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Destination Hope is accredited by the Joint Commission and licensed by the State of Florida to provide substance abuse and mental health treatment.
Dear Readers,

I welcome you to The Sober World magazine. This magazine is being directly mailed each month to anyone that has been arrested due to drugs, alcohol and petty theft in Palm Beach County. It is also distributed locally as well as being mailed to rehab centers throughout the county and country.

Many petty thefts are also drug related, as their need for drugs causes addicts to take desperate measures in order to have the ability to buy their drugs.

Drug addiction has reached epidemic proportions throughout the country and is steadily increasing. Florida is one of the leading States. People come from all over to obtain pharmaceutical drugs from the pain clinics that have opened virtually everywhere.

The availability of prescription narcotics is overwhelming, and as parents our hands are tied because it is legal.

Doctors continue writing prescriptions for drugs such as Oxycontin, and Oxycodone (which is an opiate drug and just as addictive as heroin) to young adults in their 20’s and 30’s right up to the elderly in their 70’s, thus, creating a generation of addicts.

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

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

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

There are Psychologists and Psychiatrists that specialize in treating people with addictions. There are Education Consultants that will work with you to figure out what your loved ones needs are and come up with the best plan for them. There are transport services that will scoop up your resistant loved one (under 18 yrs old) and bring them to the facility you have chosen. There are long term programs (sometimes a year and longer) as well as short term programs (30-90 days). There are Wilderness programs and there are sober living housing where they can work, go to meetings and be accountable for staying clean.

Many times a criminal attorney will try to work out a deal with the court to allow your child or loved one to seek treatment instead of jail.

I know how overwhelming this period can be for you and I urge every parent or relative of an addict to get some help for yourself as well. There are many groups that can help you. There is Al-Anon, Alateen (for teenagers), Families Anonymous, Nar-Anon and more. This is a disease that affects the whole family, not just the parents.

These groups allow you to share your thoughts and feelings. As anonymous groups, your anonymity is protected. Anything said within those walls are not shared with any one outside the room. You share only your first name, not your last name. This is a wonderful way for you to be able to openly convey what has been happening in your life as well as hearing other people share their stories. You will find that the faces are different but the stories are all too similar. You will also be quite surprised to see how many families are affected by drug and alcohol addiction.

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

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

My son was 7 months clean when he relapsed and died of a drug overdose.

I hope this magazine helps you find the right treatment for your loved one. They have a disease and like all diseases, you try to find the proper care. They need help. Please don’t allow them to become a statistic.

There is a website called the Brent Shapiro Foundation. Famed attorney Robert Shapiro started it in memory of his son. I urge each and every one of you to go to that website. They keep track on a daily basis of all the people that die due to drug overdoses. It will astound you.

I hope you have found this magazine helpful. You may also visit us on the web at www.thesoberworld.com.

Sincerely,

Patricia
Publisher
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Parents don't know how to parent a young adult who is an alcoholic and/or drug addict. Period! What they do know, is that there comes a point when they reach outside of themselves, their family unit and ask for help. Usually, when everything they have tried to do to save their child from alcohol and drug addiction hasn't worked. And, when they get to this point, we the professionals can hear their emotional exhaustion and psychological desperation. But most importantly, we can hear the unconditional love that they have for their children. They can only hear it, if we, as professionals are actually listening. And if we are; it is that love, that bond that we the professionals should be nurturing. We should be utilizing every clinical skill we have attained to strengthen the individual and secure the foundation of their relationships, which are based on unconditional love.

Every professional working in the mental health/substance abuse field has been exposed through either education or work experience to the terms: enabling, family dysfunction and co-dependency. And each professional has also been exposed to: family dynamics, emotional bonds and unconditional love. Yet, it appears that over the years we have focused on the prior; rather than the latter in dealing with addicted young adults and their families. We have forgotten that these parents have just spent months or years immersed in a situation without the skills to stop this horrendous dream from ending. They have spent the majority of their waking moments reflecting back to happier times and wondering where or when did it all go wrong. They wonder how this could have happened to their child and their family. They replay every memory they can think of to try and find some logical reason for their child using alcohol and drugs to the point they no longer recognize their own sons or daughters. These thoughts consume them. We have forgotten that these parents lay in bed at night with their secret thoughts of: what did I do to cause this maybe it’s my fault, maybe I’m not a “Good” Mom or Dad, and maybe I should have done more or provided more. The would haves, should haves and could haves. These thoughts continue throughout the night, as silent tears run down their cheeks and another sleepless night goes by. They wonder where their kids are and who they are with and they wait for that dreaded phone call to come in the wee hours of the morning. The call that tells them their child has overdosed, or is in the hospital emergency room or has been injured in an accident. They lay there remembering the dreams of planning the pregnancy or being scared and then excited when they found out they were having a child. Moms remember nurturing their growing babies from the day they knew they were pregnant. They can think back and remember rubbing their abdomens and trying to picture if they were having a boy or a girl. They wondered what they would name the baby and who the baby would look like. They were excited and counted the days to the delivery date. Now heartbroken, never did they imagine, or even conceive, the thought that that their baby, the child they nurtured before they were born, would ever get involved with alcohol and drugs. But here they are, and they are grasping for any sign, just a sentence from their child that this nightmare could be over, that their family can start over; that they can go back in time; a time when they were all happy. A time before drugs and alcohol took over all of their lives.

We, as professionals need to embrace these dynamics; use these dynamics as a therapeutic tool in helping their children attain recovery. We must educate families by helping them learn new parenting skills, which have in the past been foreign to them. Learning how to parent a child with the disease of addiction is a skill set all unto itself. Families who are dealing with addiction have a strength in which families who have never had to deal with this issue can’t even imagine. Their strength lies in still loving their children even after their child has: lied to them so many times they can’t even count it any more, stolen from them, verbally abused them and manipulated them at every opportunity. It is an emotion that we, as professionals in the recovery field, can help them to redirect ever so slightly. Addiction does not have to be the curse, or stigma, that society has proclaimed. By gently using the bond of love that comes so effortlessly between parents and their children we as mental health and addiction professionals can help families to reformulate and strengthen their ties in ways never imagined. Co-Dependency doesn’t have to be a dirty word anymore. We have learned techniques that can be administered in such a way as to foster the bonds of love through cognitive restructuring, emotional management, behavioral redirection, and spiritual enlightenment. You mean use the tools that we already know. Yes! That’s exactly what we’re saying. Here’s the twist. We swing the pendulum back toward the midline of a healthy balance. We have personally witnessed much too much personalization of the client and/or families tendency toward dysfunction. All families are co-dependent, enmeshed and enable each other. Let’s use these traits as strength, as a way to engage the family and strengthen their bonds with each other to attain a positive outcome. No, a client does not have to learn recovery how I learned recovery. No, a family does not have to love their child how I may love mine or how I think they should love theirs. You see, we learned a long time ago how easy it is to find what an individual or collective is doing wrong. The glass was never half empty; it was shattered! The field of addiction teaches all of us how to look at things differently.

