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Vol. 16 No. 1

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Ms. Karen Relf has served as a Corporate Services Clinician at the Illinois Institute for Addiction Recovery at The Abbey in Bettendorf, Iowa, since January of 2010. In this capacity, Relf orchestrates the admission process for out-of-state and local clients for ease of entry into treatment, cultivates professional relationships with various service providers to ensure best practice for client care, develops and facilitates onsite and offsite training series and workshops for professionals and community members, conducts addiction assessments as needed, and promotes and markets the services of the Illinois Institute for Addiction Recovery locally and nationally. Prior to her work at the Illinois Institute, she was employed for over twenty-three years at a Quad City community-based service organization. Throughout her tenure there, she provided direct services to individuals and families, authored and administered many successful grants, conducted workshops and trainings for community service providers, and served on the organization's management team.

Ms. Relf earned her Bachelor's degree in Education from the University of Northern Iowa in Cedar Falls, Iowa, and her Master's degree in Education and Interdisciplinary Studies from Western Illinois University in Macomb, Illinois. Relf holds a strong conviction in the importance and value of education, and this belief has been the foundation for her service throughout her professional career.

For over twenty-five years, Ms. Relf has had the opportunity to interact with a diverse population of individuals of various ages, backgrounds, and experiences. Much of her work practice has included educating, guiding, coaching, and ultimately empowering people to make healthier decisions to better themselves and improve their circumstances. Ms. Relf has a rich history of creating curricula and developing workshops and presentations regarding the disease and the prevention of addiction, sexuality education, teenage pregnancy prevention, eating disorders, parenting education, life-skill development, and AIDS instruction. She has been published in *The Leader*, a publication of Active Parenting Publishers, and has presented locally and nationally on various health-related issues.

Ms. Relf is a Quad City native and a very proud parent of two (now adult) daughters, Anna and Samantha. In addition to spending time with family and friends, she is active in her church and enjoys singing, writing, and walking. Ms. Relf is also a passionate biker (the pedaling type), with three RAGBRAI journeys under her belt.

PROCTOR
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Cover art courtesy of NARSAD Titled "The Winding Road" by Jan Kobe

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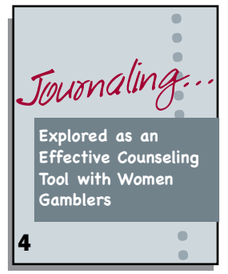

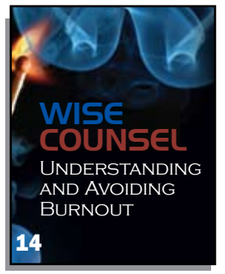

FEATURES

DEPARTMENTS

Journaling...

Explored as an Effective Counseling Tool with Women Gamblers

By Sonya Corbin Dwyer, PhD, Noëlla Piquette-Tomei, PhD, Jennifer L. Buckle, PhD and Evelyn McCaslin, MEd

With ever-increasing opportunities to gamble and a record number of women reporting problem gambling, evidence-based treatment protocols closing the gap between research and practice are required to best treat female gamblers. One tool with the potential to enhance gambling treatment is journaling.

The process of journaling has been called "expressive writing" or "therapeutic writing" (Kerner & Fitzpatrick, 2007). Just as these terms are often used interchangeably, there is no single approach that can be recommended for every client (Stone, 1998). Stone maintains that it is journaling's process, not its content, that offers enduring benefits. Calling journaling storytelling to ourselves, Stone claims our stories are how we interpret our lives.

Journaling has been shown to have diverse therapeutic benefits (Zyromski, 2007): clients can use journaling to create their narrative, track their emotions and cognitions, and use this information to make decisions and evaluate their progress. It has the potential to provide clients with a means for working on their issues between sessions and offers another tool for reflection and contemplation (Stone, 1998). This approach, however, is underutilized in many settings.

This article presents one aspect of a larger study focused on the success of an all-woman therapy group for problem gamblers and considers the effectiveness of the journaling process as a therapeutic technique.

Study Background

Selected participants in this study were those attending an all-woman gambling counseling group offered through a health agency in a Canadian city. The goals of the group were to provide education, therapy, and support for women problem gamblers.

For the study, the women were provided journals and asked to reflect on their experiences, thoughts, and emotions after their weekly meeting. Data were gathered from the participants over a six-month period. At the conclusion of six months, the women were invited to continue reflecting on their experiences through a semi-structured, individual interview. At the end of the study, all participants were given an additional data collection tool, a Research Evaluation Form, which asked for feedback on the research process. Questions included *Was the journaling helpful in providing you with insight into your gambling?* and *What did you like best/least about the journaling?* The women's journals, interviews, and Research Evaluation Forms were then analyzed for themes using hermeneutic phenomenology.

Journaling as a Counseling Tool

The concept of journaling can be intimidating, particularly for people who believe "I can't write." Because short, structured, contained entries can lead to open-ended, unstructured journaling, the women were given a sample of journal entry starters to help them develop journaling skills (Adams, 1998). The women had not previously used journaling as part of the group intervention, so for most of them, this process was new.

Nine women completed the Research Evaluation Forms, which provided the researchers feedback on the journaling process. Out of the nine women, seven submitted journals. Five indicated they found the journaling beneficial and enjoyable, while four did not.

The words of the participants are used below to describe and expound the meaning of their experience. Although they are presented individually, these sentiments were in actuality intertwined throughout the women's stories of their experiences of participating in the group:

"Intimate details on paper can be very liberating."

"It helped me to realize where I had been, where I currently am and where I hope to go in the future. The need to analyze what was done at group, the need to pay more attention at the meetings to my thoughts and feelings so I can journal."

"You can write down your anger, be it at yourself, someone else, etc. and no one gets hurt."

In response to the question of whether journaling was helpful in providing insight into her gambling, one woman wrote, "Absolutely. I'd write down a question asked, or some question I was asking myself or whatever came to mind. I was surprised (am)." In response to the question *Was the journaling helpful in providing you with insight into your issues?* she wrote: "Yes, yes, yes. I have written volumes of rationalizations, then self condemnations—then I saw how isolated and self destructive I had become." The same woman wrote that what she liked best about journaling was that "When journaling, I can hear my thoughts before I place them on paper. It is an excellent way to **listen**—to slow down."

Another woman noted on the Research Evaluation Form that she "did not do a lot of journaling as it reminded me of the terrible addiction I had." However, looking at her journal, she wrote two reflective entries: over five pages on one day at the beginning of the research study, and almost five pages on one day three months later.

In response to the question *Was the journaling helpful in providing you with insight into your issues?* a woman who reported she was "*not really a journalist*" responded "yes," and that what she liked best about journaling was "getting it off my chest," though she disliked "reading back all the things I did."

For many of the women, the journaling they engaged in for this study was beneficial. Results illustrate that the participants often felt helped by the journaling process, gaining insight into their own behavior and motivation. It is important to note, however, that this was not the case for all participants. "*Journaling this time did not give me insight,*" one woman wrote. "But when I first quit gambling, journaling definitely helped, as well it helped release a lot of anger. I find with journaling that you think you have nothing to write down but once you start writing, those deep-dark feelings come flowing thru your pen." She acknowledged that "trying to get into the habit" was something she disliked about the process.

Those who found that journaling did not provide insight often explained it as a failure of their writing ability: "I am not a writing person. I prefer to express myself verbally;" "Not really a journalist;" "When you look at my journal, you will see it consists mainly of my excuses for not journaling. I feel badly that I had such a block when it came to writing;" "I need direct questions. I am not very disciplined in just writing."

When asked what they liked least, one woman noted "That I was the only one listening—and that my perceptions are often narrow minded or **self centered**. Me-me-me." Another wrote, "I sometimes feel I am too repetitive and not gaining from the experience." Another said the journaling process didn't help provide insight into her issues because "I seem to be partially unaware of my issues, or at least in denial as to what they are and how I can identify them or what I need to do."

Reflections on the Study and Journaling Process

For the women in the group who utilized journal writing, the process appeared to serve as an important addition to therapy. Journaling provided an opportunity to add thoughts and explore issues that came up in or out of therapy in greater detail. The women also had the opportunity to share their journal in group, an added opportunity to discuss its contents with the therapist and the other group members.

While participants' responses illustrate that most perceived the journaling process as beneficial, there were different reasons for the positive perceptions. Journaling helped some of the women pay more attention to their thoughts and feelings. It also helped extend the process of self-reflection outside the group meeting. It is also important to note that one woman found seeing details of her addiction on paper very difficult. Likewise, the reasons women gave for disliking journaling are consistent with the literature (Adams, 1998), not being a writer and not having time being the two biggest hurdles. However, was it the process of writing or the process of reflection that the women found uncomfortable? Stone (1998) emphasizes that the skill of reflection, like all skills, needs to be practiced, and that journaling is only one way of becoming reflective.

As this study was the first time most of the women engaged in journaling about gambling treatment, the task may have been too abstract or undefined. While most of the women were long-time group members in various stages of recovery, they may have needed explicit instructions in developing journaling skills: building structure, containment, and pacing in their journals (Adams, 1998). Journaling has to feel safe, comfortable, and nurturing. This was accomplished for some of the women, but not all. Likewise, as with any therapeutic technique, it is not universally applicable (Stone, 1998). It is not a good fit for all clients at all stages of their recovery. This may be a difficult balance to achieve in a group counseling setting.

Future Directions

Findings from this study can only be directly applied to the group of women studied; results cannot be generalized to all women-specific group counseling for problem gambling. This research, however, is an important starting point of inquiry for other researchers and practitioners. When considering journaling in a group counseling setting, the facilitator should consider structured versus informal journaling approaches, cultural implications and considerations, and whether participation is compulsory or voluntary. The benefits of journaling suggest that it can be an effective component of group counseling for women problem gamblers as it provides an opportunity for women to write their own stories, and, by doing so, create their own narrative of addiction and recovery.▼

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Authors' Notes

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AGGRESSION and Emotional Maturation

...aggression turned against the self early in life can inhibit emotional maturation.

