GENETIC INNOVATION FOR ADDICTION RECOVERY AND PREVENTION
By Kenneth Blum, Ph.D., David Siwicki, M.D., Mary Hauser, Msc. and Jennifer Neary, Ph.D.

DYING YOUNG: DEPRESSION, SUBSTANCE USE DISORDERS AND SUICIDE
By Mark S. Gold, M.D. and Dr. Drew W. Edwards

LOVE = INTERVENTION A MATTER OF LIFE AND DEATH
By Kim Koslow, LMHC, MCAP, CTT, BCPC

ADOLESCENT BORDERLINE PERSONALITY DISORDER
By Robert A. Moran, M.D., F.A.P.A., F.A.S.A.M.
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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 as well as distributing to schools, colleges, drug court, coffee houses, meeting halls, doctor offices and more. We directly mail to treatment centers, parent groups and different initiatives 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.

If you are experiencing any of the above, 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 need 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.


Sincerely,

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Patricia@TheSoberWorld.com

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Family history of suicide attempts

Other warning signs may include:

- Exposure to violence
- Impulsivity
- Aggressive or disruptive behavior
- Access to firearms
- Bullying
- Feelings of hopelessness or helplessness
- Acute loss or rejection

For children and adolescents, making statements or comments such as, “I wish I was dead,” or “I won’t be a problem for you much longer”, are serious warning signs and should never be taken lightly. Other warning signs may include:

- Loss of interests, friends, “face” or standing amongst peers
- Changes in eating or sleeping habits (loss of appetite and insomnia are more commonly observed than overeating and hypersomnolence)
- Frequent or pervasive sadness, crying
- Withdrawal from friends, family, and regular activities
- Frequent physical complaints and symptoms such as stomachaches, headaches, fatigue
- Declining interest and performance in schoolwork or extracurricular activities
- Physical or emotional pain
- Preoccupation with death and dying

People who are contemplating suicide often have on-line evidence for depression, anger, despair, and stop talking about the future, or cease making any long term plans. They may give away important possessions to those they care about.

Substance Use Disorder and Suicidality

Depression is the number-one risk factor for suicide, but alcohol and drug abuse are a close second. The best available evidence has established that drug and alcohol abuse during adolescence is a major risk factor for depression. Specifically, persons with substance use disorders are approximately six times more likely to commit suicide than the general population.

Substance Use Disorders (SUDs) not only increase the likelihood that a person will take their own life, but also provides the means for committing suicide. Approximately one-third of suicides are committed under the influence of drugs or alcohol. Most recently, opiates, such as oxycodone or heroin (often cut with fentanyl), are associated with both accidental overdose and suicide. Often, it’s difficult to determine if an OD was intentional or not. Yet, in 2015, over 33,000 Americans died from misusing opioids.

We do know that men with an opioid use disorder were twice as likely to commit suicide compared to same age men without opioid use disorder. It’s even worse for women. Recent data informs us that these opioid abusing women are eight times more likely to commit suicide compared to age matched cohorts. In general, opioid misuse is associated with a 40%-60% increased risk for suicidal thought, and a 75% increased likelihood of a suicide attempt.

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Most impaired professionals---essentially those individuals who are often licensed, financially successful, autonomous, and have achieved “success” are nevertheless high-functioning and invisible to themselves and others. They are your neighbors, your friends, your colleagues. They live double lives which would make Jason Bourne proud.

As you readers know, addiction of any person is an elusive charade of denial, private logic and anti-social behavior. Family, friends, and peers are eventually driven away. The addict is typically isolated and unwilling to seek or accept help. Multiply this by 10 and I present to you the high-functioning impaired professional.

Who Are They?
He or she protects their career at any cost. They are seldom fazed when personal relationships, health, hobbies, balance, and emotional stability gradually disappear from their lives. Until their disease strips away their defenses, they perform their job without mistakes, slips, or apparent consequences. In their heads a battle rages as their demand for perfectionism wars against the constant obsession to drink or use. But none of this is visible to others.

They look nothing like stereotypical addicts. They and most of their colleagues believe an addict is the person they step over as they enter their office building, operating room, or cockpit. There they are transformed into masters of the universe, convinced that no real addict could do what they do at their job. They also believe they could stop using if necessary if their careers or licenses were at stake.

Even if they sense they need help, they do not want to risk that others may find out they have sought it. Fear of losing their careers or compromising their reputations muscle all objective indicators of their disease aside. In addition, they do not have the time to treat this problem because they believe they are too valuable to their clients or patients or passengers. Others enable them. Often, they have little accountability. So, as long as they act the part, their secrets are safe, and because of the slow progression of the disease, they are commonly able to maintain this charade for years and even decades.

What Do They Look Like?
This gets us to the heart of the issue. They look good---sometimes even better than good. They are invisible until, suddenly, they are not. This is the moment when they begin to miss deadlines and meetings. There are cancellations and postponements, often with different excuses proffered. Mornings are often rough as they arrive at work disheveled, groggy, with little energy and a short fuse. It is not unusual for them to be in a blackout, later forgetting conversations or having difficulty with linear comprehension.

Put into the most concrete terms, by the time the disease has progressed to the point that the professional can no longer sustain peak performance, is the opportunity when the professional, his/her colleagues or family needs to reach out for expert help, especially since the impaired professional may still be unwilling to acknowledge the disease and lack of control.

How to Get Them Help Before it is Too Late
At this juncture, the addict is on the brink of severe consequences. Because of the inevitable progression of the disease, all that awaits is the proverbial “rock bottom.” It is commonly assumed (correctly) that hitting this bottom for the addict or his support system is often the catalyst to seek help. Unfortunately, this is also the later and more irreversible stage of the disease, and when the professional arrives to treatment, his or her addiction, career, health, family situation, or legal status may be in profound distress.

This is precisely why those who are concerned about the impaired professional---before rock bottom---should exercise leverage (i.e., a wife with a husband, a managing partner with a lawyer) to coerce the professional into treatment---preferably residential, where work pressure and family dynamics are removed. This is also the opportunity to retain an interventionist when it will be most valuable. Good interventionists are routinely successful with impaired professionals, especially when they can engage the right team of people to participate in the intervention. And by the way, the professional knows deep down this was coming, and often it is an internal relief. Interestingly, those who arrive at treatment via intervention are just as successful in recovery as those who choose treatment without a nudge.

All of this is easier said than done. The impaired professional, although he is increasingly a danger to himself and others (e.g., driving his children and other children to a soccer game on a Saturday afternoon), is so extraordinarily entrenched in his own denial that he refuses help. He will bargain and delay and cajole for any outcome short of permitting others to treat the addiction. This moment is when the rubber truly hits the road for those pursuing the intervention.

The Road to Recovery
This short piece will not explore the treatment of the professional (an article for another day, especially with the advent of specialty residential tracks for professionals), but will provide these suggestions for this population and successful long-term recovery:

• The first year of recovery is the most crucial. Recovery comes first, always.
• Monitoring for alcohol and drugs by a third party greatly increases the rate of recovery (doctors and pilots are routinely compelled to submit to testing).
• Joining a sobriety support group (such as AA or Smart Recovery) is essential.
• A gradual return to the professional world is strongly recommended. Whether the professional is returning to a job, looking for another or changing careers, it is important to not “hit the ground running.” It will take time to build a recovery program upon discharge.
• Remember that there are fewer chances to professionally survive relapses for this person.
• Consider a “recovery job” for a period of time which is not connected to a career and does not involve taking the job home.
• Engage with a therapist to assist with underlying issues and problems in recovery.
• Connect with other professionals in the same field who are in recovery.
• Do not isolate. This is especially easy to do if alone or not employed. Schedule activities which force you out of the house and involve social interaction.
• Have a relationship with a psychiatrist for medical help with mental health or addiction issues.
• Volunteering for a cause you believe in can be helpful, especially because it can take you outside of your own head and moods.

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Fact or alternative fact? Poor impulse control, chaotic interpersonal relationships, identity problems—a psychiatric disorder or typical adolescence? The issue of diagnosing borderline personality disorder in adolescence has been somewhat controversial for years. Adolescence is a time of tremendous change in brain development. A great deal of neural pruning is taking place in an effort to improve the efficiency of circuitry leading to more effective overall function. Some studies have shown that the diagnosis of borderline personality disorder is not stable, especially in adolescence. Given the significant neurologic development that is occurring during adolescence, is it appropriate to make a diagnosis of a personality disorder at a time that is marked by ongoing change and likely to fail to demonstrate diagnostic stability?

Borderline personality disorder exists in the individual who may be described as meeting at least five of the following criteria:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., excessive spending, substances of abuse, sex, reckless driving, binge eating).
5. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
6. Chronic feelings of emptiness.
7. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper tantrums, constant anger and recurrences fights).
8. Transient, stress-related paranoid ideation or severe dissociative symptoms.

But, is it appropriate to diagnose in adolescence? In a review written by Miller et al., 2008, they reported that recent studies, in fact, have shown that symptoms of borderline personality in adolescence “have construct validity and can be reliably identified among adolescents.”