Loretta Lukic, LMHC, ACS, CAP, NCC is the Clinical Director at 12 Palms Recovery Center, Inc. in Jensen Beach, Florida

Tom Edwards, BS, CAP is a Primary Counselor at the 12 Palms Recovery Center, Inc. in Jensen Beach, Florida

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How can someone who has completed all 12 steps relapse? The Alcoholics Anonymous: Big Book says, “What we really have is a daily reprieve contingent on the maintenance of our spiritual condition.” (pg.85) Regardless of what we have done, it only matters what we continue to do. Our recovery from alcoholism and addiction is only as strong as what we do today. So how and what does happen to recovery when we relapse.

The Addiction Treatment Field teaches that a relapse starts long before the substance is ever actually taken. The first year of recovery is usually based around just staying clean and sober. Recovery is something new, and there is a joy in at last having found some relief from our damaging and demoralizing addiction that has plagued us for so long. A lot of times we talk about a “pink cloud” or new sense of well-being that overwhelms us in early recovery. If this is where we stop working a program, simply because we feel better, we are doomed. But, that is not what this article is about, it is about the person who does buy into the 12-step program, simply because we feel better, we are doomed. But, that is not what this article is about, it is about the person who does buy into the 12-step program and starts a life of recovery. At this stage of the game, we are usually willing to take suggestions and keep an open mind.

As time moves on, we start to get things back. Things we have placed on the back burner, in order to ground our lives in recovery, begin to return. Usually in years 2-5, we begin to seek a more serious form of employment or even a career, return to school or maybe enter into a relationship. For women, perhaps it may be child birth. We may forget how we got to this point in our lives. Some just get cocky.

As time moves on, we start to get things back. Things we have placed on the back burner, in order to ground our lives in recovery, begin to return. Usually in years 2-5, we begin to seek a more serious form of employment or even a career, return to school or maybe enter into a relationship. For women, perhaps it may be child birth. We may forget how we got to this point in our lives. Some just get cocky. Contact with recovering addicts starts to diminish, meeting attendance declines, and so on. This is the un-working of Step 12, failure to carry the message other addicts and alcoholics. We can begin to be so caught up in the other aspects of life that one of the fundamental pieces of our recovery begins to fall by the wayside.

Next we may stop praying or meditation. This is the undoing of our conscious contact with a Higher Power. It may be a subtle change at first. It is common for many in recovery, who once got on their knees to pray, to discontinue this practice. Where is that desperation for recovery we once had? Our awareness of a higher-power begins to fade.

Here we plummet; un-working steps 10 through 4 in one mighty swoop. A nightly personal inventory slips into weekly or non-existent. If there is no inventory, there is no need for amends. There are no shortcomings visible to us. Controlling our defects of character becomes like trying to corral a litter of energetic puppies, trying to escape in all different directions. We lose sight of the moral inventory we once made.

Now comes the really scary part: We make a decision to take our will back. Not just a little, as we may have done with certain situations in the past, but the whole enchilada. The power we once believed could restore us to sanity has gone out the window, most likely with our sanity. If our sanity is gone, we once again believe this time will be different. We believe we now have the power, and we can manage our own lives. As we spiral down to insanity, we end up in that disheartening space we thought we had left behind. We once again get that feeling of a deep dark hole in souls, a void so vast that nothing can fill it no matter how hard we may try.

So what can we do? One way to maintain our program is make sure we have a home group. A meeting we attend, at the very minimum, on a weekly basis. Allow these people to really know us. Take commitments such as coffee maker, greeter, or many of the others available at meetings we attend. Allow close friends in our support group to take our inventory. Keep your sponsor close and be open to feedback. All these little things help us to be accountable to our program of recovery. The Alcoholics Anonymous: Big Book says, “We are unable, at certain times, to bring into our consciousness with sufficient force the memory of the suffering and humiliation of even a week or a month ago. We are without defense against the first drink.” (pg. 24) If we thoroughly understand this, we can see how imperative it is to remain perseverant with our recovery.

Thomas Sibilia, CAC, is the Program Director at Destination Hope Inc. and on the faculty at The Academy for Addiction Professionals. Destination Hope is a gender specific addiction recovery program located in Fort Lauderdale, Fl. Thomas can be reached at tsibilia@destinationhope.net.
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Choosing a Treatment Center

By Mitchell E. Wallack PhD, CAP CAGC FABFCE, Executive Director at C.A.R.E. Addiction Recovery

Searching Google for an addiction treatment center results in 1,620,000+ listings. Most have fabulous websites, enticing advertisements and generally speaking strong marketing techniques. The real question is how one determines the appropriate treatment center for yourself and/or a loved one?

Let’s face the facts; most of us are not familiar with either addiction and/or treatment. We want the very best treatment outcomes we are able to achieve for ourselves and/or loved ones. This is an important, life and death situation. This may be the only chance for us to get the help that is needed. This means that we must become knowledgeable and be able to recognize the best place for us.

The following are a list of things that as an informed consumer you should be looking for:

1. Determine the specific needs of the person that is to receive treatment.
   a) Does the person require detoxification?
      i. Is the person using alcohol to excess?
      ii. Is the person using Benzodiazepines?
      iii. Is the person using an opiate?
   b) Does the patient require in-patient treatment? This is the highest and most intensive level of care. Generally speaking, this level of care is required for those patients who either medical complications and/or are at high risk for flight. Some residential programs will take other types of patients… and should be considered.
   c) Day/Night with Community Housing is often a very good alternative to inpatient care. Often significantly less expensive, this type of program is extremely useful for those who require greater supervision but do not have significant medical complications.
   d) Intensive outpatient is appropriate for those who can live on their own and do not require the amount of treatment provided by the other three programs. It is often recommended for those who have completed the levels of treatment in order to provide continued support and guidance in the road to continued recovery.
   e) Last but not least is outpatient treatment. This is most appropriate for those who have completed treatment and/or whose problems are relatively controllable.

It is important to understand that in addiction, breaking the cycle is important.

Day/Night with Community Housing as well as Residential Programs offer the patient the safety of 24/7 access to staff and peers to help support their recovery.

2. Having decided on an initial level of care, the next step is choosing a program. In my opinion the following are the things that should be considered.
   a) Certification and Licensure: All programs in Florida must be licensed by the State of Florida. This means that they have passed minimum standards that the state believes are necessary for the treatment and safety of clients. The next level of a measurement of competency is Certification by a nationally recognized certification agency like Joint Commission. (This is the organization that certifies hospitals and behavioral health programs). In my opinion, this is an absolutely essential requirement for assuring that a program is of high quality.
   b) Cost: As important as good treatment is, we must be realistic. Some programs are simply beyond our financial ability to pay. This means that affordability is an area that must be considered. It is important to remember that not necessarily is the most expensive program the best. The following are questions that should be asked when making a determination about where to go for treatment:
      i. Does the program except my insurance?
         1. If so, what will my responsibility be?
         2. What will happen when the insurance runs out?
      3. What will my responsibility be if the insurance company does not pay the full amount?
   c) Does the program offer any financial assistance?
      i. Scholarships
      ii. Payment Plans
   d) In the event that insurance is not available, one should ask?
      i. What is the total price of the program?
      ii. Are there any extra costs not covered by the program. (e.g. extra M.D. visits, special services like massage therapy etc.)
      iii. What is the program’s refund policy?
      iv. Are there any scholarships and/or payment plans available?
   e) Are the clients allowed to leave the program unescorted?
   f) What is the supervision like? (Be sure to ask about who is supervising and if they are awake at night.)
   g) Is the program prepared to treat, if needed:
      i. Dualy Diagnosed Clients
      ii. Special Need Clients
      iii. Forensically involved clients
      iv. Clients with unusual addictions.