By Joseph Acosta, LPC

It's the blank stare that gives it away.
What did you say? You are saying that it might be helpful for my patients to get mad at me?
A lengthy silence ensues.
Yes, that's right, I say. Welcoming your patients' anger can be an essential part of emotional development.
The silence lingers. I can see thought processes firing, a facial expression that seems to say "does not compute."

Group therapy is a powerful therapeutic modality for emotional maturation. Because group therapy offers multiple levels of relating, many psychological resistances can be addressed and interpersonal functioning improved. *The hallmark of emotional maturation is the capacity to be emotionally connected with oneself and simultaneously connected with others.* Getting emotionally connected with oneself means tolerating and allowing full ranges of emotions, from sadness to fear and joy to rage.

A Full Spectrum of Feeling

When I ask potential group members what they would like to accomplish in group, I often hear: "I just want to be happy." Many of us are content with the upbeat side of the feelings spectrum, yet not so content with its more challenging side. Whenever I hear "I just want to be happy," I wonder what objections this group candidate might have to feeling sadness, fear and anger. What kind of complicated grief reactions remain? How does this group candidate deal with rejection? How does his or her aggression work internally? Does aggression emerge in some form of acting out? Has a self-attack thinking system developed?

Hyman Spotnitz first introduced the idea that aggression turned against the self early in life can inhibit emotional maturation. Trained as a neurologist, Spotnitz studied how people developed emotionally. He noticed what happened when his patients blocked certain feelings and became particularly interested in blocked aggression. When stifled, aggression can turn back on the self and become a circular system of self-attack. Spotnitz believed this self-inhibition hobbles a person's capacity to connect with others. We see this in action when new patients come to our offices and simply talk as if another person were not even present. I experience these patients as self-sealed people who contain emotional processes internally. Often, they will tell stories about events in their lives. One story morphs into the next and ten minutes will pass without interruption. When I experience this with a new patient I move slowly because I understand this protective mechanism has developed for good reasons.

In group therapy, we want our patients to learn to simultaneously be fully aware of themselves while engaging emotionally with others. If a group member has a strong internal self-attack system, emotional engagement with other group members is not possible. Once such a member has become established in group, we begin noticing and describing the ways self-attack systems work. We don't try to change anything; we simply begin to articulate how the internal system operates. We want the group to get involved by articulating the processes and noticing them when they are active in group. We also have the understanding that one day, the full force of that stifled aggression will be directed toward the group leader.

Handling Aggression in Group: Detecting Internal Responses

Many group therapists have a natural inclination "to be there" for patients suffering with grief, loneliness, and isolation. For some therapists, the very thought of a patient being angry with them sends shivers through their nervous systems. At worst, an angry patient stirs the deep fear of potential legal action. These reactions can create a dead-end for accessing the emotional life hidden behind a group member's aggression.

Most of us find aggression directed our way uncomfortable. Indeed, the fight or flight response of the limbic system activates quickly when we're addressed aggressively. Before we even become consciously aware of what is happening, the limbic system responds in as few as 14 milliseconds, with conscious thought occurring around 300 milliseconds. We are wired to respond instinctively—to fight or flee to survive threat. It is this very threshold of the limbic system's activation and conscious thought that we actively work with in group. Once a patient has had an internal limbic system response and the resulting neurophysiological activation, we can begin to detect aggression. My favorite question, much to the irritation of my group members, is "what just happened?" Immediately, the group member in question begins to engage the neocortex as the limbic system activates.
"Struggle finding words," I say. "This is what creates new neural pathways."
"Umm, I don't know," the group member struggles. "Well, I notice this sensation in my...."
"Yes, yes," I respond.
Once a group member can be made aware of most internal responses, we can start thinking more about inviting them to relate with other group members emotionally. Slowly, we work with the self-sealed system, gradually working towards a relational system in group.

Mark's Story
Take "Mark," for example. Mark wanted to join group because of severe isolation. His individual therapist had diagnosed him with Asperger syndrome and referred him to group to learn social skills. In the first few weeks of group, he sat quietly and listened. Within a few months, Mark began telling the stories of his painful dating experiences and revealed his contempt towards women. Unbeknownst to the group and me, he harbored rage towards women for having had only a few sexual experiences in his lifetime. As he became more comfortable in group, he seethed speaking of the many women who had rejected his invitations. It became clear that he had an immense tank of rage stored inside. I also realized he hurt deeply. Yet because he was so cautious around people, I thought we wouldn't see any of his sadness or despair in group until he knew he was safe feeling his rage.

I joined his rage, raising my voice as he raised his, wondering why these women treated him the way they did.
"Why don't they see what you have to offer?" I would ask emphatically.
"Yes, yes," he would respond.

This scenario repeated itself for a few months. All along I had the sense we were boring down on the hardened emotional cap covering his sadness. I knew we would repeat this emotional cycle over and over again. A hardened cap of aggression often protects a much deeper and more painful well of sorrow and isolation. I believed the repetitive cycle of being aggressive with each other in group was creating a safer container for much more painful feelings to emerge. I strongly believed that welcoming and joining his aggression was an emotional communication that would allow for the emergence of something else we could not yet know.

Then, one group, we engaged in the familiar cycle of wondering why women did not take interest in him. We exchanged all the established words with angry affect. And then I noticed a softening in his face. "What just happened?" I asked.
Without hesitation he said, "I feel sad."
Inside, I was overjoyed. *We're getting closer,* I thought. Soon afterwards Mark said he'd had enough for that day and requested the group move on to someone else.

The contempt resonating from this man was visceral. I felt it strongly when he spoke about people, particularly women. He wanted to be loved by a woman so deeply, yet felt so unskilled in his attempts to engage. I told him women do not find contempt attractive. Still, he wanted to be loved by the same women he also wanted to hurt.

A few months later, Mark was talking during group when I noticed his eyes well up. I asked him what was happening.
"I don't want to talk about it," he said.
"Absolutely," I responded. The group members sat quietly, noticing Mark's display of emotion. He was fully aware of this attention. After a few moments of acknowledging silence, the group moved on.

Shortly after in group, another member turned to Mark and said, "We see much more of you now than just your anger." Looking at the ground, he sat quietly and nodded. Developmentally, he is adjusting to having feelings in the presence of others. He is preparing psychologically to tell other group members about them. I think of him as "percolating" inside.

Since the day he first noticed his sadness, Mark has progressed to talking more about how vulnerable he feels in group. Talking openly about his vulnerability is challenging. He gets concerned about what the other men in group will think about him. He fears he will be seen as "too gay" if he has too many tender feelings. He particularly objects to feeling sad.

Welcoming Aggression

Often, we discover that intense aggression hides fear, even terror. Aggression can be an adaptive response to feeling unsafe. It is protection, a vital life force that allows some of us to keep living. When we know our own aggressive impulses, and welcome them instead of exiling them to distant places in our minds, we can work with group members who arrive feisty and aggressive.

Welcoming Mark's contempt and normalizing his rage has allowed us to access emotions he wasn't consciously aware of when he joined group. Engaging with him and matching his aggression allowed him to deepen emotionally. By meeting him at his own level of emotional development and working with him just as he arrived in group, he has been able to expand into a broader range of emotional availability. The sadness and fear we are now addressing in group would not have been possible without first welcoming his aggression. He needed to know that his aggression didn't have to destroy himself or others. He needed to feel safe.

Group offers three assets for emotional development. First, group provides containment. The sense of being emotionally held is vital to this type of work. Group members work on their own development within the confines of established relationships. Group therapy provides an exceptional containing function as a result. Secondly, group offers a learning environment, a place to try new behaviors on. When a behavior does not go well, group members can learn from mistakes and try again. When a behavior does go well, it becomes a part of body memory. The experiences are internalized and new neural pathways are formed. The group process continually refines the engagement process, making each person more emotionally skilled. And finally, group members can risk and rest at a self-directed pace, a pace that honors the unconscious and allows choice in how much to engage. When someone has had enough, they simply state this and the group moves on. I think of this as self-regulation within an established relational process. This ability to choose provides a level of psychological and emotional safety.

Aggression is an essential aspect of the human experience. When we acknowledge and welcome our own capacity to be aggressive, we can live more freely. We are not afraid of any intense aggressive feelings we have. In fact, we acknowledge them, know them, and continually have a choice about mobilizing these feelings. Sometimes, we simply notice them and keep quiet. Other times, we notice them and talk. There is something powerful in acknowledging our own and others' aggression. Keeping it available to ourselves can contribute to a much richer life, internally and relationally.▼

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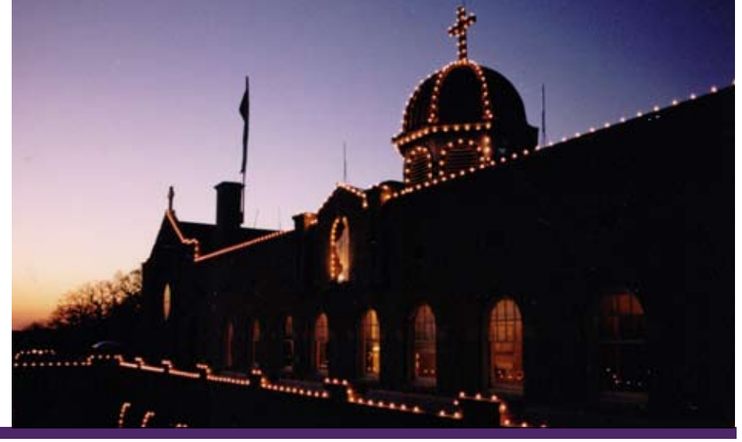
The Abbey



The Illinois Institute for Addiction Recovery (IIAR) has been managing The Abbey in Bettendorf, Iowa (Quad Cities) for over a year and we have seen much growth and success. It has been exciting to see the professional development within the staff, as they have become experts in treating individuals suffering from Process Addictions. The Abbey staff fosters a sense of community and "family" striving to provide the clients with a safe place to discover recovery. You will find clients and staff playing scrabble, exercising, or watching a movie together, using these experiences as teachable moments for the clients.