Personality disorders are defined as enduring patterns of perceiving, experiencing, relating to, and responding to others in such a way that leads to distress or dysfunction. Genetics determines temperament, i.e. traits such as novelty-seeking, harm-avoidance, and reward-dependence, upon which the social environment molds to determine ultimate personality. Research has been revealing that determinants of personality are present long before adolescence.

Borderline personality in adolescence has been found to have the same degree of reliability and validity in adolescence as in adulthood. Prevalence estimates have been determined to be approximately 0.9%. Adolescents with borderline personality disorder have been found to have an abnormal pattern of brain maturation. Risk factors for the development of borderline personality disorder in adolescence include low family of origin socioeconomic status and adverse childhood experiences. Attachment disorganization, parental hostility, and maternal inconsistency have all been shown to play a role in increasing risk. Sexual abuse is a common finding in the histories of those adolescents with borderline personality disorder; however, it has been found to be a weak and nonspecific risk factor.

Adolescents with borderline personality disorder have significant impairments in social relationships and academic performance, with overall poor quality of life. Non-suicidal self-injury and suicidal behavior are prevalent and are the most frequently met criteria. The lifetime suicide rate for borderline personality disorder is estimated to be 8%. Substance use is highly prevalent as is sexual risk-taking.

Adolescents with borderline personality disorder are at increased risk for other psychiatric disorders, the most common of which are mood disorders, eating disorders, dissociative disorders, Post-traumatic Stress Disorder, substance use disorders, and other personality disorders. Borderline personality disorder has been found to be moderately heritable without the identification of specific genes as of yet. Neurobiologically, structural imaging studies have revealed reductions in volume of orbitofrontal cortex and anterior cingulate cortex. The hypothalamic-pituitary-adrenal axis activity has been shown to be abnormal, in that adolescents engaging in repetitive non-suicidal self-injury have an attenuated cortisol response to acute stress.

Adolescents with borderline personality disorder have been shown to have abnormal theory of mind tasks. Their ability to perceive socially is impaired. They have been described as having an “over-interpretive mental state”, i.e., they “hypermentalize” that leads them to make assumptions about other people’s mental states.

Given the serious long-term consequences of borderline personality disorder, including poor psychosocial functioning and high risk of ongoing sickness and possible death, it is important to recognize this illness as early as possible and to intervene appropriately. Treatment can be highly effective. A number of psychotherapies have been found to provide success. Cognitive analytic therapy was derived from object-relations theory and cognitive psychology. Mentalization-based therapy is based upon psychodynamic theory and encourages the use of one’s ability to mentalize representations of self and other. Dialectical behavior therapy for adolescents developed by Linehan was derived from cognitive-behavior therapy and involves skills-training for stress-tolerance, emotion regulation, and interpersonal difficulties. Finally, transference-focused psychotherapy is based upon object relations analytic technique, developed by Kernberg and has been adapted for adolescents.

There is no current evidence for specific medicines found to be helpful in borderline personality for adults or adolescents. However, given the high prevalence of comorbid psychiatric illnesses which do respond to psychopharmacologic agents, medicines are likely to be indicated. In addition, some studies have shown symptom-focused pharmacotherapy to be helpful. For example, naltrexone has been shown to decrease frequency of self-injurious behavior in borderline personality disorder in some studies.

References Upon Request

Dr. Robert A. Moran is Board Certified in Psychiatry, Addiction Psychiatry, and Addiction Medicine by the American Society of Addiction Medicine and the American Board of Addiction Medicine. He is a clinical instructor of psychiatry at Cornell University, and a member of the faculty of the Biomedical Science at Florida Atlantic University. Since 1993, Dr. Moran has dedicated his life to the study and treatment of substance and mental health disorders.

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The statistics are staggering. State and local agencies across the US report shocking comparisons. In one year, drug overdoses killed more Americans than the entire Vietnam War. The opioid epidemic has killed the same number of people who were dying of AIDS during the 1980’s AIDS epidemic. The Center for Disease Control found an estimated 63,600 people died of drug overdoses nationwide in 2016.

More than ever before, addiction is a matter of life and death. The difference between life and death (really death and life) can be an Intervention. Unfortunately, this life saving event carries a lot of heavy baggage with it. Oftentimes in the media, an intervention is depicted as a surprise event, where family members ambush a member of their family who needs help. Depending on the individual, a surprise intervention may or may not be necessary. If you have a family member or loved one who has expressed a desire to break free of their addiction but has not followed through on it yet, you may want to schedule a time for a family meeting. Under these circumstances, a family mediator can help keep everyone calm and on track for the purpose at hand.

By the time an intervention is needed, families are physically, mentally and emotionally drained. They find themselves at a loss, not exactly sure where to go, what to do, or whom to trust. Addiction has destroyed trust and ruined relationships between people who love each other. Alcoholism and drug addiction is a sensitive topic for anyone, and the individual who is suffering from addiction may present as defensive and angry. Addiction is a disease of the brain that changes how people behave, therefore, having a trained professional who understands the issues without being directly affected by them, can often help keep the peace.

With the support of a trained intervention professional, families are guided every step of the way to help get their loved one into treatment and allow the healing to begin for everyone. There are many models and different ways of doing an intervention.

I was trained as an interventionist many years ago and have facilitated hundreds of interventions since then. While not one intervention has been the same, I have carried the same intention for each one. **Love someone enough to tell them the truth.**

It is not a sign of loving someone when you see them destroying themselves with alcohol and drugs and conducting dangerous behaviors yet still no one says anything to them. If you love someone enough to tell them the truth, you can tell them that you cherish and honor them, but you hate what the untreated disease of addiction has done to them. In an intervention, you may not know what to say or how to say it, but you will be guided and, because you have a professional on board, the way will be made clear.

You have to really love someone to tell them the truth and because you love them, you want them to have all the information available so they can be their best self. You tell them the truth because you want them to make healthy choices and decisions. You want them to have everything they need to fully weigh their options. You also want to tell them the truth as a sign of your respect for them and that you believe they can handle the truth. Whatever has to be said or written to the one needing treatment should begin and end with, “I love you.” We often feel very unlovable in the hands of our addiction.
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It wasn’t that long ago that I felt encouraged about the activity surrounding our drug policy. That is not to say I agreed with every aspect of policy, in fact there are many facets that I strongly disagree with, but at least the opioid epidemic found its way to the foreground and something was being done about it. A lot of my enthusiasm stemmed from the actions of a little agency in the White House that not many people have heard about, the Office of National Drug Control Policy (ONDCP), or its impact. It’s one of those smaller agencies that doesn’t get talked about that much but has had an over-sized influence on our drug policy and how it’s carried out – that is until now.

The Anti-Drug Abuse Act of 1988 created ONDCP during the Reagan administration. The bill was approved almost unanimously by margins of 346–11 and 87–3 in the House and Senate, respectively. The agency’s director, who is often referred to as the ‘Drug Czar,’ is selected by the president and must be approved by the Senate before taking the helm. The office was intentionally placed under the executive branch so that its policies would carry the full weight of the president. It quickly became the center piece of then President Ronald Reagan’s war on drugs.

Among its responsibilities, the agency serves as a coordinating body for the nation's drug control effort by overseeing international and domestic anti-drug efforts of executive branch agencies. The programs that the agency developed contributed heavily to the modernized public health and safety initiatives. The ONDCP has always had the unique ability to plan, elevate, and execute the vision of the president’s drug policy.

Like past presidents, the current administration has pledged to fight the opioid crisis and drug addiction in America, making it a priority for this administration. However, congressional members from both sides of the aisle have said that the efforts are not enough.

The devil is always in the details. From early on, this administration’s solution to the opioid epidemic has been firmly based in law enforcement and little else. In fact, the ONDCP was nearly obliterated this time last year by proposed budget cuts. Dissenting congressmen and senators from both parties saved the agency but many speculate that they will not be able to replicate their success in the coming years.

The ONDCP was thought to be on the chopping block when the administration proposed slashing the agency’s budget by 95 percent in 2017. This would have effectively pulled the teeth out of the agency’s ability to reduce drug use and its consequences, and end the two grant programs to law enforcement and drug-free community programs that help fund cities hardest hit by this avoidable epidemic. However, preliminary indications are that the ONDCP will be funded for at least another year.

But there’s more than one way to defang a government agency that could cause a thorn in your side, such as replacing leadership with someone more amenable and loyal to one’s objectives. Richard Baum has served as interim director of ONDCP – ‘Drug Czar’ – for over a year. He has worked in the agency for two decades – through four presidential administrations – and is considered a valuable expert on addiction and its treatment by his peers. The last permanent director was Michael Botticelli (March 2014 to January 2017) whose bold actions in combating addiction convinced many experts to believe he had been the most consequential director in ONDCP history.

Baum’s replacement, if approved by the senate, will be deputy White House chief of staff Jim Carroll. Before joining the administration just a few months ago, Carroll was Washington counsel to the Ford Motor Company. As far as his health credentials are concerned the White House said that after law school, Carroll spent five years as the assistant commonwealth attorney for Fairfax, Virginia; where the majority of the cases were drug-related and he worked directly with those affected by drug abuse.