3. What are the qualifications of staff? Most programs will list the qualifications of their staff directly on their website. I suggest that you look for programs that have certified (CAP) or licensed staff (LMHC and/or LCSW). In addition one should ask:
   a) Will the client be seeing the staff listed on the web site?
   b) How often and for what duration will the client see them? Does the program have a Psychiatrist specializing in addictions? How often are clients seen?
   c) What is the client to staff ratio?
   d) Is the program prepared to treat, if needed:
      i. Dually Diagnosed Clients
      ii. Special Need Clients
      iii. Forensically involved clients
      iv. Clients with unusual addictions.

4. What are the living arrangements like?
   a) How many people in the program.
   b) How many people are housed in an apartment? Room? Etc.
   c) What are the amenities? (Gym, alternative therapies …)

5. Other necessary questions:
   a. Does the program provide aftercare?
   b. Is the aftercare provided in house?
      i. Can the program arrange for more convenient aftercare locations?
      ii. Does the program have access to sober living?
      iii. What are the requirements for aftercare?
      iv. What is the cost of the aftercare?
   c. Does the program provide family programs?
      i. How often are these programs provided?
      ii. Are there any additional costs for these programs?
      iii. Does the program provide individual counseling?
      iv. Is there a cost for individual family counseling?
   d. Can I visit the program? Even if you can’t this is a good question to ask to make sure the program is what is represented in their advertising.
   e. What are the hours for visitations? What are the requirements?
   f. What are the rules regarding mail?
   g. What are the rules regarding telephone use?

6. How long should I wait before I go or send my loved one to treatment? The answer to that question is “not at all”. Remember that an addicted person can change their mind very quickly. The very best advice is that when the person says that they are ready to go, put them in the car and/or airplane and send them.

Now let’s talk about you. As a prospective client, and/or family member, the operational word is going to be nervous, spelled S C A R E D. Understand that this is a natural reaction. It is a new experience, new people and above all you or your loved one are being asked to do this without the use of drugs, alcohol, gambling or whatever addiction they are experiencing. It is going to take resolve, support and above all the courage to change. Recognition that that is all for the good will come quickly after treatment begins.

Last but not least, I feel compelled to give warning about the dreaded “Pink Cloud”. This is the time in treatment when the client feels physically better, but still has their addictive thinking. I remind you that you or your loved one’s best thinking is what got them to where they are today. This is a disease of the thinking process, and as such the best advice that I can give is to follow the advice and recommendations of the treatment staff.

The only other advice that I can give is to have everyone remember, “Recovery is something we do for ourselves. No one can do it for you. If those who loved us could, there would be no more addicts.”
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SEALING AND EXPUNGEMENT OF CRIMINAL RECORDS:

By Myles B. Schlam, J.D., CAP / CCJAP

I decided to write this article because people ask me all the time if they are eligible to get their criminal records sealed or expunged, what is the difference and how to go about the process. There are many technicalities regarding Sealings and Expungements, but I am going to try to sum up the most important points in one page.

To have a criminal record either “sealed” or “expunged” a petitioner must be eligible for either a “sealing” or “expungement” under Florida Statutes section 943. I can tell you right off the bat that if you have EVER been convicted of any crime, felony or misdemeanor, you are not eligible to have any criminal record sealed or expunged. However, if you pled Nolo Contendere “No Contest” or Guilty, but the court “withheld adjudication” you may still be eligible for either a sealing or expungement. In order to determine if you were in fact convicted of a certain charge, you must get the case disposition “dipso” from the clerks office of whatever county you were charged in.

One common question I get asked is, “What is the difference between a “sealed” criminal record and one that is “expunged”?

Here is the way I explain it:

A Sealed criminal record cannot be viewed by the general public. Although it is in essence hidden from public view, certain people will be able to see that there is a file on that person, but they cannot see what is in that file. A sealed record can also be viewed by law enforcement and government officials.

An Expunged record is where the entire file is actually destroyed. There will be no indictia of the arrest or that there even was a charge when a record is properly expunged – and I stress the word properly.

While it is true that an Expungement is the best option, a very small minority of people are actually eligible for an Expungement. In order to be eligible for an Expungement, one of three things must occur.

1. The State decides to decline prosecution of your case before it goes to trial. (commonly called a “Nolle Proseze”)
2. The court dismisses the charge or grants a motion for Judgment of Acquittal. (“JOA”)
3. A client is given the opportunity to complete a court diversion program (i.e Drug Court) and after a set period of time, either 6 months or 12 months, the charge is dismissed. This is known as a “deferred prosecution”.

A Sealing of a criminal record would be an option where someone pleads “No Contest” or “Guilty” and while they are usually found Guilty, the court agrees to “Withhold Adjudication”. Again, you would need to check your case disposition to see whether the Adjudication was withheld or not. If the dipso says “Convicted”, then the Adjudication was NOT withheld and you are not eligible to get the record sealed.

Another common question I am asked is, “Can I still get a record expunged even though I have already had one sealed in the past?” or “Can I still get a record sealed, even though I have already had one expunged in the past?”

A person is only eligible to get ONE criminal record EITHER sealed or expunged in a lifetime. Therefore, if you already had a record sealed as a juvenile for instance, you cannot now have another record expunged as an adult. It is a common misbelief that a person can have one record sealed and still be eligible to have another expunged. This is false. However, if a person has had a record sealed for a period of ten years in the state of Florida, that record is eligible to be expunged.

“How long does a sealing or expungement of criminal record take?” is one of the first questions I usually get.

The answer for Expurgations is approximately six months, but that is if everything is done properly and there are no set backs caused by either the petitioner or one of the several agencies an expungement must be processed by. A Sealing can be completed in less time, approximately four months, since it does not need to be processed by the State Attorney’s Office like an Expungement does.

“What charges would disqualify me from getting a record sealed or expunged?”

There is a whole list of enumerated charges that will disqualify a petitioner from getting the record sealed or expunged even if the Adjudication was Withheld. Some of these offenses which are listed in Fla Stat §907.041 include: Arson, Child Abuse, Carjacking, Robbery, Sexual Battery, Kidnapping, Burglary of a Dwelling, Homicide, Manslaughter, and “Aggravated” anything – such as Battery, Assault or Child Abuse. Acts of Domestic Violence would also be disqualifying.

