on topics such as The Hanley Center’s Dr. D. John Dyben’s discussion on “There is No Such Thing as a Discount Human Being;” Dr. Elaine R. Rotenberg’s conversation about “When Denial Becomes an Affliction;” to the main speaker for the evening, the nationally renowned conversationalist Dr. Carl Hammerschlag’s topic of “Healing In Community: Not Cutting Edge Nor Leading Edge, But ‘Healing’ Edge!” which led to a standing ovation.

Taking groundbreaking action in the recovery field is nothing new for the Delray Beach Task Force or for Mrs. Spencer. We hope this is simply the beginning of the next level of open community-based conversations to take place not only in Delray Beach, but countywide, statewide, and nationally.

Above Left:
Executive board Delray Beach drug task force
Tony Allerton
Suzanne Spencer
Jeff Steiner

Above Right:
Patricia Rosen- Publisher of The Sober World
Terry Shapiro- Origins at Hanley

Left:
Panel Discussion
Marc Woods
Jeffrey Lynne, Esq.
Dr. Kevin Wandler
Dr. Elaine Rotenberg
Dr. Carl Hammerschlag
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information that sheds light on the commonality concept of food and drug co-morbidity. For example, after several years of effective bariatric surgeries used to treat obese patients, clinicians now report that some patients are substituting compulsive overeating with other compulsive behaviors. These behaviors involve decreased dopamine (DA) type 2 receptors (DRD2) and include alcoholism, gambling, drugs, compulsive shopping, and exercise (Cuellar Barboza, et al. 2015; Dunn, et al. 2010). Potentially because of neurochemical similarities, overeating and obesity may act protectively by decreasing drug reward (Hodgkins, et al. 2007). Similar to the process of opiate withdrawal, in animal sugar addiction withdrawal models, imbalances occur in neurotransmitters such as acetylcholine and DA (Avena, et al. 2015; Gold and Avena, 2013). Additionally, several human neuroimaging studies have reinforced the link between food craving and drug craving (Avena, et al. 2015).

The authors suggested that these findings show that cocaine cues activate similar, though not identical, pathways to those activated by food cues and that striatal D2/D3 receptors modulate these responses, suggesting that chronic cocaine exposure might influence brain sensitivity not just to drugs but also to food cues (Tomasi, et al. 2015).

The term Reward Deficiency Syndrome (RDS) was coined to describe the genetic determinants that predict addiction. The predictive value of being a carrier of the DRD2 Taq A1 allele, which may cause future RDS behaviors, was 74% (Blum, et al. 1995). People with the DRD2 Taq A1 allele, carry a reduced number of D2 receptors and, therefore, have reduced DA function. Additionally, RDS is polygenetic, involves a cascade of reward genes. The deficiency concept of DA may not be the only way to gain weight there is also evidence for a DA surfet theory (Yokum, et al. 2014). However, DA function disruptions, in particular, may predispose people to obesity and other addictive disorders. A family history of alcoholism is considered to be a substantial obesity risk factor (Pach, et al. 2014). Thus, we hypothesize that RDS is the cause of replacing food addiction with other addictive behaviors and may describe this recent phenomenon of addiction transfer that is common following bariatric surgery.

Research into the neuroscience of glucose and cocaine treatments have shown that both food and drug abuse treatment should include DA agonist therapy inducing dopamine release as opposed to present Antagonistic DA therapy (Adler, et al. 2000).

Several molecular and metabolic processes involved in the interaction of dopaminergic system and glucose may provide possible common therapeutic targets for both food and drug abuse. They include:

- In the mesolimbic structure, the enkephalinergic neurons are found close to the vicinity of glucose receptors;
- Highly concentrated glucose triggers the calcium channel to activate DA P12 cell release;
- A significant connection between blood glucose and cerebrospinal fluid levels of homovanillic acid the DA metabolite;
- In pharmacological doses, the glucose analog, 2-deoxyglucose (2DG), is related to improved DA yields and produces acute glucoprivation.