Carroll was not the administrations first choice to run the ONDCP. That distinction belongs to Rep. Tom Marino (R-Pa.) – another politician with no medical, health or addiction treatment background. Marino has a history of advocacy for legislation friendly to opioid manufacturers; but after a joint Washington Post/60 Minutes investigation which named him the chief advocate of a bill that critics say made it harder for the DEA to freeze suspicious drug shipments, he withdrew from consideration. Marino tried to clear his name and defend his record by claiming the bill he championed was different from the one ultimately signed into law.

There are other glaring red flags that signal the demise of the ONDCP. In the past year seven top level senior officials in the agency have resigned. Many posts remain vacant or filled by political loyalists such as Taylor Weyeneth. The 24-year-old and recent St. John’s University grad was installed by the White House in the number two position at the agency. As the Deputy Chief Of Staff, Weyeneth was responsible for coordinating the anti-drug efforts of public health and law enforcement authorities. This would seem to be a lot to ask of a person with no professional experience, whose only credentials according to the Washington Post are campaign duties which included low-level tasks like “coordinating voter services” and “arranging travel and temporary housing for senior campaign officials,” as well as “special projects.”

The ONDCP was once the pride of President Reagan. It has served as the vision of five president’s drug policy for twenty-nine years, and one year for the current president. In the last twelve months the ONDCP has been reduced to a shell of its former prestigious self with neither the talent nor authority to influence our drug policy and/or how it’s carried out.

But equally concerning are reports from reputable news organizations regarding White House counselor and former campaign manager Kellyanne Conway’s work at the administration’s opioid abuse policy. It has been reported that Conway and other political types with no relevant health, medical and/or addiction experience – including the 32-year-old son of Rudy Giuliani, Andrew, who the White House says has no background in drug policy – have taken control of drug policy and have quietly ‘frozen out’ drug policy experts and professionals – such as Rich Baum – of the decision-making process. In fact, Baum has not been invited to, or attended, Conway’s meetings. According to a report from Politico “Two political appointees from Baum’s office, neither of whom are drug policy experts, attend on the office’s behalf, alongside officials from across the federal government, from HHS to Defense.' Former ONDCP officials say that Conway’s drug policy office is taking a leading role in addressing the crisis.

Now layer all of this over the Department of Justice’s new policy on sentencing guided by the vision of the Attorney General of the United States, Jefferson Beauregard Sessions; the former Assistant U.S. Attorney in the Office of the U.S. Attorney for the Southern District of Alabama, Attorney General of Alabama and a four term senator from Alabama.
WHAT IS A LEVEL 4 TRANSITIONAL CARE HOUSE?

Sunset House is currently classified as a level 4 transitional care house, according to the Department of Children and Families criteria regarding such programs. This includes providing 24 hour paid staff coverage seven days per week, requires counseling staff to never have a caseload of more than 15 participating clients. Sunset House maintains this licensure by conducting three group therapy sessions per week as well as one individual counseling session per week with qualified staff. Sunset House provides all of the above mentioned services for $300.00 per week. This also includes a bi-monthly psychiatric session with Dr. William Romanos for medication management. Sunset House continues to be a leader in affordable long term care and has been providing exemplary treatment in the Palm Beach County community for over 18 years.

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.
SOOTHING THE BRAIN ON THE ROAD TO RECOVERY

By Dr. Kathryn Seifert

Many people afflicted with a substance use disorder have histories of trauma, as well. The impact of trauma on the individual depends on the age and developmental stage of the person at the time the trauma occurs, the interpretation of harm the victim experiences, the frequency and severity of the trauma, and the response of caregivers when the trauma occurs. The ACE’s study further verified this and listed the negative outcomes associated with childhood trauma. These include mental illness, substance abuse, criminal activity, aggression, negative health behaviors and physical problems throughout the lifespan.

When one experiences trauma, cortisol levels rise and the autonomic system goes into overdrive. The Cortex or the thinking side of the brain stops working effectively or efficiently. This is a normal reaction to extreme stress, crisis or trauma. When the trauma is frequent or severe, cortisol remains high and the brain becomes chronically over-roused. The stress response in this case interferes with brain development and the development of social, emotional, and communication skills.

For instance, trust in caregivers and the development of the primitive brain for safety and basic life skills occur between the ages of 0 and 2 years. If there is severe and/or chronic trauma at this age (including severe neglect), there is damage to the development of these skills and essential parts of the brain that regulate emotions, cognition, trust, and behavior.

Severe trauma from 2 – 4 years will interfere with the development of communication, social skills and delayed gratification. Without resolving the trauma, people often can remain at this earlier social developmental level while the body grows at a normal pace. In that way, people that are 16 to 100 years old can act as if they are 2-4 years old in their interactions with people and the world. They are developmentally delayed. The attitude represented by “I want what I want and I want it now and if you have it, I am going to take it” can occur at any age when one has a history of severe trauma, however sharing with others should be developed by the time children enter school when those children have not been traumatized.

Additionally, the brain becomes either hyper-roused (out of control and acting out behaviors) or hypo-roused (withdrawn). A chronically hyper-roused brain cannot learn anything effectively because it directs the body’s energy to flight, fight, or freeze, not developing necessary coping skills and not learning well in school.

To turn on the cortex of the brain for cognitive thinking and logic, and regulating behavior, trauma must be resolved and the brain must learn to regulate itself. It takes calm and focus to attend to school or work tasks. This develops when a caregiver soothes a child and teaches him to sooth himself and his brain. Empathy for others cannot develop without these building blocks. Therefore, there are people of any age that are behaviorally and emotionally not well regulated or out of control (inwardly or outwardly).

The brain must learn to regulate the various parts of itself before it can regulate behavior, have effective relationships with others and restart the developmental process. The amygdala is underdeveloped so the ability to regulate one’s emotions is impaired. Because the emotions are out of control, some people turn to mood altering drugs and alcohol to manage their feelings.

It is estimated that as much as 80% of the people with substance use disorders have unresolved childhood (parental abuse or neglect), teen (bullying and rejection by peers), and adult trauma (difficulty in establishing a relationship with a significant other or job).

Consequently, stage 1 of trauma work is safety, helping the brain regulate itself and building trusting relationships. You must help the brain to learn to regulate and soothe itself before it can restart the developmental process and before you begin to deal with any trauma specific therapy narrative. A positive, supportive relationship is needed to establish the ability to trust. Effective interventions include using rhythmic, soothing activities, such as: mindfulness, Yoga, meditation, comfort and support, relaxation, music, dance, drumming, biofeedback and neurofeedback, taking walks, art, EMDR, karate practice, play, and rocking in a rocking chair.

Our clinics have used these techniques and have had marvelous results. One woman reported that she had not had a full night’s sleep in 20 years and she was too anxious to talk about her trauma. After a few biofeedback sessions she began talking about and processing her trauma and sleeping through the night. Another struggled with substance abuse, had a difficult relationship with his parents and trouble holding down a job. He has a much better relationship with his parents, has a regular job, and is clean and sober. Additionally, one of these devices is FDA approved for reducing the symptoms of opiate withdrawal. Methods of soothing and regulating the brain include the use of biofeedback techniques. There are several biofeedback methods on the market, such as Cranial Electro-stimulation, neuro-mapping and neuro-stimulation, EEG technology, and meditation apps for your phone or tablet.

Stage 2 is trauma work and deals directly with exploring the trauma narrative and should not be started before stage 1 is accomplished.

Stage 3 is reconnection with home, community, and purpose (3 of SAMHSA’s wellness domains). It will take a variety of methods to meet all of these needs and reduce the negative effects of the social determinants of health problems.

In my 5 clinics, I encourage comfort, soothing, support and positive relationship, as well as setting proper boundaries to occur from the waiting room to the therapy session. That means all staff showing respect and support and good boundaries at all times. Showing a person empathy helps them develop their own empathy. Additionally, a calm approach to the interaction with others helps the brain allow the Cortex (thinking part of the brain) to work more effectively so that people can learn more easily. The bottom line is that it takes multiple types of activities to support recovery. It also takes a higher intensity of services, such as Intensive Outpatient Services.

Dr. Kathryn Seifert is a Psychologist, author, lecturer, and owner of 5 Public Behavioral Health Clinics. She has appeared on CNN, Fox News, and Discovery ID. Dr. Seifert wrote 2 books on youth violence and developed the CARE-2, a trauma informed treatment planner for “at risk” youth which can be found at www.CARE2systems.com.
Hello,

I’m Real Estate Agent Austin Frankoski with Arena And Company. I make the renting, buying, or selling of any Recovery Housing Property easy and stress free for treatment centers and housing care providers. I’m extremely knowledgeable of the treatment industry and as a supporter of recovery myself I understand the importance of providing safe and affordable housing for your clients at all levels of care. Stop spending months searching on your own, Call me Today! New inventory is constantly coming available. I look forward to working with you and do not hesitate to call.

Thank you and God Bless.