“So what is the process for sealing or expungement?”

The process would begin with finding out if you are eligible for a sealing or expungement before wasting a lot of time and money. At ASI, we usually recommend a background check for those who are not sure if they may have other past convictions out there that they may have forgotten about, perhaps in another state. ASI will coordinate the background check for $50. If there are no past convictions or disqualifying offenses we would begin the process.

First, an application must be filed out stating specific and general information about the petitioner, the case and the charge/charges in question. The application must be signed by the Petitioner before a licensed Notary. If an Expungement is being sought, the application must then be turned into the State Attorney’s office in the county/circuit where the case transpired. Attached to the application should be a certified court disposition which can be obtained for about $3 from the clerk’s office. It will usually take about 45 days for the SAO to process Part B of the application, which is what they confirm or deny that the charge in question is eligible for sealing or expungement.

Once the application is signed off on by the SAO, it must be sent to Florida Dept. of Law Enforcement (FDE) in Tallahassee to be processed. The petitioner must include fingerprints on a special card which can be obtained by ASI or the police department. The Petitioner must also include a money order or cashiers check for $75 made out to FDE for processing. This FDE part of the process can take anywhere from 2-3 months, depending on what time of year it is and other factors. If everything checks out OK with FDE, after 2-3 months the petitioner should be issued a “Certificate of Eligibility”. This certificate simply states that FDE has determined the petitioner is eligible for a sealing or expungement. However, ONLY the court can order a sealing or expungement. Once the petitioner has received the Certificate – a Petition, an Affidavit and a proposed Order needs to be filed with the court in which the charge was disposed. A copy of everything needs to be provided to the State Attorney’s Office as well. A self-addressed, stamped envelope should also be provided to the clerk.

The SAO will then have an opportunity to object to the petition if they feel strongly that it should not be sealed or expunged. I have only had one case where that happened and the charge was Battery on LEO (Law enforcement Officer) which was later dismissed. In that case, the Judge overruled the SAO’s objection at a hearing. The Judge would then sign the prepared Order and it would be sent to the Clerks Office. Whether there is a hearing on a Petition to Expunge or Seal is at the court’s discretion. In Broward County, there are hardly ever such hearings, while in Palm Beach County a hearing is always required for an expungement. Before the Clerk will enter an Order of Expungement or Seal, they will charge a fee of approximately $75 for the Expungement/Sealing and the cost of forwarding the order to all agencies which may have records of your arrest, and Dept. of Corrections (D.O.C) who in some cases will have probation records relating to an expunged or sealed case.

One additional note: Even if you are granted a Petition to Seal or Expunge, there are five agencies that you are required by law to disclose your charges to if you are seeking employment with them. They include: 1. The Florida Bar (if applying to be an Attorney) 2. The Dept. of Education (teacher, etc.), 3. Any law enforcement agency either State or Federal, 4. Dept. of Health, 5. Any employment dealing with adolescents, the elderly or the disabled.

If you or someone you know has had criminal charges and would like more information on the sealing or expungement of criminal records, feel free to contact ASI for a free consultation. 

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"Recovery is about living more in truth than in lies...it's about facing reality and growing up."

- Pia Mellody

Over 2,500 years ago, in Athens Greece, playwrights like Sophocles introduced a form of theatrical art known as the tragedy. Greek tragedies typically dealt with weighty themes such as betrayal, loss, pride, jealousy, rage, love, courage, honor, life and death. Often these dance-dramas also explored man’s relationship with God and the existential questions of man’s potential to be divine. Actors would wear elaborate masks with exaggerated facial expressions so that their character’s role, emotional state, and intentions might be accessible to the audience. Commonly, one actor played several characters during the course of the theatrical performance, changing masks for each character and sometimes for each scene.

Fast-forward to our lives today and the Greek tragedy might be used as a metaphor for some of the key aspects of recovery from trauma and addiction. Like an actor in a play, often we are reacting to life’s existential challenges as if we are another character. This script can influence how we move about on the stage of life; it can spell out our roles in relation to others, how we think and feel, and how we act in various situations.

From the first moments of conception and throughout development, by way of ongoing interactions between ourselves, others, and the environment, this narrative is written into our psychobiology – it becomes an implicit script in the mind-body system.

Moreover, similar to actors in Greek tragedies, our implicit scripts encourage the use of certain masks or personas. In many ways, this is completely natural and necessary for a life in which we are constantly experiencing the enormous rawness of our reality. As in the case of emotional abuse or sexual abuse, the lives of our life stage are constantly changing; we may transition from a family mask to a work mask, then to a friend mask, and back to a family mask, all within the course of one day.

However, unlike the actors in a Greek tragedy, for us these personas are not distinct, separate people – they are aspects of a single being, linked together by the person behind the masks.

For some of us, our own life resembles a Greek tragedy, with painful experiences of betrayal, loss, abandonment, and trauma. These experiences are written into the mind-body script that taints our thoughts, feelings, and behavior. Some of these life events can be so traumatic that we don’t even want to look at the script – we would rather not face the reality of our situation, it’s just too painful. Yet, our bodies and minds still play the part, even when we don’t pay attention to the script; something happens on the stage of life and we just react according to our past experiences, maybe without even being aware of the script.

Also, when there are painful and traumatic aspects to our life scripts, wearing a mask can become an adaptive way to hide our vulnerabilities from ourselves and others. The various personas create a sense of security and a safe distance from the troubling realities deep behind the masks. While this strategy is protective, over time it can further obscure the truth of our scripts and disconnect us from what drives our thoughts, feelings, and actions. In fact, under these circumstances, we risk becoming over-identified with the personas, forgetting who is actually looking through the masks.

Moreover, sometimes these protective measures fall short and the truth of our scripts threatens to come bubbling up into awareness. In those moments, the pain, fear and shame can seem overwhelming, leading to desperate attempts to push it all back out of awareness. Compulsive behaviors with drugs, sex, relationships, and food will facilitate temporary relief from the vulnerability and pain of our tragedy scripts. While addiction can bring a range of relief from our implicit script within human life, it comes with a whole host of complicating problems. In time, addictions only add painful prose to the narrative of our mind-body scripts and further disconnect us from our truth and from people that we love.

For several decades, Pia Mellody has been encouraging people to remember and rediscover the truth behind the masks and to face reality without addiction. For her, what started as a journey to understand the dis-ease of codependence, so that she could better help her clients, turned into an elegant, comprehensive model for addiction recovery. This model continues to be used at The Meadows of Wickenburg, a world-renowned treatment center, and has been a source of healing for many patients and practitioners.