Libby Bier, Site Manager for The Abbey has this to say:

"We put emphasis on a sense of family or community at The Abbey and that seems to resonate with everyone that walks through our doors. We encourage the clients to remain connected with their peers and The Abbey staff once they are discharged. We have an alumni group that meets each week to discuss how they are doing. The alumni are great encouragement for those who are just starting out on this unknown adventure of recovery. Once a client enters treatment they begin to see that they aren't a bad person needing to be good, but a sick person needing to get well. They begin to see subtle changes in themselves and feel good about their efforts.

Being able to offer clients and their families the tools necessary for recovery, through compassionate and well-educated staff, in this beautiful and tranquil setting, is such an honor for me."

The Abbey is an extension of the IIAR. Many of you are familiar with the wonderful work we provide along side our clients. The Abbey allows the IIAR to provide unmatched addiction treatment experiences...everyday!

We invite all of you to tour The Abbey to experience firsthand the compassion within our staff to assist clients in taking their first steps towards recovery.▼

For more information about The Abbey, please contact Coleen Moore, Marketing and Admissions Manager at (309) 573-2760 or coleen.moore@proctor.org.

Recovery in Motion

On Saturday, September 25, 2010, over 420 peoplegathered on the campus of Proctor Hospital to celebrate recovery in motion, one step at a time, by participating in Recovery Walks! 2010. The event featured outstanding entertainment, fabulous food, and a silent auction.

Magician Gordon Snow amazed participants with great feats of magic and illusions while No Access provided music throughout the event. Face painting and delicious Sno-Cones were a popular attraction with the young and young at heart. Following the Walk, participants gathered for a lunch catered by Barrack's Cater Inn and music by Danny Blakey.

Members of the Honor Guard took center stage as they received special recognition for their years of sustained recovery. Recovery is celebrated by recognizing an individual's years of recovery as noted by the color of his or her T-shirt: 0–9 years = Green, 10–19 years = Blue, 20–29 years = Orange, and 30+ years = Gold.

All proceeds from the event benefited the Ameel Rashid Scholarship for Addiction Recovery. This scholarship was established in 2007 to help people who, while appropriate for treatment services at the Illinois Institute for Addiction Recovery, are financially unable to meet the cost of treatment.

Recovery Walks! 2011 will be held on Saturday, September 24, on the campus of Proctor Hospital in Peoria. We are also excited to announce that Recovery Walks! 2011 is expanding and that a Walk will be held in Bettendorf, Iowa, on Saturday, September 10. For information, contact Laura Schoon, Executive Director of the Proctor Health Care Foundation, at (309) 693-0414.▼

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IIAR The Abbey Staff

Is Self-Disclosure in Addiction Counseling Clinically Effective?

By William A. Rule, MS/Psy CASAC

Professionals and non-professionals alike are aware that in the field of alcohol and substance abuse counseling there are many counselors and therapists who themselves are recovering addicts/alcoholics. Both recovering and non-recovering counselors can be clinically effective. It is important to consider, however, whether recovering counselors should self-disclose their personal stories to their clients. What might be the clinical and therapeutic advantages, or disadvantages, of self-disclosure?

When mental health and/or substance abuse counselors consider self-disclosure to clients, it is important that the counselor and supervisors make responsible clinical decisions based on criteria most advantageous to clients. Mental health and substance abuse counselors must also consider the clinical effects of self-disclosure on their clients.

Step One: Be Genuine

Before deciding whether counselors should self-disclose, counselors and supervisors need to ask themselves if their personal feelings, biases, or self-interest might affect their clinical judgment and reasoning. Herein may lie the most difficult decision for a counselor, who is in recovery, and treating a newly recovering addict either individually or in a group setting. Therapists and counselors are human beings and, as such, have feelings. These feelings might affect clinical judgment and reasoning with regard to setting professional boundaries. This is not to say that therapists and counselors cannot be genuine. Genuineness is the ability to be oneself and feel comfortable in the context of a professional relationship with a client. It does not imply a high degree of self-disclosure, but it does imply a genuine presence in the therapeutic relationship (OASAS, 2008).

The primary reason professional relationships and boundary setting are so difficult for mental health and addiction counselors are that treatment takes place in a healthcare setting. In this setting, it will be necessary for the counselors to place the needs and care of the client above their own needs. For example, the counselor may have to listen more than talk. This practice allows the client, through guidance by the counselor, to discover his or her own solutions (Rule, 2010). Counselors should not disclose how they overcame a similar problem in their recovery. In some cases, individual counselors like to talk more than listen and may end up using the client for their own self-gratification. Beneficence, doing good for the patient, is essential to establish a relationship between clinician and patient where the interests and welfare of the patient always predominates.

It is reported by White (2006) that self-disclosure has become increasingly discouraged or discredited in the addiction counselor's role. According to White, using one's own personal and cultural experiences to enhance the quality of counseling has changed dramatically over the past four decades. In present-day professional alcohol and substance abuse counseling, such self-disclosure has come to be seen as unprofessional and a sign of poor boundary management. Having reported that, I can assert that self-disclosure or the use of one's own personal recovery story is thriving in the Twelve Step recovery programs. There is a role for self-disclosure, sponsorship, and having a recovery support network. This strategy is integral to ongoing recovery and should be a component of your client's discharge and relapse prevention plan. Does it have a place in the clinical setting, or is therapeutic anonymity the proper professional boundary to be established?

Unsure: Seek Supervision

Warren D. Zysman, LMSW, CASAC (personal interview, June 6, 2010), Clinical Supervisor of Employee Assistance Resource Services, Inc. in Smithtown, New York, addressed the issues surrounding a counselor's self-disclosure to a patient. Mr. Zysman explained that counselors should rely on their clinical training and ability to be present in the therapeutic relationship to facilitate the client's progress towards their treatment plan goals and objectives. For a counselor to tell their personal story and explain to a client, "I did it, you can do it," is not an effective clinical strategy. A clinically effective counselor must facilitate and assist the client in advancing in his or her treatment without shifting the focus onto the counselor. After all, the counselor's and the client's primary objective in the therapeutic relationship is the client's recovery.

Psychodynamic theorists since Freud have generally regarded therapist self-disclosure as detrimental to treatment because it might interfere with the therapeutic process, shifting the focus of therapy away from the client. According to this perspective, the therapist is thought to act as a mirror on which the client's emotional reactions can be projected. If a therapist discloses personal information during therapy, this therapeutic anonymity could be disrupted. Further, it is argued that therapist self-disclosure may adversely affect the treatment outcome by exposing therapist weaknesses or vulnerabilities, thereby undermining client trust in the therapist (Barrett & Berman, 2001). Counselors know they will be challenged by their clients to reveal their vulnerabilities.

Be Prepared in Advance

Often, clients seeking help for addiction or alcoholism will ask a counselor: "What do you know about addiction, and how can you help me?" This dilemma requires an immediate preconceived clinical decision whether or not the counselor is in recovery. Would the therapist's self-disclosure clinically and therapeutically help the client move forward in treatment? Or, would it be detrimental to the client to share this information? Who would be affected by the decision of the counselor to self-disclose? In this scenario, both the client and therapist will be affected by this decision at several levels. The level of trust in the relationship could go either up or down. The client potentially will view the counselor as a peer and relate to their shared experiences rather than focusing only on the counselor's professional ability to treat the client. The resulting shift in differentiation will damage the therapeutic relationship for both the client and the counselor (Rule, 2010).

Alternative Responses

The alternative course of action is for counselors not to disclose that they are also in recovery. If a counselor is asked questions about his or her experience and knowledge in treating clients with addictions, the counselor should also be prepared for the question, "Are you in recovery, too?" The counselor must invoke a preconceived alternative response other than self-disclosure. A possible alternative could be: "This is not about me—it is about you. How can I help you to develop a recovery plan that works for you?" Incorporating these alternative response strategies will get the focus back on the client and make his or her recovery the primary objective of treatment.

Be In the Moment

Counselor self-disclosure exists and will continue to exist in the field of mental health counseling. There are times when self-disclosure works if it relates to information that the client may be stalled in understanding or it relates to a feeling the client is currently wrestling with. There will be times when a client may become upset at discussing an issue he or she has kept hidden from family and friends. This issue may not be directly related to the treatment modality (i.e. addiction/mental health). If the counselor has resolved this issue in recovery, it may be appropriate for the counselor to share those struggles with the client and that it is indeed possible to process the conflicting feelings. The counselor should then guide the client to find his or her own resolution of the issue. This effective therapeutic technique of intentional self-disclosure is based on support and alliance building. For example, if a client is revealing troubling parenting issues, a counselor may self-disclose that he or she is also a parent and offer professional therapeutic insight. This strategy is not to be confused with the argument that counselor self-disclosure aids in client self-disclosure.

Barrett and Berman (2001) address this concept: "Although our evidence indicates that therapist self-disclosure can be helpful for treatment, it does not confirm the argument that therapist self-disclosure exerts its impact by encouraging client self-disclosure" (pg. 602). This research further explains that the analysis failed to detect systematic differences in either the frequency or intimacy of client self-disclosure. According to these findings, counselor self-disclosure is not an effective technique to aid the client to be more open and forthcoming.

Clinicians repeatedly encounter dilemmas for which a clear professional clinical response can be elusive. Intentional self-disclosure can be clinically effective when based on supportive alliance building. Poorly examined self-closure could be reflected as seductive, exhibitionistic, or care seeking, all of which is detrimental to the client-counselor relationship. Awareness of the ethical standards and codes is crucial to competence in the area of ethics, but standards and codes cannot take the place of an active, deliberative, and creative approach to fulfilling clinical responsibilities. Being prepared in advance and having an ethical decision making process in place is important because in the human services and healthcare industry, these situations may arise without warning. Clients may attempt to deflect the attention away from themselves. As suggested, return the focus where it belongs—back onto the client.

Pope and Vasquez (2007) address this issue by pointing out five potential causes that may present difficult scenarios for counselors and therapists. First, major boundary dilemmas often catch counselors off-guard and unprepared. Second, opportunities to cross boundaries can tap into some of one's most basic needs and strongest desires. Third, the need for clarity about boundaries can be misunderstood as the need for inflexible boundaries reflexively applied. Fourth, boundary decisions can evoke anxiety and even fear. Finally, there may be relatively little guidance in making real world decisions about boundary crossings in our classrooms and treatment guides. Self-disclosure is primarily a professional boundary setting issue; for this reason, clinical training and effective supervision are essential to patient welfare.