Austin Frankoski
561-572-1536
**March Groups at Within**

**Monday**
- Hope Starts Here (Open AA) 5:30pm
- Life Recovery 12-Step Group 7:00pm

**Tuesday**
- On Awakening (Open) 7:00am
- Candlelight Meditation (Open) 7:00pm

**Wednesday**
- Back to Reality (Open AA) 12:00pm
- Recovery After Work (Open AA) 5:30pm
- Worthy of Love & Respect (Open AA) 7:00pm
- Caduceus (Closed AA) 7:30pm

**Thursday**
- Women in Sobriety (Open AA) 7:00pm
- Al-Anon (Open) 12:00pm
- Open NA Meeting 7:00pm

**Friday**
- Night Out Within
  - Check our schedule online for weekly events!

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- Host Your Recovery Events Here
- See Our Site for Upcoming Events
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Friday 7:30am-5:00pm*
Saturday 8:00am-4:00pm*
Closed Sunday*, *open for events

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WithinRecoveryCafe.com

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Alumni Support Line: (561) 714-0541

Residential Inpatient Treatment
Utilizing the newest techniques in addiction treatment, The Treatment Center’s in-house doctors and nurses is ready to provide you with a comfortable detox and firm foundation for recovery.

Outpatient Care
Our Intensive Outpatient Program and Partial Hospitalization Program is available after detox and stabilization for those who need support in our community.

Faith-based Options
Road to Freedom is our faith-based inpatient program led by Pastors, therapists and medical professionals. Our program has in-house church and worship services and individualized groups.
Following 27 years of extensive worldwide research, a panel of ten reward gene risk variants, along with a proprietary scoring index called the Genetic Addiction Risk Score (GARS®), has been developed.

In unpublished work, when GARS was compared to the Addiction Severity Index (ASI) used in many clinical settings, GARS significantly predicted the severity of both alcohol and drug dependency. In the midst of an epidemic where we see over 100 Americans (of all ages and backgrounds) dying daily from opioid overdose, we believe that early testing (maybe in birth) for addiction and other Reward Deficiency Syndrome (RDS) subtypes is a clinical tool with great potential benefit to providers and patients. Recent evidence in Science Journal clearly shows shared genetic mechanisms between autism, schizophrenia and even bipolar disorder previously suggested by our group in 1995 as all subtypes of RDS.

In the past, families may have never worried that their loved ones could harbor increased risk for opiate addiction, but the dangers of opioid use have become clear in recent years. Further, links between other RDS behaviors and elevated addiction risk are increasingly evident. In the 1990’s, author Bill Moyers (Parade Magazine) insightfully reported that as he traveled around the United States he observed that many children with ADHD and Autism Spectrum Disorders also had related conditions like substance abuse. He called for better ways to identify these children and treat them with approaches other than addictive pharmaceuticals.

The GARS addresses this need.

The Brain Reward Cascade and Implications of Chronic Low Dopamine

The interaction of genetics and neurotransmitters controlling the release of dopamine is termed the brain reward cascade (BRC). Variations in the BRC, possibly genetic or epigenetic, may predispose individuals to addictive behaviors and altered pain tolerance. The GARS panel is based on established polymorphisms (gene variations) that are known to perturb the BRC; to our knowledge, GARS is the only panel of its kind to have been correlated with the ASI-MV alcohol and drug risk severity score. Further studies are in development to confirm, and also enlarge, the GARS test by adding additional polymorphisms associated with hypodopaminergia (low dopamine function). GARS results have the potential to improve clinical interactions and decision-making. To further support addiction recovery, Blum’s laboratory has developed pro-dopamine regulatory neuro-nutrients (tested, to date, in more than 35 clinical trials [figure 1]) which enable personalized treatment for all behavioral addictions following GARS testing.

The interaction of at least four neurochemical pathways: serotonergic, GABAergic, endorphinergic, and dopaminergic,

together constitute the “brain reward cascade” (see Figure 2). BRC is a natural sequence of events that produce feelings of well-being. These events include the synthesis, storage, metabolism, release, and activity of neurochemicals. These processes are regulated at the genetic level, where genes are transcribed to messenger RNA, and RNA is translated to protein. Genetic testing can be utilized to better predict individual neurochemistry, and then respond with more personalized treatment options [5].

![Figure 2: Brain Reward Cascade](image)

Figure 2. Brain Reward Cascade [6, 7]. In this cascade, the stimulation of the serotonergic system within the hypothalamus, through innervation, stimulates delta/mu receptors via the release of enkephalin. Further activation of the enkephalinergic system leads to inhibition of GABA transmission in the striatum via enkephalin stimulation of mu receptors upon GABA neurons. This inhibition allows the fine-tuning of GABA activity. Additionally, this provides the normal release of dopamine at the projected area of the Nucleus Accumbens (NAc).

The dopaminergic pathway is most directly involved with addiction. Dopamine is a neurotransmitter with multiple essential functions including behavioral effects such as “pleasure” and “stress reduction.” In the absence of typical dopamine function (hypodopaminergia), an individual will suffer from cravings and may face difficulty coping with stress. Therefore, the hypodopaminergic brain predisposes people to seek out substances and/or behaviors that can be used to overcome the craving state by activating mesolimbic brain dopaminergic centers. This represents the “Addictive Brain” first proposed by our group in 1990. Self-medication with psychoactive substances (such as alcohol, psychostimulants, and opiates) and/or risky behaviors (for example gambling, overeating, and thrill-seeking) induce the release of dopamine in the synapse at the NAc, temporarily overcoming this hypodopaminergic state, and resulting in temporary relief from the discomfort, and a false sense of well-being.

With regard to RDS behaviors, it is noteworthy that both substance and non-substance addictive behaviors (like music, food, sex, internet, gaming), cause a preferential release of dopamine in the NAC, suggesting that people self-medicate in many forms to obtain their required dopamine fix. The acute release of dopamine leads to feelings of well-being in the very short term, especially in individuals who through either gene polymorphisms (variants), or gene/environment interactions (epigenetic-methylation, reduced expression) and or inhibition of deacetylation (increased expression) on histones in the chromatin material involving many genes affecting mRNA expression, have compromised dopaminergic function. This concept is clarified by the simple formula, whereby Phenotype = Genes + Environment [P = G + E]. It is understood that this is a very complex interaction involving many polymorphic genes and their subsequent interaction with the environment (genes X environment).

Chronic abuse of substances or continued risky behaviors often lead to further neurotransmitter imbalance and depletion, which...
The addiction treatment market has unfortunately not seen any major diagnostic advances in over 20 years. Geneus Health is changing that...

Backed by nearly 40 years of research and patents pending, Geneus Health has created the Genetic Addiction Risk Score (GARS™) Test to help people better understand their genetic predisposition toward substance and non-substance abuse behaviors.

Coming mid-March 2018

Check our website or follow us on Facebook and Twitter for updates
An epidemic of drug addiction with our kids today is scarier then ever! Every day on national and local news, more and more stories keep pointing to the opiate epidemic, overdoses, and addiction of our young people. These kids have parents whose hearts are breaking and need ongoing support and strategies to take back their parenting from the addiction of their teens and young adults. I believe no parent ever intentionally wakes up each day and decides to harm their kids. Yet, with the affects of addiction on their parenting, most of these parents find it difficult to believe that their kids really care about them and they feel overwhelmed and powerless. Many of these teens and young adults have the following in common that parents need to know:

1. Remorse for what they have done to their families
2. Loneliness, sadness, rage, fear, and shame
3. Love for their parents

How do I know? I surveyed 300 teens and young adults newly sober from a recovery high school and sober living programs during the past 4 years. Their responses were heart felt, wise, and important to share with parents. They want you and need you in their lives even if they show otherwise.

One of the questions asked to the teens and young adults was:

"Dear Parents, I wish you knew this about me-

• I did my best and tried to be stable, but couldn’t.
• I wish you knew how much I have suffered. Sometimes I feel that they only saw my maladaptive behavior as an attack against them rather than a cry for help or an act of desperation.
• I’m trapped in a vicious cycle of using because I can’t gain trust and I’ve given up.
• I have really struggled.
• I deeply regret hurting them.
• I love them and never wanted to hurt them with my addiction.

Who are these kids?

Many of these teens and young adults have been through treatment anywhere from one to nine times. Drugs of choice range from alcohol to marijuana to street drugs, prescription drugs, designer drugs, opiates, and heroin. Many of them have been bullied in grade school, middle school, and high school. Quite a few of them have been sexually or physically abused. Developmentally, many experience delays socially, emotionally, intellectually, and spiritually.

Through the years, I have worked directly and indirectly with thousands of adolescents and young adults all over the country. Their stories are heart felt and telling. Many are children of addicts, many are in recovery, and many have co-occurring mental health challenges. Most of them don’t know how to step out from active addiction and remain sober. Many of these children have mental health challenges that went untreated or were unsuccessfully treated. These include depression, anxiety, severe mood disorders, and learning disabilities. Many of these children mask untreated mental health issues with addiction to ease their pain. Most of the teenagers and young adults have dual diagnoses of chemical dependency with coexisting mental health challenges.

"How did addiction affect your relationship with your parents?"

• When I was depressed, I totally shut down and blocked my parents out, which caused them to try harder.
• They lost trust in me, and I’m not sure when it will ever be back.
• They were scared I would kill myself.
• I completely disappointed them.

Different Children, Similar Messages

No matter where these children come from, no matter their substances of choice, and no matter their ages, the message to their parents is the same:

• Be present with me physically and emotionally.
• Build a relationship with me.
• Console me if I am having a problem.
• Do absolutely everything to stay together and not get divorced.
• Don’t let your mental health problems wreck your family’s life.
• Don’t try to buy me with things or trips.
• Give me more attention.
• Have family dinners and get to know me.
• Help me know I’m not a bad person.
• Listen to my point of view. Make sure I know that I can tell you anything without judgment.
• Show me that you love me.
• Take time to learn how I think and feel.