Dopamine function deregulation is a significant cause of addictive behaviors, like drug abuse and alcohol, and food addiction. Dopamine and other reward neurotransmitters are also part of a largely dispersed neural network responsible for regulation of eating behavior, affecting both homeostatic and hedonic mechanisms (Berridge and Kringelbach, 2015; Li, et al. 2015). Considering this, the dopaminergic and opioidergic mechanisms are especially involved in palatable food modulation, and opioid antagonists weaken drug cravings and palatable food appetite. Therefore, palatable food cravings could be contemplated as a type of DA-opioid-related addiction. Though there are at least five dopaminergic receptors, the D1 and D2 have been most associated with reward according to research (Li, et al. 2015).

Interestingly, McCutcheon (2015) suggested that post-ingestive mechanisms occurring from nutrients in the gut could impact food consumption and behavioral conditioning. The physiological processes essential to these mechanisms are multifaceted and are thought to join in mesolimbic DA signaling to translate post-ingestive sensing of nutrients that have a reinforcement reward value.

Presently, there are three chief families of opioid receptors (μ, κ, and δ), of which the μ-receptors are most involved in reward. The cases that show common phenotypy between food and drug addiction suggest a common therapeutic target (Karlsson, et al. 2015). They found that low Mu opiate receptor (MOR) availability results in increased feeding behavior. Similarly, dopaminergic agonists reduce appetite (Frank, 2014) while DA antagonists, especially at D2 loci, increase ingestive behavior (Liu, et al. 2012). Have we hatched the common phenotype egg and should we consider common treatment for these two seemingly diverse substances?

Obese versus lean humans have less striatal D2 receptors and show fewer striatal reactions to palatable food intake (Stice, et al. 2010). These findings align with the idea that those who have hypo-functioning reward circuitry are inclined to overeat, to satisfy a reward deficit. Also, decreases in striatal response to food intake, forecasts weight gain in the future for those at genetic risk for lowered signaling of DA-based reward circuitry, particularly in adolescents (Stice, et al. 2010). There is also the alternate possibility that a surfeit of DA may also cause weight gain as well (Stice and Yokum, 2014).

However, animal studies specify that palatable food intake causes down-regulation of D2 receptors, decreased D2 sensitivity, and reduced reward sensitivity, suggesting that overeating may denote diminished striatal responsivity.

Stice et al. (2010; 2014) examined whether or not overeating causes decreased striatal responsivity to palatable food intake in humans utilizing repeated-measures of functional magnetic resonance imaging (fMRI). Outcomes specified that females who gained weight during a 6-month period showed a decline in striatal response to palatable food ingestion compared to females who had stable weight. Together, these results imply that low sensitivity to reward heights the risk for overeating and additionally overeating may diminish the responsivity of reward circuitry in a feed-forward manner, specifically in DRD2 A1 allele carriers (Carpenter, et al. 2013).

Elevated stress levels, along with dopaminergic gene polymorphisms and additional neurotransmitter genetic variants, may have an aggregate effect on the susceptibility to both food and drug addiction involving epigenetic effects (Wright, et al. 2015). Recently Badgaiyan et al. (2015) clearly showed that dopaminergic tone at rest is reduced in RDS. This work suggests that subjects presenting with co-morbid abantian seeking behavior may have a common rubric displaying a hypodopaminergic trait state.