Conclusion

Continuing training and counselor wellness are key components to the operation of an effective treatment program. Counselor wellness and client wellness are intrinsically and proportionally related. Clinical supervisors should provide adequate and ongoing training to counselors and social workers who are in recovery and working with recovering addicts in treatment. In conclusion, therapists and counselors may self-disclose in other areas when they are genuinely "in the moment" and as long as the welfare of the client predominates. Use your clinical training and education to therapeutically facilitate for the client's forward progress through the treatment process.▼

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Evidence-Based Interventions in Children with Fetal Alcohol Spectrum Disorders

By Natalie Novick Brown, PhD

For over 20 years, an extensive body of research has documented significant neurodevelopmental deficits in individuals with Fetal Alcohol Spectrum Disorders or FASD (Mattson et al., 1998; Streissguth et al., 1991). FASD is an umbrella term that includes three conditions involving brain damage and associated central nervous system impairment: Fetal Alcohol Syndrome (FAS), Partial FAS, and Alcohol Related Neurodevelopmental Disorder (ARND). This impairment involves primary neurocognitive disabilities such as cognitive deficits, memory problems, attention deficits and hyperactivity, speech and language impairment, internalizing and externalizing behavior problems, and deficits in executive, social, and adaptive functioning (CDC, 2004).

Due to an interaction between these primary disabilities and adverse environmental experiences, individuals with FASD who do not receive appropriate interventions in childhood struggle with serious secondary disabilities (Carmichael Olson et al., 1999; Streissguth & O'Malley, 2000). For example, children with FASD are at significant risk of learning disabilities and classroom behavior problems (Carmichael Olson et al., 1992; Mattson et al., 1998) and, ultimately, school disruption (Streissguth et al., 1996). Adolescents with FASD also are at increased risk for mental health problems, alcohol and substance abuse problems, sexual misconduct, and delinquency and juvenile commitment (Streissguth et al., 1996, 2004).

Although researchers have long recognized that in order to reduce the risk for secondary disabilities, early diagnosis and disability—targeted interventions are necessary throughout childhood and beyond (e.g., Streissguth et al., 1996, 2004), only a few FASD interventions have been developed at this point. Several of these treatments have been empirically tested in randomized control studies and show positive, albeit short-term, efficacy with respect to targeting specific skill deficits in alcohol exposed children.

Parenting Skills Training

In the Parent and Child Assistance Program (PCAP; Grant et al., 2004) at the University of Washington, paraprofessionals in advocate case manager roles worked with 19 young women diagnosed with FASD conditions to connect them with appropriate services, teach them how to access services for themselves and their children, and support their ability to provide a safe caregiving environment for their children. Results of this 12-month community pilot intervention indicated improved outcomes (including reduced substance use, increased contraception use, increased use of medical/mental healthcare services, and stable housing). The researchers concluded that services of this nature might contribute to the prevention of additional alcohol-exposed pregnancies.

In an intervention (Families Moving Forward; FMF) based generally upon parenting training programs with documented efficacy in families with non-alcohol exposed children, researchers (Olson et al., 2005) designed an intervention aimed at improving caregiver self-efficacy and reducing problem behaviors in children with FASD. Caregivers were taught two skills: *1)* how to change unproductive cognitions and attitudes ("reframing") from a perspective that viewed child disobedience as willful to a perspective that viewed child disobedience as a byproduct of brain damage, and *2)* how to substitute reactive punitive responses with positive behavior reinforcement. The study sample involved 52 children 5-11 years of age and their caregivers. At enrollment, all child participants had clinically significant externalizing problems or attention deficits, as measured by standardized assessment procedures. The intervention involved 16+ sessions of supportive behavioral consultation on a biweekly basis. Post-treatment results indicated that compared with caregivers in a community standard of care group, caregivers involved in the FMF intervention experienced a significantly improved sense of parenting self-efficacy, perceived that their family needs were met more often, and reported a significantly decreased number of disruptive behavior problems in their children. The researchers concluded that the FMF model showed initial promise with respect to improving caregiving practices and reducing child disruptive behaviors.

Bertrand (2009) reviewed a University of Oklahoma study that compared two evidence-based FASD interventions designed to decrease behavior problems in children and reduce parenting stress. One treatment, based on an adaptation of Parent-Child Interaction Therapy or PCIT (Eyberg & Boggs, 1998), involved in vivo coaching of targeted parenting skills with parents and children. The other intervention involved a parent-only Parenting Support and Management (PSM) program that incorporated components of other generally effective behavioral modification programs. The study sample involved 58 children ages 3-7 with FASD diagnoses and their caregivers. The intervention was delivered in 14 weekly 90-minute sessions of caregiver training for both study groups. In addition, the PCIT group received conjoint parent-child sessions. Overall, significant improvements in parent distress and reduced child behavior problems were found in both intervention groups, with no significant differences in outcomes between the two groups. According to Bertrand (2009), these results suggested that caregivers of children with FASDs could benefit from both relationship-focused and behaviorally oriented interventions.

Early Education Interventions

In the first systematic study to test a school-based FASD intervention, Adnams and colleagues (2007) demonstrated the efficacy of school-based language and literacy training (LLT) in a group of South African elementary school children. The intervention involved phonological awareness training and teaching of pre- and early literacy skills necessary for reading and spelling competency. The study sample involved 40 children with FASD, all age 9, who were randomly assigned to either the intervention condition or a control group. A third group of non-exposed children were assigned to another control group. Outcome measures involved standardized tests, questionnaires administered to teachers and parents, and classroom observations. Both at baseline and at the conclusion of the nine-month intervention, subjects with FASD were significantly weaker than nonexposed children in tests of early literacy tests and in a teacher-rated assessment of adaptive behaviors. Although average post-treatment test scores for prenatally exposed children remained lower than their nonexposed peers, post-intervention academic and literacy scores for all groups showed improvement. Moreover, there were significantly greater improvements in the FASD intervention group compared to the FASD control group on academic and literacy measures.

In a math learning readiness intervention, a research group in Georgia (Kable et al., 2007) assessed whether a consistent method of instruction across therapeutic, home, and school environments could improve mathematic skills and behavioral problems. The intervention involved the teaching of learning strategies to compensate for FASD-associated visual-spatial processing problems and executive function deficits (e.g., learning ability and working memory) that manifested in poor math and pre-math skills. The study involved 56 children ages 3-10 with a diagnosis of either FAS or Partial FAS. All subjects received educational support, including a neurodevelopmental assessment, as well as guidance to their caregivers on how to obtain appropriate educational placements and individualized education plans. Caregiver education, case management services, and psychiatric consultation also were used to support learning readiness. Children in the intervention group received six sessions of individualized instruction while their caregivers received training on how to support their children's learning readiness by incorporating math concepts into free play, providing structured mathematical activities to their child, and facilitating completion of math homework. Compared to the control group, the intervention group made greater gains on math outcome measures, and these gains were maintained at a six-month follow-up (Coles et al., 2009). Positive gains also were made with respect to a reduction in child behavior problems. These results suggested to the researchers that a psychoeducational program that targeted specific neurodevelopmental deficits could help remediate math learning deficits.

In a study aimed at reducing the working memory deficit commonly seen in children with prenatal alcohol exposure, Loomes and colleagues (2008) developed an intervention that trained children in using rehearsal techniques to recall numbers prior to a digit span task administered in three different trials (pre-intervention, immediately following the brief intervention, and approximately 10 days after the intervention with an intervention "reminder"). The study involved 33 prenatally exposed children ages 4-11. Compared to the control group, the intervention group showed a significant increase in recall on the digit span task given 6-21 days after the training.

Neurodevelopmental Habilitation

Children with FASD are viewed by caregivers and teachers as having significantly poorer social skills (e.g., failure to consider the consequences of actions, difficulty understanding social cues, indiscriminant social behavior, poor choices in peer relationships, and difficulty communicating in social contexts) than their non-impaired peers, even after controlling for differences in cognitive functioning (Mattson et al., 1999), and these skill deficits continue into adulthood (Streissguth, 1997). In the first systematic evaluation of a treatment designed to improve the social functioning of children with FASD, O'Connor and colleagues (2006) adapted an evidence based parent-assisted social skills intervention called Children's Friendship Training (CFT; Frankel & Myatt, 2003) to address the social, cognitive, and behavioral impairments common among children with FASDs. CFT teaches children how to interact with peers, how to enter a group of children already playing, how to arrange and handle in-home play dates, and how to avoid and work out conflicts. Caregivers are trained in how to assist their children with these skills. In this study, 100 children with FASD between 6-12 years of age were randomly assigned to either an intervention group or a delayed treatment (control) group. Children in the intervention group received 12 weekly 90-minute sessions of training, and caregivers attended separate concurrent sessions where they received education on FASD and were instructed on the social skills their children were learning. Skill training included simple didactic rules of social behavior, modeling, rehearsal, and performance feedback during treatment sessions, in-home rehearsal, homework assignments, and caregiver coaching during play between children. Results indicated that compared to the control group, those in the intervention group showed statistically significant improvement in their knowledge of appropriate social behavior, made gains in social skills, and decreased their problem behaviors. These improvements were maintained over a three-month

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WISE COUNSEL

Understanding and Avoiding Burnout

By K. Ramsey McGowen, PhD and Merry N. Miller, MD

Burnout is a serious concern for counseling professionals. It happens more often than many realize and its impact is broader than most comprehend. Burnout is not just a matter of losing passion for one's work or experiencing career dissatisfaction; it also leads to poor performance and increases the likelihood of professional errors, potentially causing harm to clients. What happens in burnout? What are the factors that lead to it? What steps can a counselor take to prevent burnout or to recover from it when it occurs?