Addiction/mental health challenges often suck the life out of parents due to their enmeshment, and inability to know how to detach and make difficult decisions. To take charge again in their families, parents need support during that first year of recovery when there are so many new challenges. Family programs only begin the journey. Parents have years of parenting habits that maintained an addicted family system. The 5 steps below teach parents how to shift their family, empower their parenting and not let addiction be in charge again. There are very few ongoing programs after treatment that support parents directly. They need an aftercare support while their kid is using to help them rebuild and sustain a strong parental foundation.

From my research and interviews with parents, the following 5 steps of foundational parenting were instrumental in teaching parents to regain their parenting, and restructure their relationships with their kids. Parents who were part of groups, weekend programs and coaching, regained hope and strength to heal their parenting and in turn their families. Identifying concrete action steps or strategies that can be used in their relationship with their kids gives parents something tangible that can be practiced at home daily.

The following 5 steps of Foundational Parenting, teaches parents to:

• Practice being present with their children
• Develop emotional attunement
• Act and respond non judgmentally with their children
• Create sacred family time and recreate rituals
• Clarify values, rules and boundaries-natural/logical consequences

Healthy parenting is vital for a child’s continued sobriety. A healthy parenting approach does not allow for a child’s moods or actions to cause reactions that escalate into a destructive situation. The addiction or threat of a relapse is no longer permitted to rule the home, depleting the parents’ energy and power. When parents are clear about their values and expectations and adhere to them, children can push and test, but healthy parenting doesn’t allow this to influence them into bending the rules. In this way, children know that parents “mean what they say and say what they mean.”

Continued on page 32
Coordinating Palm Beach County’s efforts to keep our communities healthy, safe and drug free.

All members of the community are welcome to join us at the two upcoming events listed below! We are working together to bring awareness to the positive impact that recovery has made in South Florida.

**STAND UP FOR OUR COMMUNITY**  
**REACH OUT FOR RECOVERY RALLY**  
March 10, 2018 9AM-10:30AM  
The block of Old School Square

**MEET THE CANDIDATES MODERATED FORUM**  
March 7, 2018 7:00 PM  
St. Paul’s Episcopal Church  
188 South Swinton Avenue, Delray

Thank you to the following partners and volunteers for coming together and being part of our positive outreach.

For more information on ways to get involved, please contact Joe Bryan (561) 573-5334 or Annie Murray (561) 373-1968
The ancient proverb, “It is better to give than to receive,” having grafted roots in many religions, is acknowledged in the Bible, the Torah, and the Quran. Helping others is a form of altruism, the unselfish interest in the welfare of others. It asks for nothing in return but receives the gift of satisfaction for making a positive difference.

As affirmed by Indian activist and practitioner of non-violence, Mahatma Gandhi (1869 – 1948), “The best way to find yourself is to lose yourself in the service of others.” To give people what they need is the greatest joy. It can be as basic as lending a helping hand, the central theme of one of the most-beloved films of all time.

**It’s a Wonderful Life**

The message of altruism was cleverly articulated by director Frank Capra (1897 – 1991) in his classic film *It’s a Wonderful Life*. Based on The Greatest Gift, written in 1939 by Philip Van Doren, it starred James Stewart as George Bailey, a man who gave up his dreams in order to help others.

Capra’s 1946 epic reflected the desperation of the Great Depression and the Dust Bowl. Times were tough. Nearly 700 banks failed in the waning months of 1929. More than 3,000 collapsed in 1930. Because there was no Federal deposit insurance, when banks failed, people lost their money. By the end of the decade, more than 9,000 banks had failed. Considered among the most critically acclaimed films ever made, *It’s a Wonderful Life*, released after one of America’s bleakest periods, was essentially a film about helping others.

Some researchers believe that helping others helps to relieve stress in the body and is therefore beneficial to our health. There is something valuable, something tangible, when we step outside ourselves and place the welfare of others first. It is empowering to negate our egocentric stance and see the world through the eyes of someone else as we do good deeds and perform good works. Providing help to friends, acquaintances, and even strangers can mitigate the impact of daily stressors on our emotions and our mental health, according to new research published in *Clinical Psychological Science*, a journal of the Association for Psychological Science.

“Our research shows that when we help others we can also help ourselves,” explains study author Emily Ansell of the Yale University School of Medicine. “Stressful days usually lead us to have a worse mood and poorer mental health, but our findings suggest that if we do small things for others, such as holding a door open for someone, we won’t feel as poorly on stressful days.”

Helping others can be transformational, granting ourselves a new awareness and new self-identity. “Extend to each person, no matter how trivial the contact, all the care and kindness and understanding and love that you can muster, and do it with no thought of any reward. Your life will never be the same again,” was espoused by the incredible mind of progressive thinker and author Og Mandino (1923-1996).

What we do is important. We journey through life at different stages of adolescence and maturity, of pain and joy, as we collide, ever so slightly, with one another. We learn from one another, mentoring each other and shaping each other’s destiny. At times, we help others by simply being ourselves, our life story a template leading through example.

To quote the wise and scholarly Ralph Waldo Emerson (1803 – 1882), “Every man is hero and an oracle to somebody, and to that person, whatever he says has an enhanced value.”

American existential psychiatrist Irvin D. Yalom (1931 - ) spoke of the altruism that his patients experienced, many for the first time, during structured group psychotherapy sessions. Yalom, writing in *Theory and Practice of Group Psychotherapy* (1967) said, “From group interactions and interactions within the activity, patients learn that they can be helpful and contribute. This works to increase their sense of self-worth, and their belief in what they have to offer.”

Individuals participating in group psychotherapy discover that their personal experiences, including their lowest moments, have value within the group and that group members may learn from that experience. Those same individuals soon discover that merely by being themselves, merely by existing, they possess self-worth.

**Self-transcendence**

The theme of helping others was viewed as the highest summit of human accomplishment by humanistic psychologist Abraham Maslow (1908 – 1970). Humanistic Psychology attempts to examine what is really right with people, rather than just what is wrong with them. That is to say, it wants to focus on psychological health and well-being rather than merely on mental-emotional-behavioral disorders.

Maslow’s Hierarchy of Needs, developed in 1943, remains one of the most important theories to explain human progress. It provided a framework tracking self-growth and realization of ultimate potential. Maslow initially viewed self-actualization as the highest achievement possible, but later believed that Self-Transcendence – helping others to find self-fulfillment and realize their potential – is the greatest good that we can do as human beings.

Maslow amended his model near the end of his life, rendering the conventional portrayal of his hierarchy incomplete. In his later thinking, he argued that there is another, higher level of development, what he called self-transcendence. We achieve this level by focusing on goals beyond the self like altruism, spiritual awakening, liberation from egocentricity, and ultimately the unity of being.

Maslow wrote: “Transcendence refers to the very highest and most inclusive or holistic levels of human consciousness, behaving and relating, as ends rather than means, to oneself, to significant others, to human beings in general, to other species, to nature, and to the cosmos.”

Placing self-transcendence above self-actualization results in a radically different model. While self-actualization refers to fulfilling your own potential, self-transcendence refers literally to transcending the self. And if successful, self-transcenders often have what Maslow called peak experiences, in which they transcend the individual ego. In such mystical, aesthetic, or...
emotional states one feels intense joy, peace, well-being, and an awareness of ultimate truth and the unity of all things.

**Twelve stepper**

Making a spiritual connection is necessary to achieve joy and happiness. As we search for meaning and for the truth, we explore the mysteries of the ancients. It validates our place and purpose in the world. But, at the end of the day, the truth persists that we are all mystics and teachers and prophets, the oracles cited by Ralph Waldo Emerson. We were put here to teach one another. And, like the mystic emerging from the desert, we too can rise and fall as we embrace the truth.

Alcohol Anonymous remains the driving force behind the premise of being a twelve stepper; a person sharing the message of recovery with those still suffering. It is often heard in the rooms, “in order to keep it, we must give it away.” Step Twelve is about helping others and ourselves to embrace emotional sobriety. It reads: “Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.”

Twelve stepping is a form of stewardship. Of mentoring. It is part of the journey, part of the plan. This mentoring process encourages a connection, a beautiful chemistry or synergy that is greater than the sum of the parts and as tangible as the ebb and flow of the sea.

It is not about us, it is about our purpose in the world. That purpose may be helping others and that may be the greatest thing and the greatest good that we can do.

*Maxim W. Furek, MA, CADC, ICADC has a rich background that includes aspects of psychology, addictions, mental health and music journalism. His book Sheppton: The Myth, Miracle & Music blends facets of the psychological, miraculous and supernatural in a true ordeal of survival. Learn more at shepptonmyth.com*
“You are talking about him again? That is all you talk about. I wish you would talk about something else.”

These are the words that finally got my attention. My daughter had heard enough and she started to voice her opinion. As hard as it was to hear, I started to pay attention to how much I was speaking about her brother in front of her. I started to pay attention to how she was reacting to what was going on in our home. I was consumed with fear for months. I spent hours scheming how to fix her brother. I had no idea the extent to which I, too, had become sick—sick in a way that every action and thought was about my son.