You might ask, “How is codependence related to addiction?” Pia Mellody kept asking herself this same question when she repeatedly encountered the coexistence of these two conditions in her clients. What she and her colleagues came to understand is that codependence and addiction are frequently linked together by a history of childhood abuse and neglect. These traumatic experiences can be overt (i.e., "big "T"), as in the case of physical or sexual abuse, or covert (i.e., little "t"), as in the case of emotional abuse, abandonment, enmeshment, and loss/death. Relational trauma of this kind often results in deep wounds, painful paragraphs in our mind-body scripts, which can lead to developmental immaturity and negative consequences for adult functioning.

More specifically, Pia Mellody found that people usually entered recovery treatment because of addiction, mental/emotional symptoms, resentment/anger, negative control of others, intimacy/relationship problems, and impoverished spirituality. However, usually these issues only become “problems” because other people tell the person in treatment that they are indeed problematic! Yet, given an opportunity to step back from the tornado of unmanageability created by these issues, most people in treatment are able to admit that help is necessary.

Pia Mellody came to understand that these presenting problems were only “secondary symptoms” of deeper, core developmental issues related to childhood trauma. She surmised that relational trauma causes an individual to become polarized along five core dimensions of development: 1) self-esteem (less than versus better than), 2) boundaries (too vulnerable versus invulnerable), 3) reality issues (bed/rebellious versus good/perfect), 4) dependency (too dependent versus needless/wantless), and 5) moderation (too little versus too much self-control). Furthermore, she discovered that when people are able to address their childhood wounds and identify their core issues of developmental immaturity, they discover a measure of reprieve from the secondary symptoms of addiction and relationship turmoil.

Pia Mellody has consistently taught that the recovery process requires that we honestly and courageously face the truth of our past, both what has been done to us and what we have done to others. It is no coincidence that she titled her now-classic book “Facing Codependence” (italics added). As suggested by Pia Mellody, “The recovery process is about living more in truth than lies.” Yet, paradoxically, the painful truth of our mind-body scripts is what drove us to hide behind the masks and disconnect through addictive processes. The prospect of facing the reality of our condition doesn’t appeal to many people – that is why the bottom can be so low.

So, how do we go about facing the truth of our scripts and reaquaint ourselves with the person behind the masks? Here are a few suggestions:

- Develop a willingness to surrender. In the recovery process, a willing heart can take us a long way. The path of recovery has many twists and turns and very often we don’t know what is around the next bend. Remembering the powerless and unmanageability of our past can invite the willingness we need to surrender to the recovery process.
- Be willing to accept help. Recovery isn’t a solitary affair. Often we need the help of a director or producer when facing the truth of our tragedy scripts. Guidance and support can be found in friends and family, recovery communities, professional treatment, and something or someone wiser and vaster than us (i.e., nature, spirit, higher power, etc).
- Cultivate self-compassion and patience. Under the gentle, soft stage-lights of self-directed compassion and patience, we can begin to peer into the darkness behind the masks and face the perilous paragraphs of our mind-body scripts. Rugged honesty isn’t the same as self-defeating judgment and blame. Let us be kind to ourselves.
- Some discomfort is inevitable. As we learn to accept and be with the uncomfortable sensations, emotions, and thoughts associated with our implicit scripts, we find that these mind-body states are generally transitory, like storm clouds moving across a desert landscape. Gradually, our recovery can become imbued with a quiet confidence that we can weather life’s storms.
- Recovery is about growing up. If trauma leads to developmental immaturity, as suggested by Pia Mellody, then recovery must be a maturational process. Don’t fight it – let go of old ways and exercise a willingness to embrace new, more mature ways of living.
- Recovery involves grieving. As we more fully inhabit and live from our truth, we can expect to grieve what we didn’t ever receive, what we lost along the way, and the gradual disillusion of the fantasies that we created about ourselves and others.
- It’s a process, not a destination. It is tempting to think of recovery as a goal or a to-do item to be checked off. But, in recovery, no one ever truly arrives...each step on the path brings fresh challenges and opportunities. “Life is a mystery to be lived, not a problem to be solved.” ~ Søren Kierkegaard.

Perspectives and practices like these support a recovery process where we begin to live more in truth than in lies. The traumatic narratives of our tragedy scripts are not necessarily erased, but they can be rewritten and reinterpreted on the stage of life. Gradually, we become less invested in, and identified with, our various masks – we are able to more comfortably embody the person looking through the masks.

In many ways, the recovery process is about becoming more conscious – more connected with the truth of ourselves and others. Within this field of heightened consciousness there begins to be enough space and security for the emergence of an authentic self. Generally, this kind of conscious presence brings us into contact with our own humanity, our foibles, short-comings, character defects, and our deepest wounds. However, at the same time we are able to make intimate contact with our own immutable and unconditional worth.

In that authentic space of conscious awareness we come back home to ourselves and, if only for a moment, we experience our wholeness. When we are at home with ourselves, we are better able to make meaningful connections with other humans, all creatures, nature, and a higher power. This is the essence of spiritual practice; ultimately, this is the spiritual path. May we all find and inhabit this path of recovery by facing the truth behind the masks.

Dr. Jon G. Caldwell, D.O., is a board certified psychiatrist who specializes in the treatment of adults with relational trauma histories and addictive behaviors. He currently works full-time as a psychiatrist at The Meadows treatment center in Wickenburg, Arizona.
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I believe that each and every client with an addiction to drugs or alcohol, benefits from case specific, individualized treatment.

Although as clinicians we have many treatment modalities and interventions available to us, we must be keenly aware that the implementation of any modality will have differing results depending on their individual scenarios.

Our client’s identifying symptoms, psychological development, biological makeup, environmental stressors and spiritual alertness, are only some of the factors we need to be attuned to. Therefore, it’s essential to weigh all specifics as we go about choosing a specific treatment course.

As a licensed clinical social worker and psychotherapist, I can attest to clients benefitting from regular attendance at self-help meetings. Alcoholics Anonymous has had an amazing impact on my client’s recoveries. Clients I treat who also attend AA meetings have had very impressive turnarounds in character development and personal integrity.

However, in other cases, I’ve found Alcoholics Anonymous treatment to prove counter-productive, and at times even destructive to a client’s recovery. For these clients, the Alcoholics Anonymous meetings reinforced deeply rooted self-esteem issues, encouraged them to manage newly-experienced traumatic symptoms unsafely, and created a false sense of commonality that was a step backward in understanding their own addiction and recovery plans.

Psychotropic medication has helped many clients of mine minimize their anxiety and depressive symptoms; thus eliminating the need to abuse not only their drug of choice, but any mood/mind altering substances. Their specific medications became the linchpin of their treatments. Without responsibly using these medications, it could be argued that no progress would have been made.

It should also be stated that I have seen the reckless manner in which some “addiction psychiatrists” recklessly prescribe pills, in a manner that to the addict mirrors the former drug culture/lifestyle they were so heavily involved in. In these cases the choice of medication was inappropriate, the dosage frequency was off, or the medication was simply not needed. Situations like this often resulted in dangerous lethal outcomes.

Psychodynamic therapy has helped many of those suffering from chemical dependence unlock years of anger, self-loathing and devastating trauma. Therapy can help unlock the burden of past pain and unspoken emotion, allowing the recovery process to finally start and the healing to really begin.