The term "burnout" was first used in the literature by Freudenberger (1974), a psychiatrist who described the gradual loss of motivation and commitment he observed in volunteers in a humans services agency. Burnout soon became the subject of empirical investigation and has been a major concern in human service professions ever since. A work-related syndrome distinct from depression, burnout is characterized by emotional exhaustion, depersonalization (or cynicism) and a sense of personal inefficiency or impeded accomplishment (Maslach, 1981). These characteristics manifest in a number of ways, including loss of enthusiasm for work and feeling one has nothing to give; developing negative attitudes toward work and treating others, including clients, as if they were objects; and feelings of incompetence or inadequacy. Some refer to burnout as "compassion fatigue," a term that perhaps better captures burnout's subjective experience. Maslach and Leither (1997) describe burnout as the deterioration of dignity, values, spirit and will and call it an "erosion of the soul."

There are many factors inherent in the practice of counseling that increase the likelihood of burnout. Counseling involves exploring sensitive issues, dealing with difficult situations, hearing many painful stories, confronting interpersonal conflict and challenging obstacles to change. These challenges make it emotionally taxing and intense. Other factors that contribute to burnout in addictions counselors were identified by Sobon, Davison, Bogear, Steenberg and Sneed (2010). These include work variables such as heavy caseloads and working with clients who have chronic conditions and who are prone to relapse. Many of these factors cannot be avoided, so developing appropriate coping strategies and maintaining motivation to prevent burnout to protect oneself is important. Understanding the high cost of burnout is one way to develop such motivation.

What Are the Consequences of Burnout?

Burnout adversely affects the entire continuum of the counseling experience: the recipients of services, individual clinicians, treatment teams, agencies and institutions (Garman, Corrigan & Morris, 2002; Broome, Knight, Edwards & Flynn, 2009). For clients, having a counselor who experiences burnout is associated with reduced levels of satisfaction with services, an increased chance that a treatment error will affect their care (Taris, 2006), reduced support and empathy from counselors and a decrease in trust within the treatment relationship.

For counseling professionals, a wide array of negative consequences may arise as a result of burnout. These include career consequences such as dissatisfaction, increased absenteeism, intolerance and reduced empathy toward clients and even a desire to leave the profession. Personal consequences may include poor health and functioning, increased substance abuse, a sense of incompetence and self-reproach, adopting rigid approaches to work situations and an increased risk of depression and suicide. These effects can potentially undermine a counselor's ability to function effectively and certainly suggest that when burnout occurs, it exacts a high cost.

Burnout takes a toll on agencies and the service delivery system as well. Burnout is often contagious, spreading from one individual to entire teams (Taris, 2006). Counselor absenteeism and turnover results in the loss of expertise and creates the need to hire and train new clinicians, reducing the resources available to meet other organizational goals. As the expenditures for hiring and training rise, "institutional wisdom" decreases with the loss of an experienced employee. Client dissatisfaction associated with counselor burnout reflects poorly on the employing organization and undermines an agency's reputation as a resource for reliable and effective treatment.

What Are the Causes of Burnout?

Many factors that increase the occurrence of burnout have been identified. Some are elements of the work environment, while others are related to personal characteristics.

In the work setting, organizational structure plays a role in precipitating burnout. Burnout is more likely in agency settings than in private practice, perhaps because of the flexibility and autonomy that private practice permits. In a 2007 guide for addictions professionals, the Central East Addiction Technology Transfer Center identified five sources of workplace stress: manager-employee relationships, coworker relationships, bureaucracy, performance demands, and work-home conflicts. Burnout is more common in settings that limit counselor autonomy as well as in those perceived as unsupportive and unfair or arbitrary in their practices. However, when organization leaders articulate a clear vision with defined expectations, remain open to feedback, encourage innovation and experimentation and provide mentoring, counselors are less likely to experience burnout (Broome, et al, 2009). When coworkers are supportive of one another and work together effectively, burnout is reduced (Ducharme, Knudsen & Roman, 2008). While large caseloads are often associated with burnout, the complexity of those caseloads is also a factor. Many counselors work with clients who have complicated co-morbid disorders and who frequently have co-occurring social service, financial, and legal needs. Counseling occurs in an intense interpersonal context that involves dealing with painful emotional situations, resistance to change, relapse and a chronicity of problems. All of these factors increase the demands placed on counselors and can increase the occurrence of burnout.

Personal factors are also often implicated in burnout. Traits like perfectionism and self-doubt can lead to unrealistic expectations and an inability to feel satisfied with career performance. Individuals who perceive themselves as having less control and higher stress levels are more likely to burn out than individuals who are adaptable and who proactively expand their coping strategies (Rowe, 1997). Social support is also helpful, as counselors who are able to form mutually nurturing relationships may be more protected from burnout. Gender is another factor. While the data is mixed, certain work situations may affect women and men differently. One study (Rupert & Kent, 2007), for example, found that women were more likely to experience burnout in agency settings than in private practice. The authors hypothesized that the inflexibility of working conditions in agencies made it harder to balance work and home responsibilities; a subsequent study, however, failed to replicate this finding (Rupert, Stevanovic & Hunley, 2009). In another study, Stevanovic and Rupert (2004) found that women were more likely than men to use career-sustaining behaviors and focus on the intrinsic rewards of their work, both of which may protect against burnout. Finally, age appears to confer some protection: older workers are consistently found to burn out less than younger ones. This may relate to wisdom that accumulates over time or the acquisition of emotional equilibrium in response to stressors.

What Can be Done About Burnout?

Strategies can be developed to prevent or reduce burnout as well as to cope with it once it begins. Some efforts require changes to the work environment, while others demand that individual measures be taken.

In work environments, it is important to look for settings that allow personal autonomy and control. In an agency setting, counselors can petition administrators to adopt a participatory management style and to incorporate features associated with less burnout (flexibility, scheduling options, clear expectations, openness to feedback, effective team relationships, etc.). In addition, finding ways to incorporate employee support into work settings, such as offering support groups or Twelve Step programs on-site, may be helpful. Selecting a practice setting that is compatible with one's personal values and needs (clientele, work-home balance or achievement goals) reduce stress as well. It may be necessary in private practice to change or restrict practice hours or patterns in order to achieve a more satisfactory work life.

For the individual, prevention is obviously the preferred approach. Many self-assessment questionnaires are available to help individuals appraise their stressors, coping skills and needs. Many of these questionnaires have been compiled in the self-care guide produced by the Central East Addiction Technology Transfer Center (2007). Fostering an open and flexible response to life events and adopting cognitive strategies to challenge maladaptive thinking styles can be beneficial. Also helpful is adopting strategies that improve one's sense of personal control and interpersonal support as well as strategies that enhance meaning and purpose in activities.

Seek Control

Perceived control is a common theme in burnout literature; lower levels are associated with increased burnout, while higher levels are associated with resilience. Control may seem an elusive goal, but certain helpful strategies have been identified.

Setting limits is one way to exert control. Many professionals are reluctant to say no to others' requests and, over time, find themselves drained or resentful. Combating this requires recognizing that it's possible to fulfill responsibilities while setting limits on excessive demands and thinking outside the box to find alternatives to workaholic approaches. Giving oneself permission to selectively accept invitations that fit with one's priorities is an important step in achieving balance.

Setting limits may include prioritizing healthy behaviors such as scheduling time off, exercise, and relaxation. The recognition that setting limits is saying "yes" to healthy behaviors (and not just saying "no" to requests) may help counselors understand the choices they face and encourage them to adopt self-care behaviors.

The perception and interpretation of circumstances largely determines how stressful those circumstances become. Counselors can fall prey to cognitive errors such as catastrophizing, all-or-nothing thinking and discounting positive events. Resistance to acknowledging personal limits and fallibility can lead to impossible expectations or defensive behavior. It also may lead to an unforgiving response when mistakes inevitably occur. Correcting these cognitive distortions can improve flexibility, decrease feelings of victimization, and improve problem solving, self-esteem and professional relationships, all of which protect against burnout and increase one's sense of control.

Interpersonal Support

Another factor often cited as a source of strength and resilience is having adequate support from others. The privacy and confidentiality counseling requires can make it a lonely profession, and, over time, counselors may become isolated from others. This isolation may be especially pronounced for counselors who feel down or burned-out.

Sharing feelings and responsibilities is an important step to overcoming burnout. Team meetings or consultation with colleagues to discuss

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…children with FASD are at significant risk of learning disabilities and classroom behavior problems and, ultimately, school disruption. Adolescents with FASD also are at increased risk for mental health problems, alcohol and substance abuse problems, sexual misconduct, and delinquency and juvenile commitment.

follow-up period. Reviewing this intervention, Bertrand (2009) noted that since this study was conducted within a tightly controlled university setting, it would be important to evaluate the efficacy of CFT within a community-based setting.

Impaired executive functioning is a central deficit for children with FASD (Mattson et al., 1998). In fact, many of the learning and social/emotional/behavioral difficulties displayed by children with FASD stem from underlying deficits in executive functioning (Connor et al, 2000). Executive functioning involves specific cognitive skills such as processing, organizing, and sequencing of information; goal-directed planning, cause and effect analysis, and cognitive flexibility; and emotion control and response inhibition. Deficits in executive functioning can be particularly devastating as these skills affect virtually all aspects of human behavior and adaptive functioning. In a systematic study to explore the efficacy of executive skills training for children with FASD, Chasnoff and colleagues (2009) developed an intervention adapted from the Alert Program© (Williams & Shellenberger, 1996) that involves strategies for improving memory, cause and effect reasoning, sequencing, planning, and problem solving. A total of 78 children with FASD between ages 6-11 participated in the study. Those in the intervention group received 12 weekly neurocognitive habilitation group therapy sessions while their parents simultaneously participated in a parent education group. The control group received referrals for community-based services such as occupational therapy, physical therapy, or speech and language therapy. Baseline and outcome assessment was based on standardized measures. Results indicated that compared to the control group, children who received the intervention showed significant improvement in executive functioning skills.

In another behavioral intervention, Vernescu (2007) examined whether Attention Process Training could improve the executive functioning of children with FASD. In this study, 20 Inuit children with FASD ages 6-11 were randomly assigned to either the intervention group or a control group. Both groups were seen for 12 30-minute sessions over 3 weeks, with the control group playing games and receiving academic support during those sessions. Baseline and post-intervention assessment involved standardized measures of attention, nonverbal reasoning ability, and teacher-completed behavioral measures of attention and executive function. Results indicated that children in the intervention group showed significant improvement on measures of sustained attention and non-verbal reasoning ability, but there was no improvement on measures of executive function.