Brothers and sisters have a unique relationship. Sibling bonds are innate. Older siblings are role models for younger siblings. Younger siblings rely on older siblings for protection and safety. Siblings often share problems with each other before they share with their parents.

Siblings are intuitive and know when something is up with their brother or sister. My daughter came in the house one day whispering, “Something is wrong with Gannon. He was falling asleep while he was driving. I had to keep saying his name.” Makenzie had that “uh-oh” feeling which drew my attention to his behaviors.

Sibling bonds are deep-rooted and hard-wired in our children. They cannot help but get sucked into the vacuum of chaos as they worry. They are vulnerable, opening them up to manipulation by their brother or sister. They are often asked to keep secrets. Telling lies to help protect their sibling is normal, and providing urine for a drug test is not an uncommon request. They do not understand the possible consequences of what they do to help their brother or sister.

The once playful, fun relationship becomes distant and one-sided. The sober siblings will grasp onto any attention or time they can steal with their brother or sister. They see the changes and feel the loss, but they do not understand why. Sadly, their sibling does not want to be bothered and does not want to be a part of family events. They definitely do not want anyone going in and out of their bedroom as this has become their sanctuary—a place to isolate and use.

My daughter spent much of her childhood watching her brother play sports. She too played sports and thought her brother would come to watch her play. She asked many times, but he always had a reason not to attend. She vividly remembers the one and only game that her brother attended. He was so high that she was mortified. Her resentments skyrocketed that day. The pain in her face was unbearable for a mother to see.

As caregivers, we cannot forget the healthy children in our family. We need to provide for their basic needs and be emotionally present. Our healthy children can become sick and their emotional needs overlooked. They, too, are hurting just like us. They will lose sleep and become obsessed with worry about their brother or sister. Grades may drop. They may act out to seek attention. They cannot help but get sucked into the vacuum of chaos as they worry. They may act out to seek attention. They may become overachievers in hopes to receive recognition. They are vulnerable, opening them up to manipulation by their哥哥 or sister. They see the changes and feel the loss, but they do not understand why. Sadly, their sibling does not want to be bothered and does not want to be a part of family events. They definitely do not want anyone going in and out of their bedroom as this has become their sanctuary—a place to isolate and use.

Parents become hyper-focused on the child that is using, resulting in our healthy children feeling lost and invisible. Parents do not intentionally move their healthy children to the back burner. We are human beings, far from perfect, and we do the best we can at the time. Putting effort into ensuring the security of my daughter’s emotional state meant asking how she was feeling, talking to her about her school day, and going on mother-daughter dates of her choice. I stopped talking about her brother while she was around. Most importantly, I started to listen more and react less. I did not always understand her feelings, but I worked to respect them.

As parents and caregivers, we can only move forward and make changes based on what we learn. My daughter needed to take care of herself and learned to set boundaries with her brother, just as I did. It was clear that my daughter had valid rights that needed to be addressed. The Sober Siblings Bill of Rights may include, but is not limited to, the following:

1. The right to be “me”—I do not want to be compared to my sibling. I do not want to be embarrassed by my sibling. I am not my sibling.

2. The right to be as equally important to my parents/caregiver—I want my parents to love and care about me as much as my sibling. I don’t want to suffer because of the fallout of my sibling’s addiction.

3. The right to feel safe—I want to feel safe in my own house. I don’t want my belongings stolen. I don’t want my sibling to pressure me into drinking or using drugs with them. I don’t want to hear yelling between my parents and my sibling. I don’t want to be driven anywhere if/when my sibling is using.

4. The right to live without violations of trust—I want people around me to be honest. I don’t want pressure from my sibling to tell lies. I don’t want my sibling asking me for money or to take blame for something they did.

5. The right to share my feelings and have my voice heard—I can love and hate my sibling and miss them all at the same time. I can mourn the person my sibling was before drugs and, or, alcohol. I can be angry at my parents for the time and money they’ve spent on my sibling. I can resent that they are too strict with me because of my sibling’s substance use illness.

6. The right to celebrate my successes—I want someone to notice the good things that I am doing. I want someone to compliment my good grades, feel excited when my team wins and notice when I’ve cleaned my room or gotten a haircut.

7. The right to share my experiences and have a supportive community around me—I do not want to keep the family secret. I need to talk about my sibling with a counselor, a friend or a pastor. I no longer want to feel shame, guilt or loneliness.

Lorri Irrgang is an author, a Certified Peer Recovery Coach and the President/CEO of “Let’s Get Real,” a family advocacy organization. She writes a column for the local paper, the Cecil Whig, called “Shift the Focus.” Lorri is a Family Peer Support Specialist for the Maryland Coalition of Families (MCF). She is a member of several local committees; Drug Free Communities Coalition and Drug Free Cecil. Through Lorri’s seven years of work in this field, she has become an advocate for a continuum of care that promotes family stability and unification. She believes this holistic approach improves the likelihood of successful recovery for the whole family.
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COCAINE ANONYMOUS  WWW.CA.ORG  310-559-5833
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NATIONAL COUNCIL ON PROBLEM GAMBLING  WWW.NCPGAMBLING.ORG  800-522-4700
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HOARDING  WWW.HOARDINGCLEANUP.COM
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THE BOTTOM LINE  954-735-7178
Anyone familiar with Greek mythology knows it doesn’t turn out so well for Narcissus. So transfixed with his own beauty, Narcissus died staring at his reflection in a pond. Of course this is where we get the term narcissism, a personality disorder seeping into the cracks of every corner of society. It may not have always been this way, but it’s important to examine the cultural drivers running compassion and regard off the road.

As I’ve written about narcissism before, the behavior is defined as a mental disorder in which people have an inflated sense of their own importance, a deep need for admiration and a lack of empathy for others. But behind this mask of ultra-confidence lies a fragile self-esteem that’s vulnerable to the slightest criticism.

One can imagine the kinds of problems this can cause in many areas of life. Individuals who experience narcissistic personality disorder may feel generally unhappy and disappointed when they are not given the special favors or admiration they believe they deserve. Others may not enjoy being around people with this type of personality disorder. And when communication breaks down in relationships, this can exacerbate the issue.

But how does one move from positive regard for others to an inflated sense of self? The obvious drivers are money and status, two sources that can feed the human ego with reckless abandon. Another prominent influencer, as evidenced in the #metoo movement, is power dynamics. An individual with a puffed up ego and the power to back it gives narcissism a nitro boost with little to stop it.

The first step to breaking down the walls of narcissism is by recognizing the behavior. According to the Diagnostic Statistical Manual, here are signs of developing narcissistic personality disorder:

• Demonstrate an exaggerated sense of self-importance - "It’s all about me" or “I am the best”
• Expect special favors and unquestioning compliance with your expectations - “You must do this now”
• Take advantage of others to get what you want - “Do what I say or else”
• Have an inability or unwillingness to recognize the needs and feelings of others (i.e. lack of empathy)
• Feel envious of others and believe others envy you
• Behave in an arrogant or haughty manner
• Expect to be recognized as superior even without achievements that warrant it - “I deserve this”
• Exaggerate your achievements and talents - “I am a super power”
• Dwell on fantasies about success, power, brilliance, beauty or the perfect mate

Another danger of narcissistic personality disorder - beyond an inflated ego - is that it can develop into or fuel other personality disorders, which complicate matters further. At the heart of this is attachment theory, a framework for understanding how humans interact in the world through friendships, relationships and family dynamics. There are four types of attachment:

• Secure
  - Positive view of self and others
  - Independent, secure and trusting
  - Comfortable with emotional intimacy and closeness
• Avoidant
  - Positive view of self with a negative view of others
  - Independent and self-reliant
  - Difficult to get close with others - puts up walls
  - Leaves or avoids during conflict
• Anxious
  - Negative view of self with a positive view of others
  - Dependent
  - Fear of losing relationships; clingy
  - Emotional highs and lows; may get aggressive

When attachment theory plays out in human interactions, narcissism can play a central role in the way these relationships develop. It’s important to look for the signs and seek out help if you or a loved one experiences these kinds of behaviors.

A prime example of narcissism’s choke hold on society at the moment is playing out in Silicon Valley. In Emily Chang’s new book, *Brotopia*, titans of tech are reportedly throwing orgiastic parties overflowing with drugs and young women. And “while the guys get laid [and] the women get screwed,” a hedonistic spirit takes over and the similar power structures at the heart of “Me Too” take hold.

According to the new book, corroborated by nearly two dozen people who have attended these events, the hot shots who host these parties talk them up without shame or discretion. Quite the opposite actually, the behavior “at these high-end parties is an extension of the progressiveness and open-mindedness that makes founders think they can change the world. And they believe that their entitlement to disrupt doesn’t stop at technology; it extends to society as well,” writes Chang.

Where does this entitlement come from? I’ve previously written about entitlement -- top executives, actors, celebrities and sports stars who have amassed influence and fame and feel that they deserve their latest want. This opens the doors to rampant process disorders (i.e. gambling, sex, money) and addiction because the power structures in place do little to stop it. And now a similar entitlement has seeped into tech founders and company leaders, but perhaps in a bigger way.