On the flipside, there are times when a client’s psyche is so bruised, that it becomes irresponsible to solely use psychoanalytical therapy. The client’s present “emotional rawness” makes it incredibly difficult to handle the often monumental discoveries and intense feelings that psychoanalytical therapy aids in releasing. Without the necessary ego strengths to guide him/her through the pain, the client is left with bear-naked overly vulnerable emotions, with only their drug of choice to comfort and aid them.

As the former Clinical Director of two drug treatment facilities (outpatient and inpatient), I have seen many clinicians run the gamut of other recovery modalities with their clients; removal of environmental stressors, replacement therapy medication (i.e., cameral or suboxine), holistic therapy options. Sometimes in trying to use every treatment modality available none is used effectively. The client begins to feel like a guinea pig, with little to no understanding of how their individual treatment course works.

When it comes down to it, we all know one thing to be true; treating and actually helping a person addicted to drugs or alcohol are two very different things.

I repeat again how an awareness of modality choices is paramount to an effective treatment course.

If we as clinicians can abandon rigid one-size-fits-all models of care, we can focus more deeply on in-depth personalized assessments.

If we can make singular case-specific treatment the gold standard of care, we’ll have a much better chance to help more of our beloved clients, recovery fully.

Noah Kass, LCSW is a psychotherapist and licensed Clinical Social Worker, specializing in addiction, relationship issues and work stressors. He has been Clinical Director at The Dunes East Hampton and Realization Center in Union Square, both addiction treatment facilities. He writes a weekly advice column (ASK NOAH) on Jim Cramer’s thestreet.com and The Huffington Post. Mr. Kass was the “resident therapist” on MSNBC’S The Dylan Ratigan Show (KASS COUCH) and is a frequent guest on various television programs and radio stations.
A Letter From Someone in Recovery

I have received this letter which is one among many but it really touched my heart and I wanted to share it with my readers. It reinforces in my mind, how we desperately need a magazine like The Sober World. I hope it reminds everyone why and how they initially decided to work in the addiction field. If we could all help just one person.....

For all my advertisers that have believed in me and The Sober World from the very beginning when it was just a dream, I thank you from the bottom of my heart for making this a reality.

Patricia -
I am not sure if you are indeed Steven’s mom, but, in the event that you are not, I hope that you would pass this along to Steven’s parents.

I am a recovered alcoholic and drug addict approaching 5 years of recovery. My story is of one who has bounced around the rooms of AA and NA for 25 years before finding somebody who had the solution to my problem and my life. Gratefully, I grabbed it with all of my might, and I have not let go since. The great joy and responsibility in my life is now my primary purpose, which is, not only to stay sober, but to carry the message to another alcoholic/drug addict. I would like to think my commitment would have been the same regardless of my history of failure to find hope and clarity in 12-step rooms & rehabs, however, this responsibility resonates even more so with me because of my past journey.

Of late, I have been struggling with a decision as to, whether or not, broaden my area of influence and enter the Addiction Treatment Industry in mid-life. I certainly sense a calling to do so, and am aware of the spiritual rewards that would be gained, but until now, it has been a decision I have been unable to make. The reluctance of making such a life change (due to practical and financial considerations) were likely ‘my demons shouting down the better angels in my brain’, as my favorite fictitious president once said.

Yesterday (Rosh Hashanah), I was fortunate enough to be in temple in Boca Raton to hear my nephew Danny singing in celebration of the New Year. Afterwards, while I was leaving, out of the corner of my eye, I was struck by a magazine among magazines, on display in the entryway, “The Sober World”. Hmm, I grabbed a copy with the hope that I would find something inside that would facilitate what seemingly was a difficult decision. A decision I could not make, regardless, of the inspiration I, already had found. I needed something more.

The magazine stayed unopened for exactly 24 hours until I noticed it on my coffee table an hour ago. Suddenly, I was prompted by character defect of laziness to Google “The Sober World”, and I saw the beautiful face of a child who, as it turns out, was not spared from the same exact disease that I have. I never have been sure as to why I was spared by the grace of God, while so many others were not. Once again, I was confronted by this puzzle which, seemingly, had no answer. Now, I finally, had an answer and my necessary inspiration.

Finally, it has never been clearer to me as to what I am to do with my life. What God wants me to do with my life. If I had listened to Michelle Obama just days ago, I might have had my answer when she said, “Success isn’t about how much money you make, it’s about the difference you make in people’s lives.”

NOW, I am finally listening. I am listening to Steven. One thing I know for sure is that, regardless of how many or how few soldiers there are in this battle against addiction, there can never be too many - and now there is going to be one more in the trenches.

So, thank you Steven and thank you “The Sober World” for allowing me to hear the better angels singing clearly and uninterrupted. Please know how profoundly your son has inspired me to help others to find their way. If I help even a single person to find solution in the darkness, it will truly be due to the fire that he has ignited in me. I will remember him in just that way.

Once again Patricia, thank you! I am grateful for your clarity and light needed to journey further down the only road I really had to choose from!

Don G.
Is it everyone else or is it me? Personality disorders and how they affect addiction treatment.

By Raul J Rodriguez MD, DABPN, DABAM, MRO

Please go away, go somewhere else. Please fly back home where you will be at least 1000 miles away. Please never come back. These are some of the common sentiments that people may have towards individuals with personality disorders. Sentiments held by family, friends, and often even their treatment providers.

Addiction treatment of individuals with personality disorders is usually very difficult. They frequently irritate and wear down the people that are trying their best to work with them. Many clinicians conclude that they just like to self-sabotage and just don't want to get better. They are almost always misunderstood. None of this is conducive to a strong recovery, yet this scenario repeats itself almost every day in treatment settings all over the country. So what is it about personality disorders? Why are they so difficult to deal with?

The biggest challenge that faces individuals with personality disorders is the fact that most people, including themselves, have little to no knowledge about them. A personality disorder is defined as an enduring pattern of perceiving, relating to, and thinking about one's self and one's environment that creates a substantial degree of dysfunction and interferes with long-term functioning. The dysfunction often creates a substantial degree of dysfunction and distress for the individual, which increases the vulnerability to substance abuse. Addiction frequently develops and the enduring behavior patterns predictably trigger relapses. Multiple treatment failures usually follow, with the individual being written off as poorly motivated or "not ready." The unfortunate circumstance here is that this population actually sees the specialized care needed to get better. Effective care requires attention and consideration for the specific needs of the different personality disorders.

There are a variety of different personality disorders with certain typified dysfunctional behavior patterns. The grouping that is most frequently encountered in addiction treatment settings is what is referred to as "Cluster B." Cluster B includes the Narcissistic, Borderline, Histrionic, and Antisocial personality disorders. Many people exhibit certain traits of each of these personalities, but individuals with a complete constellation of the specific traits will meet criteria for having a full disorder. Each of these disorders has specific considerations with regards to how it affects addiction and recovery.