In a computer-based intervention to increase safety skills (Coles et al., 2007), 32 children with FASD ages 4-10 were randomly assigned to one of two intervention groups and taught computer-administered safety rules and behavioral sequences involving either a fire in their home or crossing a city street. Each intervention group served as the control group for the alternate intervention. Results indicated that compared to controls, children in both intervention groups showed significant gains in safety-related knowledge and appropriate behavioral responses.

Pharmacological Interventions

In one of the first studies to investigate the impact of medication on FASD symptoms (Snyder et al., 1997), 12 children ages 6-16 with FAS and ADHD and positive response to stimulants were administered stimulant versus placebo. Results indicated significant improvement in hyperactivity with the stimulant medication per parent report but no significant effects for attention or impulsivity.

In 1998, a small randomized double-blind cross-over study (Osterheld et al., 1998) involving four Native American children ages 5-12 with FASD tested the effects of Methylphenidate versus placebo and vitamin. Results indicated no significant differences on measures of attention.

In a more recent study, a retrospective chart review of 27 youngsters ages 5-14 with FASD found "normalization" in up to 70 percent of the sample with respect to hyperactivity/impulsivity and opposition/defiance symptoms but in only 33 percent of the sample with regard to inattention (Doig, McClennan, & Gibbard, 2008). Results of this study contrasted with a previous study (O'Malley, Koplin, & Dohner, 2000), which found a preferential improvement in ADHD symptoms with dextroamphetamine (79 percent of 19 subjects) versus methylphenidate (22 percent of 23 subjects). Noting the contrasting findings in the two studies, Doig and colleagues (2008) concluded that a clearly identified preferential stimulant choice for children with FASD and ADHD had not yet been identified.

Only one study to date has investigated the efficacy of a combined intervention involving the impact of medication on psychosocial treatment (i.e., children's friendship training). In a well-designed study involving children with FASD, Frankel and colleagues (2006) randomly assigned 77 children ages with FASD ages 6-12 to one of four conditions: a group that received stimulant medication, a group that received neuroleptic medication (i.e., risperidone for 11 of 13 children, with the other two receiving olanzapine), a group that received both medications, and a group that received no medications. Following 12 sessions of Children's Friendship Training, results indicated that compared to all other groups, children prescribed neuroleptic medication showed greater social skills improvements in response to CFT on all standardized social outcome measures (parent and teacher ratings). In contrast, children prescribed stimulant medication either failed to show any improvement or showed poorer outcomes than children who did not receive stimulants. The researchers noted that the results of this study contrasted with their earlier study (Frankel, Myatt, & Cantwell, 1995) which showed a beneficial effect from stimulant medications given concurrently with CFT in children with ADHD.

Summary

Peadon and colleagues (2009) noted in their systematic review of FASD treatments that there appears to be promise in interventions that address specific clinical and neurodevelopmental deficits in children and those that focus on hyperactivity or arousal dysregulation. Unfortunately, as Paley and O'Connor (2009) indicated in their treatment review, by the time many children with FASD are diagnosed in elementary school, the opportunity for early intervention has been missed. Of course, the key to early diagnosis and treatment provision throughout the childhood years and beyond is improved training for professionals who might be in a position to detect and/or diagnose FASD. Toward that end, four FASD Regional Training Centers have been established by the federal government to develop, implement, and evaluate new training programs and enhance current training programs for medical and allied health students and practitioners.

In the educational setting, the National Organization on Fetal Alcohol Syndrome (NOFAS) has provided a comprehensive school-based FASD Education and Prevention curriculum for grades K-12 which provides information about the effects of prenatal alcohol exposure on human development while simultaneously encouraging youth to be tolerant of all individuals, regardless of individual capabilities or disabilities. Missing in such efforts, however, is specific training in FASD for teachers involving screening and appropriate referral.

In summary, while the above research is preliminary, results suggest that interventions can make a difference in domains known to be deficient in FASD. As is evident from the initial success of these studies, the key to reducing secondary disabilities is a comprehensive approach to intervention that encompasses multiple systems of care, (Streissguth, 1997) including neuropsychological assessment, case management, and interventions in multiple domains throughout the childhood years and beyond.▼

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not just clinical issues but also one's feelings about work can provide support and connection. Support can occur in the context of personal relationships with friends, family, and spouses, and can be found in group settings as well-church groups or clubs, for example. Professional organizations may also provide much-needed support, whether for simple professional collegiality or for professionals with more specific needs. For counselors in recovery from alcohol and drug problems, attendance at Twelve Step groups can help prevent relapse, one of the possible consequences of burnout.

Attitude/Meaning
Recapturing empathy with patients and a sense of meaning in counseling is another important strategy for overcoming burnout. Counselors may find that their spirituality is a source of renewal and strength that helps them preserve a sense of meaning in their work. Mindfulness has also been recommended as a way to restore compassion and empathy. It refers to the quality of being fully present and attentive in the moment during everyday activities. Continuing education programs in mindfulness training may offer a way to develop these skills.

Conclusions

Even though the external stressors inherent in counseling often cannot be changed, healthy approaches to stress can be learned at any age. ***Such strategies include:***

1. Identify and expand areas of control.
- Where possible, arrange schedules to reduce pressure.
- Recognize the choices (or control) and rewards implicit in everyday endeavors. For example: *Even though the patient load is high, I chose to work in this practice because I trust and respect my colleagues.*
- Capitalize on opportunities to pace oneself: use the time while washing hands to breathe deeply and decompress or plan a lunch break with colleagues.

2. Cultivate meaning and purpose in life.
- Focus on empathy and emotional connection to patients.
- Participate in activities that reflect your values.
- Focus on how professional activities make a positive difference.
- Preserve time for spiritual pursuits and reflection.

3. Stay connected to others.
- Talk to colleagues about professional rewards and challenges.
- Seek out supportive and trustworthy friends and offer support and trustworthiness to others.
- Initiate activities with others and be proactive in your social life.
- Avoid isolation and take risks.

4. Refresh or broaden your skills.
- Take continuing education courses on areas that interest you.
- Research topics of interest online and take advantage of information resources now widely available.
- Consider a course on resilience, relationship building or an area of your work that you find particularly meaningful.
- Seek a mentor or offer to be a mentor; recognize peer relationships as mentoring options.

5. Practice self-care.
- Develop a "role-shedding" ritual at the end of the day. For example, pay attention to mentally "leaving work" as you close your office or focus your attention on some transitional activity on the drive home.
- Develop a hobby.
- Give yourself permission to selectively accept invitations that fit with your priorities.
- Exercise regularly.
- Eat a nutritious diet.
- Consciously interpose a minute of silent reflection or mind-clearing between patients.
- Journal about your feelings and experiences and use your journal as a way to self-soothe.
- Strive for balance and moderation, including a balance between time alone and time with others.
- Actively seek help for problems or concerns when needed.
- Take heart that you are not alone in your struggles and changes are possible!▼

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Cultivating Hope in All Our Affairs

By Karen Casey, PhD

We can begin to cultivate hope in ourselves and others by acknowledging the many people who are on our path by intention. By acknowledge, I mean to **really look into the eyes of the many who surround you**. No one is "there" accidentally. **No one!**

When we embrace that awareness, the fear we so easily let fester in unfamiliar circumstances diminishes. Fear is anathema to hope. There is no way to initiate hope when fear lingers at the edge of our mind. The simple recognition that wherever we are is where we have been called to be can change our mood and expectations and suspend our disbelief.

Most of us have struggled with fear at some point in our lives. I was controlled by it for more than three decades. I grew up in a family where anger and depression were prevalent. Early in my recovery, my father, a bank officer, told me that every day of his life he had been scared that he might make an error at work that would cost the bank embarrassment, financial loss, or worse. How sad his life was. I realized during that discussion how my father had set in motion the "imprinting" I'd been controlled by for more than three decades.

My fear-based upbringing drove me to drink, to cling, to abuse others, and, on more than one occasion, to contemplate suicide. From childhood on, I kept suicide tucked away in my back pocket as a possible solution for my seemingly undiminishable fear. The thought of suicide as a way out never frightened me. It comforted me, in fact. My fear tired me greatly.

I didn't think life would ever really feel or look any different, and that was okay. But then, at my lowest point, I met a woman, an "angel" I'm sure, who changed my mind. She explained my fear to me—what it meant and how to let it go. She gave it a name: *chemicalization*. Since that day I have never looked back.

Now if I wake up a bit edgy or unsure of my direction (which happens only occasionally now), I turn to one of the suggestions on the following list. They are simple but to the point. And they free me. Any one of them can allow me to start the day again, without fear. Because it works for me, I offer them to you. No one should live in a state of constant fear. No one should live in fear for an hour or even a moment. We need not do it. Ever. Give any one of these suggestions a try and feel the new you. I promise immediate results and a hopeful heart!

Simple things we can do now to change our perceptions and become more hopeful.

- Ask God or your Higher Power for help.
- Let go!
- Surrender.
- Do one thing to inspire joy in someone else's life each day. Make a note of this in a small notebook.
- Choose kindness in all encounters; feel it change your heart.
- When feeling hopeless, choose a fond memory to change your perception. Keep a "list" of fond memories handy for just such a time.
- Make a gratitude list to help you recall the good that has already happened. Update it frequently.
- Praying for others will change your heart. Begin each day with a prayer for someone.
- Peaceful acts create more hope in ourselves and others. Make your first action of the day loving and kind. Perhaps it's as simple as a smile.
- Using a gentle voice can create more hope in ourselves and others, too.
- Embrace change. God or your Higher Power is present to help. In fact, God or your Higher Power offered the change as a conduit for more growth.
- Welcome "every messenger." We both have volunteered for the lesson.
- Honor all others who cross your path in tiny ways.
- The universe would shift if every one of us walked away from one argument every day.
- Remember: Whatever is happening is part of your own unique planning, tailor-made for the journey you have selected to experience.
- And lastly, remember: If I am still alive, I have not yet completed the purpose for which I was born. Go forth into this day eagerly. ▼

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what to consider

when deaf individuals have substance abuse issues

By Debra Guthmann, EdD

Many barriers exist to providing culturally appropriate substance use disorder (SUD) treatment to persons who are Deaf and hard of hearing. These include the lack of accessible treatment program options, a low geographic census of Deaf persons referred to treatment at any given time, difficulties in maintaining anonymity for Deaf individuals in treatment, minimal alternatives for accessible self-help support groups, and a general lack of accessible drug/alcohol information (Guthmann & Blozis, 2001; Moore & McAweeney, 2006). Nationally, few specialized substance abuse treatment programs are available that meet the communication and cultural needs of Deaf people seeking treatment for alcohol and/or other drug problems.