The reason lies in the very nature of tech companies and the wider influence these products, apps and social networks have on the world. The founder of a tech company, interviewed for the *Vanity Fair* article, put it this way: “we have more cachet than a random rich dude because we make products that touch people’s lives for years.” As such, actors like Leonardo DiCaprio, Ashton Kutcher and Jared Leto, eager to get a slice of the tech boom pie, have made personal investments in tech companies. I guess tech money even overshadows winning an Oscar.

The attitude tech founders have about their impact on the world may explain the sexism many women feel in these situations. For instance, the attendees to these lavish parties are disproportionately young women. But that’s no accident. The men at these parties want more women there so they have more to choose from. And if you’re not invited to one of these parties, plenty of women interviewed said they may be missing out on career opportunities because attendees talk business. So it’s a lose-lose

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BE THE CHANGE

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further increase cravings and discomfort. Heightened pathological and substance-seeking behavior may then become necessary to provide the same pleasurable response and/or temporarily decrease uncontrollable cravings. The behavior, or drug of choice by the individual, is a function of both genes and environmental factors like stress, availability, and peer pressure.

GARS™ Testing for Clinicians and Patients

Previously, we presented data on the potential of GARS to predict vulnerability or risk for both drug and alcohol severity as measured by the Addiction – Severity Index (ASI). However, a frequently raised question relates to how GARS testing can be beneficial in known addicts already in treatment programs. We believe that there are many important reasons for GARS testing in people expressing addictive behaviors of all types.

The Genetic Addiction Risk Score (GARS), which predicts vulnerability to pain, addiction, and various other compulsive behaviors, provides benefits for individuals suffering from Substance Use Disorder (SUD). Knowledge of a person’s precise polymorphic associations can help in the attenuation of guilt and denial, and the corroboration of family genograms. For the clinician, GARS can help to inform risk-severity-based decisions including appropriate therapies (pain medications and risk for addiction), choice of the appropriate level of care placement (inpatient, outpatient, intensive outpatient, residential), length of stay in treatment, and relapse and recovery liability and vulnerability. GARS can also predict some pharmacogenetic clinical outcomes (e.g., the A1 allele of the DRD2 gene reduces the binding to opioid receptors in the brain, thus, reducing naltrexone’s clinical effectiveness), and support medical necessity for insurance scrutiny. Innovative strategies to combat epidemic opioid addiction, iatrogenic prescription drug abuse, and death, based on the role of dopaminergic tone in pain pathways, have been previously proposed. Sensitivity to pain may reside in the mesolimbic projection system, where genetic polymorphisms associate with a predisposition to pain vulnerability or tolerance [4]. These polymorphisms provide specific targets to assist in the treatment of pain and identify risk for subsequent addiction. Testing for inherited variations among candidate genes like DRD1, 2, 3, 4, MOA-A, COMT, DAT1, 5HTTLPR/SLC6A4, OPRM1 and GABRB3 could lead to more personalized prescribing and improved clinical outcomes. Genetically identified risk to RDS behaviors, especially within compromised populations, may also be a frontline tool to assist municipalities in providing better resource allocation.

It is important to be cautious of genetic testing that uncovers reward circuitry gene polymorphisms, particularly those linked to dopaminergic pathways as well as opioid receptor(s) as a method of obtaining better treatment results. Comprehending the relationship between the reward circuitry’s participation in buprenorphine outcomes and its corresponding genotypes deliver an innovative model to enhance a patient’s clinical experience and improvements throughout opioid replacement therapy. Both NIDA and NIAAA are desperately investigating an array of innovative ideas to help restore brain function, especially hypodominergia, and we believe that our approach should be carefully considered and tested. In due respect, we are encouraging scientists and clinicians to at least embrace these simple concepts in the near future, thus providing a new message of hope to the many victims of overdose and death. The future is now and we call it Precision Addiction Management (patent protected). A disruptive novel technology whereby we couple:

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KENNETH BLUM, B.Sc. (Pharmacy), M.Sc., Ph.D. & DHL; received his Ph.D. in Neuropharmacology from New York Medical College and graduated from Columbia University and New Jersey College of Medicine. He also received a doctor of humane letters from Saint Martin’s University Lacey, WA. He has published more than 550 abstracts; peer-reviewed articles and 14-books. www.geneushealth.com www.restoregen.com

Jennifer Neary MS, PhD serves as Chief Scientific Officer for Avagen Health in San Antonio, Texas. Her research background includes microbial genetics, mammalian genetics/epigenetics, and bioinformatics, with specific emphasis on psychiatric and metabolic disorders.

Mary Hauser has worked in the addictions and behavioral health field for the past forty two years. She has directed clinical and research programs in Wisconsin and Rhode Island. While in Milwaukee at Mount Sinai Medical Center she was the oversight Vice President of the Departments of Psychiatry and Behavioral Health. Ms. Hauser was a founding member of the Board of the Wisconsin Alcohol and Drug Certification Board and helped develop the 12 core functions of counseling. After relocating to Rhode Island in 1989, Ms. Hauser was appointed Executive Administrator for Research, Psychiatry and Behavioral Medicine at The Miriam Hospital. Ms Hauser was also the Executive Administrator for Psychiatry at Brown University Medical School in Providence RI. Ms Hauser joined Dominion Diagnostics as Vice President of Addiction Services. She continues in this position currently.

NARCISSISM - ALIVE AND WELL IN BROTOPIA

By Louise A. Stanger, Ed.d, LCSW, CIP, CDWF and Roger Porter

Continued from page 28

for those who aren’t wealthy top brass and founders. Still, there is plenty of criticism for the notion that the powerful men at these parties are disruptors and innovators. “That’s exploitation. That’s old-school masculine arrogance and borderline prostitution,” says Elisabeth Sheff, a writer and professor who researches open relationships. “It’s trying to blend the new and keeping the old attitudes, and those old attitudes are based in patriarchy, so they come at the expense of women.”

When researching for this article, I was reminded of my piece about the highly addictive drug meth making its way into Silicon Valley inner circles. In similar ways, drugs are used at these parties as a way of removing inhibitions and facilitating sexual activity. Indeed, the look and feel of these parties are disruptors and innovators. “That’s exploitation. That’s old-school masculine arrogance and borderline prostitution,” says Elisabeth Sheff, a writer and professor who researches open relationships. “It’s trying to blend the new and keeping the old attitudes, and those old attitudes are based in patriarchy, so they come at the expense of women.”

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Dr. Louise Stanger founded All About Interventions because she is passionate about helping families whose loved ones experience substance abuse, mental health, process addictions and chronic pain. She is committed to showing up for her clients and facilitating lasting change so families are free from sleepless, worrisome nights. Additionally, she speaks about these topics all around the country, trains staff at many treatment centers, and develops original family programs. To learn more, watch this video: www.youtube.com/watch?v=hDi5262P7I8 and visit her website at allaboutinterventions.com.

Roger graduated with two degrees from the University of Texas at Austin. He works in the entertainment industry and writes for film and television.
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HUMANITY LOST
POLITICIZATION OF OPIOID EPIDEMIC PROVES DEADLY FOR ADDICTS

By John Giordano, Doctor of Humane Letters, MAC, CAP

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Sessions has never shied away from his position of strict adherence to the letter of the law and his belief in harsh punishments. As Alabama’s Attorney General, Sessions strongly supported state legislation seeking to punish a second drug trafficking conviction, including dealing marijuana, with a mandatory minimum death sentence. In 2005 as a senator, Sessions was one of nine Senators who scuttled a Senate amendment to a House bill that prohibited cruel, inhumane, or degrading treatment or punishment of individuals in the custody or under the physical control of the United States Government; and in 2015 opposed and defeated the bipartisan bill “Sentencing Reform and Corrections Act,” which sought to reduce mandatory minimum sentences for some nonviolent crimes.

On May 12, 2017, just months after recusing himself from any investigations into Russia’s interference in the 2016 presidential election, Sessions issued a two-page memo ordering federal prosecutors to “charge and pursue the most serious, readily provable offense.”

“By definition, the most serious offenses are those that carry the most substantial guidelines sentence, including mandatory minimum sentences.”

In a press conference, Sessions claims that the new direction is not pointed at low-level drug users; “If you are a drug trafficker,” he said, “we will not look the other way. We will not be willfully blind to your misconduct.”

However, this is coming from a man who believes that it is marijuana and not prescription opioid painkillers that is fueling opioid addiction. In a recent press conference, Sessions stated that, “The DEA said a huge percentage of the heroin addictions start with prescriptions. That may be an exaggerated number—they had it as high as 80 percent—we think a lot of this is starting with marijuana or other drugs, too.”

But what I find most concerning is the solution Sessions believes will curtail doctors from prescribing opioid painkillers. According to Graham Media Group/ClickOrlando.com, Sessions stated that, “the DEA will now ask medical practitioners when they apply or renew their license to indicate whether they have received training on prescribing opioids.” That, he hopes, will prevent doctors from overprescribing addictive drugs.

On December 22, 2017, Sessions rescinded guidelines intended to warn local courts against imposing excessive fines and fees on poor defendants.