Narcissistic Personality Disorder is exemplified by a preoccupation with the self, a heightened sense of self-worth, selfishness, devaluation of others, and a strong emphasis on prestige, power, and vanity. Narcissists are usually seen as arrogant, self-absorbed, and tend to be dismissive of others. They may be high functioning and can achieve extraordinary levels of success. Some of the same traits that helped them achieve such success in other facets of life may actually impede them in recovery. Narcissists often have difficulty taking direction in treatment settings, especially from lower level staff. They are sensitive to criticism and may reject any therapeutic feedback that may resemble such. Perceived slights or disrespect may lead to an impulsive abandonment of treatment, which almost invariably ends in relapse. Their behavior and demeanor may create conflicts with other patients, especially when they are dismissive. These behaviors can be very disruptive, garner most of the attention, and typically distract clinicians from the deeper-rooted problems. The consequence of this is that without addressing the deeper problems, most of the behaviors and thought patterns that contributed to the development of the addiction will simply continue. Knowledge of and sensitivity to these tendencies will help keep the patient engaged in treatment and allow more opportunity to address the deeper issues. Individual psychotherapy for an extended period of time is the treatment that is most effective. It is also important to be able to separate between full scale Narcissistic Personality Disorder and the rather common sub-syndromal trait clusters. The repetitive self-gratification of drug use will contribute to a certain degree of self-absorption and selfishness that resembles narcissism. These individuals usually lack many of the other traits and will not be as disruptive in this regard.

Borderline Personality Disorder is widely regarded as one of the most disruptive and difficult conditions in all of psychiatry. This disorder is characterized by severe emotional instability, rapid and extreme mood shifts, chaotic relationships, unrelenting crises, an unstable sense of identity, "black and white" thinking, chronic suicidal ideation, and intentional self-injury. Substance abuse is a common complication, often the result of failed attempts to regulate mood. Addiction actually worsens the mood instability, creating a vicious cycle of attempted mood suppression and relapse. The intensity of the mood shifts is very difficult to tolerate, which is why the risk of relapse is so high. They are often seen as the "impossible patients" on inpatient units and leaving against medical advice is common. Conventional treatment systems, including 12-step models, do not work well with this disorder and in some cases can worsen emotional trauma. Dialectical Behavioral Therapy (DBT) is the treatment of choice for Borderline Personality Disorder, whether addiction is present or not. Unless the personality elements are thoroughly addressed, the prognosis can be poor. This disorder can be the most disabling of the cluster B disorders.

Less disabling than Borderline Personality Disorder but still problematic is Histrionic Personality Disorder. This condition is characterized by a pattern of excessive emotionality and attention-seeking behavior, an excessive need for approval, inappropriately seductive behavior, dramatic expression with an impressionistic style, and manipulative behavior to help meet their needs. The extroverted behavior often mixes with substances of abuse, with addiction frequently developing. Individual psychotherapy is the most important modality of treatment for this disorder, usually with an emphasis on Cognitive Behavioral Therapy (CBT).

The cluster B disorder that is most lacking in established and effective treatment is Antisocial Personality Disorder. Individuals with this disorder, commonly referred to as "sociopaths", are characterized by a severe lack of consideration for the rights and feelings of others, disregard for social norms and rules, difficulty maintaining enduring relationships despite relative ease in establishing them, a low frustration tolerance with a heightened capacity for aggression, and a notable deficiency in the ability to experience guilt. The impulsivity and novelty seeking of this population often leads to drug use. There is growing data on deficits in the dorsolateral prefrontal cortex of this population, which would further predispose them to substance abuse and the development of addiction. The difficulty in following rules interferes with many treatment initiatives. The involvement in criminal behavior often pulls them back into the drug world, resulting in relapses and potential legal consequences. The criminal justice system is one of the more common final destinations for these individuals. Most of the inmates in any prison meet full criteria for Antisocial Personality Disorder, with estimates as high as 75% of the population. Not everyone with a criminal history should be considered a sociopath though, especially considering how frequently illegal behaviors are involved with addiction. Well-established boundaries and frequent limit setting are fundamental requirements for trying to treat this population. Treatment failure is common with this disorder. The absence of a correct diagnosis and the related therapeutic considerations contribute to this.

Accurate diagnosis requires careful analysis of a thorough clinical history as well as ongoing observation by a treating therapist or psychiatrist. Following the patient’s behavior over time gives the best picture of pathological behaviors in different situations and contexts. Awareness of a co-existing personality disorder is as important to the patient as it is to the clinical team. Many patients express a certain degree of relief and new found hope once they gain a greater understanding of themselves and their behavioral tendencies. Clinicians are better equipped to treat their patients if they can account for the myriad personality driven behaviors that may complicate treatment. This requires additional education and training on the part of the professional. In treatment settings where time may be limited, communication with prior treating clinicians is essential. Simply reviewing medical records rarely yields as much valuable information as would a phone call to the most recent outpatient therapist. When a willing patient with insight into their personality disorder engages a well informed and prepared clinical team, the prospect of a successful outcome is optimized.

Raul J Rodriguez MD is the founder and medical director of the Delray Center for Healing, an outpatient center that specializes in the treatment of addiction, eating disorders, personality disorders, and treatment resistant depression. The Delray Center for Healing is located in downtown Delray Beach, Florida. More information is available at www.delraycenter.com.
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We are in the midst of a hidden epidemic. An epidemic so large that it is affecting our youth in both the United States and the United Kingdom, in most of North America and in Europe. This hidden epidemic is a major health concern affecting over 2 million adolescent girls in the United States or 1 in every 200 girls over the age of 13. While girls generally practice these behaviors, it also is evident in at least 11 thousand boys a year as well in the United States alone. (National Mental Health Association, 2005)

The hidden epidemic is a new drug of abuse. A drug that has the same effect on the brain as heroin, but it is legal, less expensive, is always available and there is a never ending supply. It does in the brain what heroin does in 8 minutes and Prozac takes 3-4 weeks to do, but it does it in 3-4 seconds. With its massive endorphin response and dramatic elevation of dopamine and serotonin, the brain begins to crave it and the urge to have it is so strong that it is virtually impossible to stop using it without another alternative. This epidemic is growing at an astounding rate of 10% annually worldwide. Often referred to as the “New Age Anorexia” the drug I am speaking of is known not as a drug, but as self-injury.

According to the World Health Organization, the highest rates are amongst women regardless of age. The female use of it consistently outnumber the number of men who do it. In Ireland, the rate is estimated to be 196 per 100,000 of the population. There are over 10,000 identified cases seen in Irish hospitals each year.

Those that self-injure are not the ones that get piercings or tattoos. They are difficult to identify: They are often:
1. Above average in intelligence
2. Good to excellent students
3. Rarely participate in activities that require a change of clothing.

Self-injury as a coping mechanism, is highly effective.