Finally, Schulte et al. (2015) reported that processed foods, high in fat and glucose, were most frequently associated with addictive-like eating behaviors. Moreover, processing was a large, positive predictor for whether a food was associated with problematic, addictive-like eating behaviors. In a separate model, fat and glucose were large, positive predictors of problematic food ratings. This underscores the need to restrict these foods during recovery from both food and drug addiction. So common treatment

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WHAT AM I MISSING? (PART 2)
By David M. Kolker, J.D. LCSW

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A Different way to Treat People

Conclusion
Overall, what is missing in treatment today is the understanding and compassion of being relational with patients. The irony in this statement is that AA promotes compassion and being relational with individuals; however, this is the part that most traditional treatment misses. Alternatively, traditional treatment provides an education as opposed to modeling behavior that provides the ability to develop secure attachment needed for change. Unfortunately, most addicts (probably most human beings in general) have not had a model for secure attachments, thus, leading to substance abuse and addictive behavior as a means of avoiding emotional pain. For treatment and thereafter, AA and therapy to be effective, the following suggestions are necessary:

1. Treatment must be focused on modeling secure attachment. This requires risk on the part of the treatment provider and a demonstration of self-disclosure and identification from the treatment team as opposed to a one-up position of authority.

2. Development of trust and alliance with the patient is critical if the patient is going to address and change learned abusive and dysfunctional patterns during childhood; thus, leading to the need to utilize addictive behavior as a means of avoiding emotional pain.

3. Continuation of care is critical. Thirty days in treatment merely scratches the surface. Without a long-term aftercare plan, i.e., Partial Hospitalization, Intensive Outpatient and therapy, that focuses on abuse, attachment and secure attachments, we can expect relapse rates after inpatient treatment to remain near 5-7% within one year of inpatient treatment.

4. “A different way to treat people” must become the norm as opposed to the exception in treatment.

References Provided Upon Request

David Kolker is a Licensed Clinical Social Worker and a Juris Doctor. He is the Clinical Director/CEO and primary therapist at Sober Living Outpatient. He thrives on working closely with clients and watching them grow as individuals. David is published in the area of evidenced-based therapy and specializes in family dynamics and relationships as they relate to recovery.

LIVING BEYOND
A Monthly Column By Dr. Asa Don Brown

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• “Teach your child to be assertive and to resist getting involved in dangerous or inappropriate situations or activities.”

• Have an intimate working knowledge of your child’s daily routines.

• Regularly interact with your child’s friends, as well as the friend’s parents.

• Remind your child that they are always welcome to call at any time and for any reason. “Develop backup plans to help kids get out of uncomfortable or dangerous situations. For example, let them know you’ll always come get them, no questions asked, if they feel worried or unsafe.”

Whether you are a child struggling with peer pressure or an adult, peer pressure is intended to change an attitude, behavior or a perception. Peer pressure can have a positive or negative influence. It can dramatically change your life for the good or the bad.

A child should be encouraged to engage in honest and open communication. A child should never fear informing a parent of peer pressure. If they are feeling peer pressure, but they are uncertain how to react, they should discuss these feelings with their parents. Communication is key in establishing and maintaining healthy relationships.

May you begin living beyond.

Author: Dr. Asa Don Brown, Ph.D., C.C.C., D.N.C.C.M., F.A.A.A.E.T.S.
Website: www.asadonbrown.com
References Provided Upon Request

SHAME, STIGMA AND ANONYMITY
By Karrol-Jo Foster, LMHC, CAP, ACRPS

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Anonymity has its place in addiction recovery and is vital to the 12-Step program model. My aim is not to do away with anonymity but to inspire more people who are experiencing the benefits of full recovery, to live their recovery out loud. Talk to friends, family members, neighbors, even coworkers (when appropriate) about your recovery. Don’t preach, don’t advertise, don’t promote… but also, don’t hide. The alcoholic and/or drug addict living under the bridge does exist, but this symbol of addiction is not the majority. The majority now includes our children, the elderly, professionals and non-professionals from every walk of life. We are in an addiction crisis in this country and stigma only serves to perpetuate the crisis. Don’t feed into secrecy, silence and judgement.

They are the fuel for shame and stigma. Choose instead to feed understanding, hope, compassion, and love in how you live and thrive in recovery. Live recovery out loud.