Need for Culturally-Appropriate SUD Treatment for Persons who are Deaf

Although research on this underserved and often unserved population is limited, substance abuse appears to be a significant problem in the Deaf community (Berman, Streja, & Guthmann, 2010; Guthmann & Blozis, 2001). Research methods developed to gather incidence and prevalence information in hearing communities are often ineffective among Deaf people for a variety of reasons, including distrust of predominantly hearing researchers, fear of ostracism and labeling, and the inaccessibility of assessment instruments due to language limitations.

School programs serving Deaf students have enormous pressure placed on them to focus on academics and may not offer drug/alcohol education to these students. As a result, Deaf individuals may not be well-informed about the risks of using alcohol and other drugs, addiction, or treatment and various recovery programs such as Alcoholics Anonymous, Alateen, and Alanon. Additionally, the tendency of family members, friends, and even professionals to take care of and protect Deaf individuals often exacerbates any substance abuse issues. This may result in the Deaf individual not being held accountable for his or her behaviors. School-based prevention programs and public service announcements generally do not provide communication access and many young Deaf people are ill-prepared to deal with pressures from peers and others to use mood-altering chemicals.

The last thirty years have seen the establishment of several specialized treatment programs for Deaf people. These programs employ Deaf and hearing clinicians (Titus & Guthmann, 2010) and other staff members who are fluent in American Sign Language (ASL) and sensitive to Deaf culture. One such program is the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (MCDPDHHI). This specialized program, one of the first of its kind, is designed to meet the communication and cultural needs of Deaf individuals in alcohol and drug abuse treatment. All program staff are Deaf or hearing and fluent in ASL.

Programs such as the MCDPDHHI allow Deaf substance abusers access to Deaf role models as well as counselors or psychologists who are either Deaf or hearing and fluent in sign language. They also allow Deaf people to be placed with other Deaf clients who share common experiences and can identify with each other. Providing treatment in a specialized setting can eliminate some of the enabling which occurs with professionals who are not experienced in working with this population (Guthmann & Graham, 2004). Cross-cultural competency is necessary if treatment is to be effective and accessible to Deaf clients within a substance abuse treatment program.

Perspectives of the Deaf Community

There are several different perspectives used, when identifying the Deaf community. One perspective identifies a person who is Deaf as having a disability and may be referred to as the medical or pathological model. This is typically used more often by people in the medical field, and can be viewed as being a more negative way to identify the Deaf community. The second perspective recognizes Deaf people as a cultural group with common language, experiences and values. These perspectives offer differing views of the Deaf population. Conflicts may arise between a Deaf person's cultural view of him/herself and the hearing world's more common medical model perspective. Those holding a pathological view might define the Deaf community as a group of people whose hearing loss interferes with the normal reception of speech, a group who have learning and psychological problems due to their hearing loss and their perceived communication difficulties, and/or a group who are not "normal" because they cannot hear. The cultural model, however, recognizes that there are many issues to consider, and might define the Deaf community as a group of persons sharing a common language (American Sign Language) that provides the basis for group cohesion, identity, and culture—a group whose primary means of relating to the world is visual and whose language is visually received and gesturally produced (Padden & Humphries, 1988). Deaf people are unlike any other ethnic group because parents and children are likely to identify with two different cultures.

Many barriers further exacerbate potential risk factors for Deaf individuals. Communication barriers may exist within family systems as ninety percent of all parents of Deaf children are hearing (Schein & Delk, 1974). Poor communication between parent and child may be a valid predictor of substance abuse. Additionally, socializing with Deaf peers is cherished within Deaf culture. For a Deaf person in a recovery program, however, socializing with peers can be problematic since many may be using (or abusing) alcohol and/or other drugs. Letting go of using friends may mean leaving the Deaf community, at least for a period of time. While a separation from peers who are using is still recommended, an individual left with few or no Deaf friends is uniquely challenged. The Deaf Club, which serves as the central gathering and socializing place for Deaf people, is often supported by the sale of alcohol. Attitudes toward alcohol in the Deaf community are also important to understand. Because the Deaf are considered a low incidence population, Deaf people are often geographically isolated from one another. As a result, "Deaf Schools" (residential schools for Deaf children) become cultural centers, places where children learn ASL and the traditions of the Deaf community (Padden, 1980).

American Sign Language Within the Deaf Community

One of the primary languages used for communication within the Deaf Community is American Sign Language (ASL). ASL is a visual language that uses gestures, facial expression, body movements, and finger spelling for the letters of individual words. ASL is a recognized language with its own grammar, syntax, and vocabulary (Stokoe, 1980). As with any language, ASL is shaped by the culture of the people who use it to communicate.

Not all Deaf persons use the same communication method. While many Deaf individuals use ASL, some prefer other methods of communication. The client should be given the opportunity to select the communication mode that is most effective for him or her and treatment programs serving Deaf people should be prepared to provide support for the communication method that best suits the client (Guthmann & Graham, 2004).

Assessment Considerations

Substance abuse assessment of Deaf individuals can be difficult, as there are very few assessment tools specifically designed with this population in mind. If the assessor is not fluent in ASL, an interpreter is necessary to communicate effectively during the interview process. An ASL screening tool is currently being completed and will soon be available to assessors. The Substance Abuse Screener in ASL (SAS-ASL) (Guthmann & Moore, 2007) is an adapted version of the Substance Abuse Subtle Screening Inventory (SASSI), version 6, a widely used substance abuse screening tool (Miller & Lazowski, 1999).

Mainstream versus Specialized Treatment Programs

Assuming the Deaf individual is able to access treatment services, the referral will most likely be either to a mainstream program (a generic program) or to a specialized program designed especially for persons with a hearing loss. Mainstream programs attempt to deal with communication barriers by using a sign language interpreter, while specialized programs have staff able to communicate directly with the client in sign language. People who are late deafened, grew up using oral methods of communicating, are hard of hearing and do not use sign language, or those who do not identify with Deaf culture may all be appropriate clients for mainstream programs. These individuals generally prefer to be served by programs for the general population alongside clients who can hear. Their necessary accommodations include good lighting, amplification, slowed or repeated spoken conversation, oral interpreting, captioning, and use of computer technology and/or individual attention. In these cases, a program may want to use a laptop computer and have someone sitting next to the client, inputting information the client can see, or, if the technology is available, Computer Assisted Realtime Transcription (CART) services. CART services utilize a court reporter that types everything said into a stenography machine which then converts the information into a computer for the client to read on a monitor or laptop screen.

For the most part, people who are Deaf and identify with the Deaf community prefer a specialized treatment program (Moore & McAweeney, 2006). Specialized treatment components are sensitive to specific cultural, language, and communication issues and include staff fluent in sign language and knowledgeable about Deaf culture. These clients feel more comfortable in a specialized treatment facility where they can communicate with others in their own language (ASL) and have peers with the same cultural values. Specialized treatment facilities may also provide clients access to other Deaf people in recovery who can serve as role models.

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Substance abuse assessment of Deaf individuals can be difficult, as there are very few assessment tools specifically designed with this population in mind.

Technology Support

As we know, ongoing recovery support is vital for maintaining a clean and sober lifestyle. Deaf individuals returning to their home communities after treatment are at a significant disadvantage due to the lack of accessible Twelve Step meetings and the difficulty of finding sponsors fluent in ASL. Most Deaf individuals are now able to use video phones where they can converse using ASL via a computer screen. If a Deaf person wants to communicate with a hearing person, video relay interpreter services allow improved access to communication. If a Deaf person in recovery wants to talk to a sponsor, they can contact a Deaf person through a video phone or a hearing sponsor through a video interpreter relay service. "Deaf Off Drugs and Alcohol" (DODA) is a program at Wright State University focusing on e-therapy and funded by the Center for Substance Abuse Treatment (CSAT). One of the program components includes the provision of web-based Twelve Step meetings run by Deaf facilitators who are in recovery. Participants see each other in individual boxes on a computer screen, with large enough images to communicate easily. Currently the program has a number of weekly Twelve Step meetings; as more facilitators are recruited and trained, more meetings will be available online (Titus & Guthmann, 2010).

Conclusion

The principles of addiction are the same for people who are Deaf as they are for the hearing. However, Deaf individuals are at a disadvantage in receiving and realizing long-term benefits from substance abuse treatment, since treatment efforts typically fail to consider culturally specific information. Ideally, individuals who successfully complete an alcohol/drug treatment program should be able to return to the environment they lived in previously. That environment, however, must include a sober living option, family/friend support, professionals trained to work with clients on aftercare issues, and accessible Twelve Step/AA meetings. This kind of environment is unavailable to the majority of Deaf individuals. Professionals and the recovering community need to work together at the state, regional and national level to make sure that accessible services are being provided for all Deaf individuals.▼

Recommendations When Working with Deaf Clients

- **Use a Qualified Interpreter.** If you are not fluent in sign language, always use a qualified interpreter for assessment, evaluation, or counseling related to substance abuse services. A qualified interpreter means someone who is trained, certified by the Registry of Interpreters for the Deaf or the National Association of the Deaf, and who is familiar with vocabulary and concepts related to substance abuse.

- **Use Local Deafness Resources.** Access information from local resources about agencies in your area that serve Deaf persons.

- **Training.** Take advantage of training opportunities to learn more about the needs of deaf and hard of hearing people in relation to substance abuse. Provide training opportunities for Deaf and hard of hearing persons who want to work in the substance abuse field.