“Self-injury is an expression of acute psychological distress. It is an act done to oneself, by oneself, with the intention of helping oneself rather than killing oneself. Paradoxically, damage is done to the body in an attempt to preserve the integrity of the mind.” Jan Sutton & Deb Martinson –Secret Shame, 2003

The crisis we face as a field is the lack of understanding on the part of treatment providers, their over-reaction and their wrongful assumption that self-injury is an attempt at suicide. On the contrary, self-injury is the antithesis of suicide.

Many wrongly assume that the alternative to self-injury is “acting normally,” but on the contrary, the alternative to self-injury is total loss of control and possibly suicide. It becomes a forced choice from among limited options. Solomon and Farrand (1996)

Suicide versus Self-Injury

• Self-injury is distinct from suicide.
• A person who attempted suicide seeks to end all feelings.
• A person that self-injures seeks to feel better.
• Suicide behaviors are less frequent and do not provide relief rather they communicate.

Self-injury is a deliberate act used to alter mood by inflicting physical violence onto oneself. While cutting is the most common form of self-injury, there are many other self-injurious behaviors. For example:

• Cutting
• Hair-pulling
• Scalding
• Infecting Oneself
• Scab picking
• Bruising or breaking bones

Any behaviors that cause immediate pain.

Self-injury is commonly done to:

• Counteract Suicidal Feelings
• To calm & remove overwhelming tension
• To control anger, rage & dissociation
• To physcialize what could not be verbalized

• Alter a mood state positive or negative
• To self-punish
• To ground oneself to reality
• Counteract anxiety/depression

The Demographic Characteristics of the self injurer are:

(DeChello, Understanding Self-Injury, 2008)

1. Predominantly female
2. Start self-injuring between ages 13-19, and often continue into their mid-20’s to early 30’s but have self injured since in their teens.
3. They are predominantly Caucasian
4. Are extremely perfectionistic
5. Under pressure to perform in their lives, grades, friends, looks, outside activities etc.
6. Commonly are middle to upper-middle class
7. Average to high-average intelligence
8. Are well educated
9. Often a background of physical or sexual abuse or trauma though not always
10. Often come from a family with an alcoholic or drug addicted parent
11. Often have a concurrent eating disorder.
12. They use it as a way to cope with stress
13. They often lack the ability to regulate their mood by some other method.
14. Often they have a history of having been in psychiatric treatment.

Important Statistics (DeChello, Understanding Self-Injury, 2008)

• Most have had at least 50 previous acts of self-injury before seeking help.
• 57% have taken a drug overdose at least once.
• A third of them thought they would be dead within 5 years of the time they started self-injuring.
• 50% have been hospitalized for self-injuries acts
• 14% of those hospitalized stated that the hospitalization actually helped.
• 64% have been or currently were in psychotherapy
• 73% of those in outpatient therapy say it helps.
• As many as 90% report that they were discouraged by their loved ones from expressing emotions, particularly anger and sadness as children.

Why do people deliberately injure themselves?

“How-mutilation is a desperate attempt to have some control over unbearable feelings. When a teen or young adult has not learned healthy ways of managing these intense emotions, they turn to pain as a way to blot out the emotional pain or gain a sense of control over the pain that they feel. In a strange way, they are really trying to not hurt themselves – they are trying to protect themselves from something even more painful than the physical pain.” Dr. Margaret Paul

Neurochemistry &Self-Injury

• Scientist believe SI is related to Serotonin deficits.
• Serotonin levels drop -> leads to depression and/or impulsive aggressive behavior -> Self Injury ->endorphin release -> calm
• This becomes a vicious cycle.

Much work needs to be accomplished to train, orient and sensitize medical, nursing, and treatment professionals who often downplay or ignore the behaviors. As previously stated, only 14% of those who self-injure who were interviewed by myself (n=200) found hospitalization to be effective. This is handled much more effectively outside of the hospital. If professionals could get past their fears of suicide with these individuals, the rate of successful intervention would increase dramatically. In my opinion the fear of suicide often results in inappropriate hospitalization. In reality by doing so we are often treating the clinician.

The first step in recovery for the self-injurer is “admitting to the behavior.” When a person admits to a clinician that they engage in this behavior, there is no greater sign of trust. This trust is fragile and can easily be destroyed if the treating clinician over reacts. Ultimately, forcing the client back into their shell and ending hope of useful intervention.

A Harm Reduction Model where the objective is not to condone this behavior, but to acknowledge the importance of it in the day-to-day life of the self-injurer can be highly effective. Trying to take away the behavior without alternatives may lead to continued self-injury or suicide. If this is their primary coping mechanism, they need to explore new coping mechanisms before being able to let go of old ones.

Because of the potential inherent dangers associated with these behaviors, clinical supervision is necessary to monitor treatment and to aid the clinician in order to be able to maintain objectivity with this client.

While self-injury is often an alternative to suicide, self-injuries may cut too deep. Individuals engaged in these behaviors should be trained in general first aid and know how to deal with a medical emergency. First aid training should be part of the treatment protocol.

Family intervention is usually critical since the family is often either at the root of the trauma that precipitated the behavior to begin with or often exacerbated its continuance. Families tend to have a strong reaction when they first hear that a loved one is engaging in these types of behaviors. Often acting out of fear, guilt and anger, families in fact worsen the situation. If the plan is for the self-injurer to stay in their home with their family, the family must be part of the intervention if success is to be a possibility.

Self-injury is a drug and becomes habit forming. It requires the intervention of a knowledgeable clinician and sometimes non-conventional interventions that meet the client’s needs without causing further damage.

The parallels with Chemical Dependency Treatment are many. Successful treatment requires the empowerment of the user and their desire and commitment to regaining control over their lives. The choice to end the behavior or limit its use lies strictly with the user. Limiting the behavior through development of alternate behaviors is the key to success. Simply telling the addict to stop the behavior never works. Forced treatment and abstinence only based approaches leave the self-injurer with few options to deal with their life stressors. Therefore their primary alternative option may become suicide.

The substance abuse treatment communities are the most appropriate core group to work with these individuals. They are accustomed to working with additions as coping mechanisms and have the arsenal of treatment methodologies that work such as cognitive behavioral therapies, Dialectical Behavioral Therapy (DBT), Reality therapies and many others.

The substance treatment community is accustomed to treating additions with Harm Reduction philosophies that do not advocate strict abstinence. It is time that the treatment communities take our heads out of the sand and deal head-on with this increasing epidemic.

This is an area that must be addressed before it spirals out of control. Ignoring the problem will not make it go away. Self-injury can lead to death, disease and destruction to the future fabric of our society. Our call on our policy makers to be proactive and provide training, treatment and programming for this ever expanding group.

Patrick DeChello Ph.D., LCSW, MSW, RPH is an internationally recognized clinical social worker, clinical psychologist, Hypnotherapist and chemical dependency treatment specialist with well over 30 years of experience and author of 29 books and numerous articles in the mental health and chemical dependency fields.

His books and presentations have a reputation for being clear, humorous, pragmatic and cutting edge. His clinical skills and vast knowledge base make both his writings and presentations enjoyable and highly educational.
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