In October 2017 and again in January 2018, the President of the United States of America declared the opioid crisis a public health emergency. However, if you think that means that he has put the best and brightest minds in the county to work in eradicating this epidemic, you are sorely off the mark. Instead, the President has placed political loyalists with little to no health, medical and/or addiction experience in positions of authority to determine drug policy and the best course of action to end this raging epidemic, and in doing so, usurping the opinions, positions and policies of seasoned and experienced addiction experts. What could possibly go wrong?!?

64,000 Americans died avoidable deaths in 2016 at the hands of prescription and illicit drugs – 175 lives a day – and more than 600,000 Americans died from drug overdoses between 2000 and 2016. Everyone personally knows someone afflicted by this disease. According to the Centers for Disease Control and Prevention, drug overdoses are now the leading cause of death for Americans under 50. The human cost of this epidemic – the loss of American lives – is staggering and this is the best this administration can do?!

My only advice to anyone addicted, anyone who has a loved one who is addicted or is relapsing chronically- is to find treatment right away. The handwriting is on the wall – the time and opportunity to get treatment is never going to be any better than it is right now.

John Giordano is the founder of Life Enhancement Aftercare & Chronic Relapse Recovery Center, an Addiction Treatment Consultant, President and Founder of the National Institute for Holistic Addiction Studies, Chaplain of the North Miami Police Department and is the Second Vice President of the Greater North Miami Beach Chamber of Commerce. He is on the editorial board of the highly respected scientific Journal of Reward Deficiency Syndrome and has contributed to over 65 papers published in peer-reviewed scientific and medical journals. For the latest development in cutting-edge addiction treatment, check out his websites: www.PreventAddictionRelapse.com www.HolisticAddictionInfo.com

HOW TO MEET THE CHALLENGE OF THE IMPAIRED PROFESSIONAL

By Link Christin, JD, MA, LADC

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• Engage in activities which focus your mind on something besides your addiction or life problems: Meditation, yoga, exercise, fishing, golfing, reading, movies, massages, etc.

The good news is once these professionals begin a recovery program they are more successful than most. And better than ever. Everything is possible once the impaired professional can navigate the tricky currents to treatment and recovery.

Link Christin is the Executive Director of the Legal Professionals Program at Caron Treatment Centers. He is an attorney, licensed and board-certified drug and addiction counselor, therapist, speaker, and author. He has focused for the last seven years exclusively on the treatment of impaired legal professionals in both residential and outpatient settings. www.caron.org

“PARENTING THE ADDICTED TEEN AND YOUNG ADULT” 5 KEY STRATEGIES TO HELP PARENTS THRIVE

By Barbara Krovitz-Neren, MA

Continued from page 22

One parent so eloquently shared this message after a year of working on these 5 steps, “I can finally own my emotions, our family values and create a family where addiction no longer rules our life.” Recovering teens and young adults need parents on board to provide a healthy family to help them sustain their recovery and deal more effectively with the ongoing high rate of relapse. Parents also need support during the first year of their loved ones recovery to help them maintain healthy parenting and healthy family so they can learn how to detach emotionally without abandoning their kids.

Barbara Krovitz-Neren coaches parents of teens and young adults who are chemically dependent or have mental health challenges and consults with programs to enhance parent involvement in recovery using her foundational parenting model. She has been a youth and parenting advocate for more than thirty-five years. As a pioneer in the addiction prevention field, she has created dynamic programs that have impacted more than 50,000 youth, adolescents, and young adults around the country. Barbara has trained individuals in school districts, community social service agencies, and parent groups, both nationally and internationally. She was also one of the founding board members of the National Association of Children of Alcoholics. Her work on behalf of children and families has earned her numerous awards over the years. The 5-Step Foundational Parenting Program is the culmination of her life’s work in her new book, “Parenting the Addicted Teen, a 5 Step Foundational Program.” Published by Central Recovery Press. www.competentparents.com

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DYING YOUNG: DEPRESSION, SUBSTANCE USE DISORDERS AND SUICIDE
By Mark S. Gold, M.D. and Dr. Drew W. Edwards
Continued from page 6

What’s the connection?
The oldest theory asserts that substance abusers incur so much failure in their life and loss of important relationships that in their minds, suicide is a viable means to end their suffering and the differing of those who love them. In addition, we have established the causal effects of intoxicants and neuroadaptive changes within the brains pleasure and reward systems, as well as degradation to the neural circuitry involved in mood and inhibitory control.

Genetics: We know that the risk for both SUDs and depression are heritable, and thus more likely to manifest in the children of parents with either disorder. Notice we didn’t say “cause” we said increase the “risk”. However, the combination of a genetic risk, plus the exposure to intoxicants, especially early in life, dramatically increases the risk of developing either or both disorders. In fact, the concordance rate for SUDs and Depression is bi-directional and somewhere between 45-65 percent. Among the treatment population, the risk is closer to 70 percent. The risk is even greater when a parent or sibling experiences one or more psychotic episodes.

Neurobiology
Both SUD and depression are thought to be rooted in the activity of specific neurotransmitters called catecholamines (dopamine, epinephrine, and norepinephrine, as well as serotonin in the midbrain, frontal and prefrontal areas). Dysfunction in neurotransmission involving these neurotransmitters are implicated in neurologic and neuropsychiatric disorders including SUDs, Depression and Bi-Polar disease, Anxiety, Psychosis and even Parkinson’s Disease.

Collectively known as the reward center or reward pathway, drugs of abuse impact the volume and activity of the aforementioned neurotransmitters. Many drugs of abuse have chemical structures similar to endogenous neurotransmitters and bind to selective protein receptors that are reserved for transmitting dopamine, noradrenalin, and serotonin. When this occurs, the brain has been usurped by exogenous and toxic substances which produce acute euphoria, but in the process, degrade the normal and essential neuronal signaling between important centers in the brain and the body. Therefore, addiction and mental illness commonly co-occur and must be addressed and treated aggressively.

But which came first the addiction or the depression?
The answer is “it doesn’t matter”. Good medicine understands that co-occurring illness must be treated concurrently. In the case of SUDs, untreated or underrated depression leads to relapse, remorse, shame and increases the risk of suicide.

Evaluation and treatment must be multimodal. Patients who are dually diagnosed with depression and SUD’s are at increased risk for suicide and should be treated as such until stabilized. It takes a highly trained doctor, boarded in psychiatry and addiction medicine, or addiction psychiatry to effectively care for an individual with dual disorders. Equally important is the work of the therapist with the family in understanding the stressors that can be modified, especially when the patient is a teen or young adult.

Evaluation
A psychiatric evaluation is conducted for any patient that has been treated for, or attempted suicide. Because the concordance rate between SUDs and depression is so high, depression should be thoroughly assessed throughout the treatment process. Many depressed teens get a cursory evaluation and quickly find themselves prescribed antidepressants. The goals of the psychiatric evaluation include;

• Getting a complete Family Medical and Psychiatric History
• Physical, Psychoeducational and Neurological examination-evaluation looking for diseases which might cause anhedonia, depression, loss of energy, as well as for medical mimics of psychiatric disease
• Identifying family expectations, educational and other goals and comparing them to the child’s goals, aptitudes, and testing
• Identifying Drug and/or Alcohol abuse or dependence. Determining the risk of subsequent suicide attempt or suicide completion
• Identifying sexual or emotional trauma, familial, environmental and other predisposing stressors and precipitating factors that can be treated or modified
• Psychological treatment for depressed and stabilized dually disordered persons may include Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Motivational Interviewing (MI) and structured, symptom driven treatment (inpatient, partial hospital, or outpatient care)

As mentioned, a psychiatric assessment should be performed by clinicians with specialized training and experience in adolescent psychiatry, as well as addictive disease whenever possible.

The process gathers essential information from several sources including the family, previous psychiatric evaluation or assessments, school or EAP assessments, patient interviews and testing as well as family members. This is most productive when family interviews are conducted with the patient present and separately. This technique reveals important family and relational dynamics.

Suicidal ideation, suicide plan and intent are considered a medical emergency. Urgency and timeliness is the key. On demand psychiatric triage for these emergencies and same day appointments after acute care has been the most efficacious model, especially among the student population utilizing campus mental health centers. Evaluating suicidality, lethality and the risk for future attempts is a critical component of individualized, patient centered care. Information regarding concurrent psychiatric, medical or substance abuse diagnoses and a thorough understanding of the precipitating or inciting event is critically important when assessing copings skills, resilience and risk.

Treatment
Once evaluated, treatment should begin immediately with regularly scheduled re-assessments of symptoms. If SUD is diagnosed— a program that employs dually credentialed (psychiatry and addiction medicine) physicians is essential.

Both depression and SUDs are serious and life threatening disorders of the brain— but are also highly treatable. Early recognition is critical. On the prevention side, it’s equally important to teach parents and school personal about both disorders, how to identify risk factors, and how to intervene when symptoms occur.

References Provided Upon Request

Dr. Mark S. Gold is Chairman of the RiverMend Health Scientific Advisory Boards. He is an award-winning expert on the effects of opiates, cocaine, food and addiction on the brain. His work over the past 40 years has led to new treatments for addiction and obesity which are still in widespread use today. He has authored over 1000 medical articles, chapters, abstracts, journals, and twelve professional books on a wide variety of psychiatric research subjects, including psychiatric comorbidity, detox and addiction treatment practice guidelines. www.riverrmendhealth.com

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