Karrol-Jo (KJ) Foster is a Licensed Mental Health Counselor, Certified Addiction Professional, Advanced Certified Relapse Prevention Specialist, and Researcher. KJ is currently a PhD student at FAU researching the impact of shame on addiction recovery. In addition to her shame research, KJ is co-author of the research project “Spiritual Competence in Counseling and Supervision” which is currently in progress. She recently facilitated a learning institute on Integrating Spirituality into Counseling at the American Counseling Association Annual Conference in Montreal. KJ is a member of ACA, ASERVIC, FMHCA and President of the Beta-Rho Chapter of Chi-Sigma Iota professional academic honor society. She may be contacted at gratitudeflows@gmail.com.
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www.thesoberworld.com
5. Allow children to express themselves. Don’t take it personally if your child doesn’t agree with you or does things differently; they do have their own opinions even in political elections. Let them express their views and listen to how they came to their choices.

6. Set boundaries and act from a place of love and compassion. Your child is not your best friend or confidant. Healthy boundaries keep your child safe. You are the adult; it is not your child’s responsibility to take on your struggles and issues.

7. Remember to embrace and take responsibility for your life. Be sure to take care of yourself physically, emotionally, spiritually or in ways that are consistent with your values. Sit down, relax, breathe and put your feet up.

8. Ask your other caretakers what your child does when you are not around. Grandchildren often do a lot more when they are just with Grandpa and Grandma or their sitter.

9. At the playground and calling another parent to complain about their child. Keep it simple. Ask yourself what kind of lesson you’re teaching your child through your actions.

10. As long as your child is not in danger or dying, count to ten before you put your Superman cape on. Sometimes the only way to learn a task is by having to do it. If everything is done for your child, no matter what their age they will not learn. Let your child struggle – it’s healthy and productive and innate to living a full life.

THE NEXUS BETWEEN FOOD AND ADDICTION

By Kenneth Blum, Ph.D., Doctor of Humane Letters and John Giordano, Doctor of Humane Letters, MAC

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must include ways whereby brain dopamine is regulated in a “homeostatic” fashion through a whole body approach.

John Giordano is a thirty-year veteran of clinical addiction treatment. Mr. Giordano is the founder and former owner of G & G Holistic Addiction Treatment Center, a 62 bed JCAHO accredited facility located in North Miami Beach, Fl.; and has contributed to sixty-five papers on addiction and its treatment published in peer-reviewed scientific and medical journals and is considered by Research Gate to be one of the top researchers in the country. For the latest development in cutting-edge treatment check out his website: www.holisticaddictioninfo.com

Kenneth Blum is a researcher on neuropsychopharmacology and genetics and the co-discoverer of the first confirmed Reward Gene; aka/the addiction gene, the alcoholic gene. He is one of the world’s foremost experts on addiction and its treatment. Dr. Blum retired as a full professor in the Department of Pharmacology, University of Texas, where he was also chief of the Division of Addictive Diseases, chief of the Division of Substance and Alcohol Misuse, and director of the Laboratory of Pharmacogenetics at the University of Texas Health Science Center (San Antonio, Texas) Dr. Blum is also a retired adjunct professor at UFL, University of Vermont and Keck Medical School Departments of Psychiatry and Behavioral Sciences. He has written over five-hundred papers on addiction and its treatment published in peer-reviewed scientific and medical journals and 15 books.

11. Write down a pretend resume for your child of all the things that he or she can do on their own. Then get out of the way and let your child do them!

12. Be a “SUBMARINE PARENT” (Sylvania Clark) rather than a helicopter parent. Instead of hovering over your child, submerge beneath the surface of your child’s life so that he or she gets out of the habit of running to you for every problem.

13. Allow your child whether they are ages 3, 4, 17 or 67 to be the person they were meant to be. Keep Falling Up!

Dr. Louise Stanger is a speaker, author trainer and international interventionist has developed and refined her invitational method of mental health, substance abuse and process addiction interventions using the well-established research methodology of portraiture. She has performed thousands of family interventions throughout the United States and aboard. Dr Stanger is the Author of Falling Up- A Memoir of Survival which is available on Amazon.
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