- **Know and Communicate.** Be aware of the unique needs of Deaf persons who need to access services in the substance abuse continuum of care. Accessible meetings, captioned video materials, and the provision of interpreter services can help Deaf people access crucial aftercare services.

- **Support.** Support the provision of funds that support special programming for Deaf persons.

- **Communication Access.** Video Relay services are available for both Deaf and hearing people to use when communicating. These services allow hearing individuals to call a toll free number and use an interpreter (at no cost) to talk with a Deaf individual. Video phones allow Deaf individuals to communicate directly in sign language with the video relay interpreter or other Deaf individuals.

- **Refer.** Using the principles of cross-cultural counseling, be sure to refer Deaf persons to qualified professionals or agencies if you are not able to meet their communication and cultural needs.

Dr. Debra Guthmann *is the Director of Pupil Personnel Services at the California School for the Deaf, Fremont, where she oversees all clinical services as well as admissions, IEP's and due process issues. She is the founding Director of the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, one of the first inpatient treatment programs for Deaf and hard of hearing individuals in the country. Dr. Guthmann has written numerous articles and book chapters and provided trainings internationally on substance abuse and ethics. For additional information on the subject of substance abuse related to the Deaf and hard of hearing community, visit the website: www.mncddeaf.org or call the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals at 1(800) 282-3323 V/TTY. You may contact Dr. Guthmann by email at dguthmann@aol.com.*

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2011 ILLINOIS INSTITUTE FOR ADDICTION RECOVERY TRAINING AND WORKSHOP SCHEDULE

August 17th–19th & 22nd, 23rd

Problem and Compulsive Gambling: Counselor Training
Presented by the Staff of the IIAR
Training held on the campus of IIAR at The Abbey
Workshop cost: $600.00 (*must attend all 5 days*–30 CEU's)

This training will consist of a 30-hour course delivered throughout a five-day series. It will provide participants with the requisite knowledge for the State of Illinois written certification exam for counselors of problem and compulsive gambling. It also meets the coursework requirements for the national gambling certification. At the end of this workshop, participants will have developed a strong clinical base for compulsive gambling issues as well as cultural competencies and client-centered treatment for compulsive gamblers and their families. ***Training participants will be visiting the local casino as part of the training.***

About the speakers: Licensed and certified staff from the IIAR will be providing the training. The IIAR provides a full continuum of care for the treatment of chemical dependency, as well as gambling, food, Internet, video game, sex, compulsive spending addictions as well as chronic pain with addiction.

October 13th–15th

Family Meeting Approach Intervention Training
Phil Scherer, CAADC, PCGC, MISA-II, BRI-II
Training held on the campus of IIAR at Ingalls Health System
Workshop cost: $300.00 (*must attend all days*–21 CEU's)

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

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

About the speaker: Phil Scherer is the Director for the Illinois Institute for Addiction Recovery (IIAR). Mr. Scherer is certified through the Illinois Alcohol and Other Drug Abuse Professional Certification Association and is a certified Problem and Compulsive Gambling Counselor as well as a Mental Illness and Substance Abuse II professional. Mr. Scherer is also certified through the American Compulsive Gambling Counselor Certification Board and the National Council on Problem Gambling as a counselor of problem gamblers. Mr. Scherer is a trained Board-Registered interventionist and a member of the Association of Intervention Specialists.

October 21st

Blending Trauma Resolution Therapies, Anxiety Reduction, and Attachment Work into Addiction Treatments
Mark Schwartz, SC.D
Training held on the campus of IIAR at The Abbey
Workshop costs $100.00 (6.5 CEU's)

Trauma resolution is a key component in working with many clients. This training will update clinicians in therapies for trauma resolution, anxiety management, and attachment work, especially related to working with those suffering from addiction.

About the speaker: Dr. Mark Schwartz earned his doctorate in Psychology and Mental Health from Johns Hopkins University. He is a licensed psychologist and an adjunct professor in the departments of Psychiatry at St. Louis University School of Medicine. Over the past 25 years, Dr. Schwartz has achieved international recognition for his contributions in a variety of clinical arenas, including the treatment of intimacy disorders, marital and sexual dysfunction, sexual compulsivity, sexual trauma and eating disorders. He lectures nationally and internationally on these topics and has authored numerous articles and book chapters, as well as the books, *Sexual Abuse and Eating Disorders, Sexual Compulsive Behavior*, and *Sex and Gender*. Dr. Schwartz is currently on the Editorial Board of the *Journal of Eating Disorders*.

Registration begins at 8:15am and training is from 8:30am–4:30pm unless otherwise noted. For lodging information, call 1(800) 522-3784 or visit our website www.addictionrecov.org. Refreshments will be provided, but lunch will be on your own for all workshops. For future training dates please visit www.addictionrecov.org.

If you have questions regarding addictions please call 1(800) 522-3784 or write to Coleen Moore at Proctor Hospital, 5409 N. Knoxville Ave., Peoria, IL 61614; email Coleen.Moore@Proctor.org. For additional answers and information visit www.addictionrecov.org.

Continuing Education Units

Illinois Institute for Addiction Recovery and *Paradigm* magazine Offer CEUs

The Illinois Institute for Addiction Recovery is now offering continuing education credits (CEUs) for the *Paradigm* magazine. 2 CEUs for $30.00 with completion of a post test. To obtain your continuing education credits visit our website at www.addictionrecov.org.

The Joint Commission

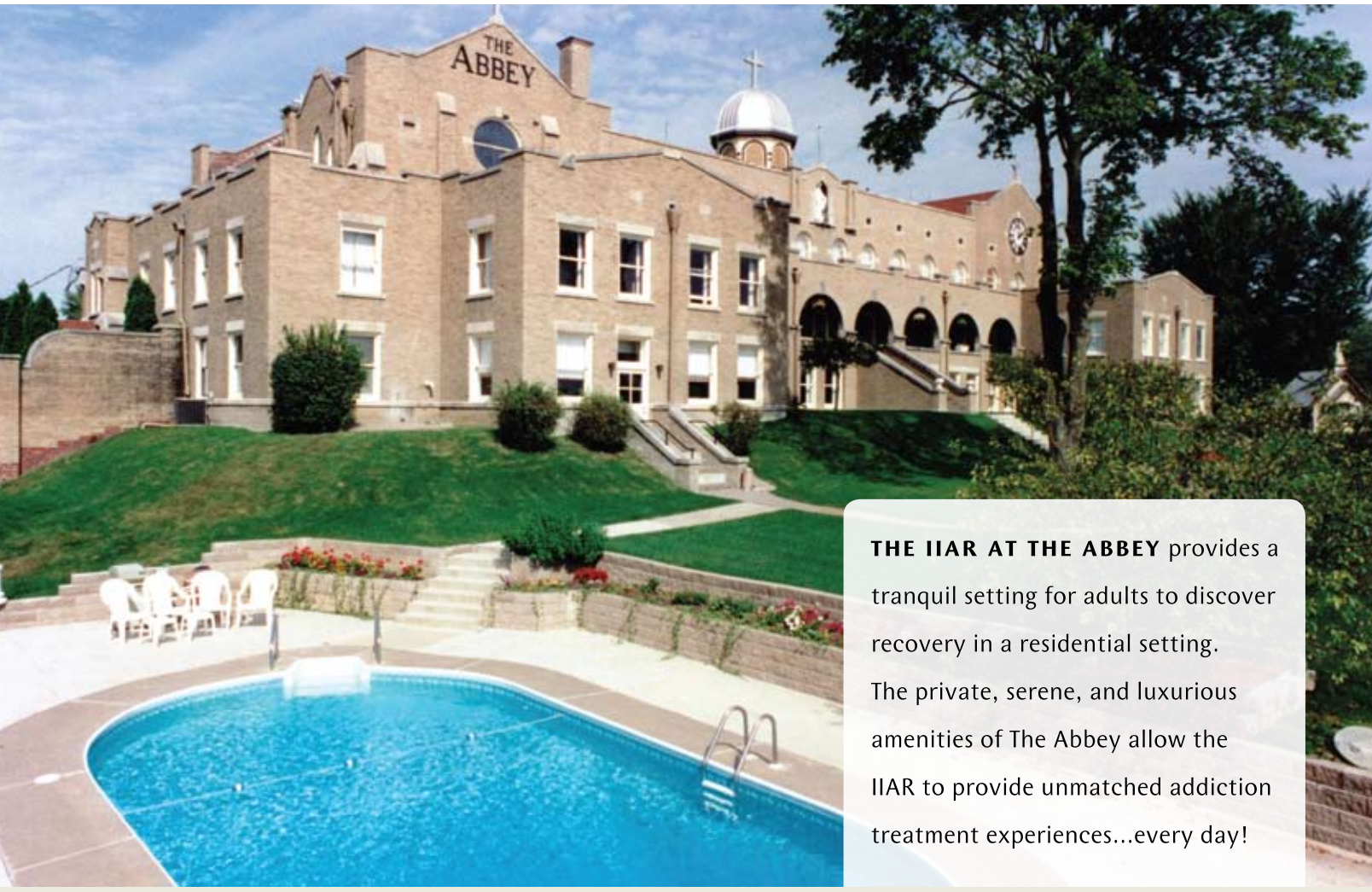
If you have concerns regarding your care, please contact our Patient Advocate at (309) 691-1065. If we cannot resolve your concern, you may also contact JCAHO, an independent, not-for-profit, national body that oversees the safety and quality of healthcare and other services provided in accredited organizations. Information about accredited organizations may be provided directly to the Joint Commission at 1(800) 994-6610.

Information regarding accreditation and the accreditation performance of individual organizations can be obtained through the Joint Commission's website at www.jcaho.org.

Discover Recovery.

Get back what you've lost due to mood-altering chemicals and addictive behaviors.

We offer comprehensive addiction treatment for alcohol, drug, gambling, food, sex, Internet, video game, spending, and chronic pain with addiction.



THE IIAR AT THE ABBEY provides a tranquil setting for adults to discover recovery in a residential setting. The private, serene, and luxurious amenities of The Abbey allow the IIAR to provide unmatched addiction treatment experiences...every day!

The Abbey is on the National Register for historic places.

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