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Contrary to what she had expected, she found herself working with adults with addictions. During this time as a counselor, Shannon began to understand the overlap between mental illnesses and addiction.

Ms. Shannon Chrismore is the Training and Quality Coordinator at the Illinois Institute for Addiction Recovery (IIAR). Shannon initially joined the IIAR in May 2007 as a Young Adult Counselor. Early in 2008, Shannon became the Clinical Coordinator of the Springfield satellite outpatient facility. With the opening of IIAR at Ingalls Memorial Hospital, Shannon relocated back to the IIAR facility on the Proctor campus to coordinate start-up projects and staff training. It was the work on these projects that helped prepare her for the new role she was to assume as the Training and Quality Coordinator. Shannon will continue to coordinate staff trainings and education; develop training protocols for start-up programs; and perform quality improvement activities, among other responsibilities.

Shannon attended Illinois State University, where she earned a bachelor's degree in psychology and criminal justice sciences in 2005 and a master's degree in Clinical Counseling Psychology in 2007. When Shannon first began preparing for her future career, she saw herself working with mentally ill clients in a criminal justice setting. She was introduced to the field of addiction after working with chemically dependent adolescent males in a local residential treatment center while attending college.

During her graduate year, she had the opportunity to pursue a practicum placement in providing counseling to clients in nearly any social service setting. Shannon initially thought she might like to pursue a practicum at a local mental health agency. Contrary to what she had expected, she found herself working with adults with addictions. During this time as a counselor, Shannon began to understand the overlap between mental illnesses and addiction. She began to realize that it didn't matter what direction her career would take her—she would always be faced with clients struggling with addictions as long as she chose to work in a social service setting. Shannon continues to attend trainings, read articles, and participate in recovery-related events in order to increase her knowledge and awareness of the disease of addiction.

While working with the IIAR, Shannon has worked on professional development by acquiring certifications and a clinical license. She currently is a Licensed Professional Counselor, Certified Reciprocal Alcohol and other Drug Counselor, and a Problem and Compulsive Gambling Counselor. She resides in her hometown of Lincoln, Illinois, with her two dogs, Murphy and Molly. When she is not working, Shannon enjoys riding her bike, walking her dogs, running, and traveling.



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OneRecovery

Ongoing Solutions for Life™

...one of the latest breakthrough solutions to combine the best of social networking capabilities with current clinical addiction recovery principles and methodologies.

Social media, including Facebook, MySpace, and Twitter, have taken the world by storm. While many recovery professionals use the Internet for marketing purposes, leveraging online social media to provide aftercare and increase recovery outcomes is still in its nascent stage. However, three out of four Americans now use social technology and the time spent on social networks is growing at three times the overall rate of time spent on the Internet. It's time to start leveraging the power of social networking to increase patient-centric recovery and outcomes (Forrester, 2008; Nielson, 2009).

As social technology fundamentally shifts the way everyone accesses and participates in their health services, its impact on behavioral health will be like nothing we have seen before. Most notably, OneRecovery is one of the latest breakthrough solutions to combine the best of social networking capabilities with current clinical addiction recovery principles and methodologies.

OneRecovery is a behavioral modification solution that extends the reach and benefits of professional care through the use of online and mobile social networking technologies to increase outcome-driven wellness and to reduce the cost of healthcare. With a rapidly growing clientele that includes Illinois Institute for Addiction Recovery, Brighton Hospital, and Touchstone Treatment, OneRecovery features substantial, unique benefits and services for both individuals in recovery, as well as the treatment centers that utilize its proprietary Social Solutioning™ platform.

OneRecovery's Social Solutioning platform was built upon the understanding that the share of adult

Internet users who have a profile on an online social network site has more than quadrupled in the past four years—from 8 percent in 2005 to 35 percent now (Pew Internet & American Life Project's, 2008). Studies also increasingly show that the friendship and fellowship found online can lead to significant health benefits due to the fact that "a stable and supportive social network improves health outcomes for people with a wide range of conditions from heart failure to post-partum depression" (Lenhart & Fox, 2009). OneRecovery's patent-pending Social Solutioning™ platform facilitates the creation of a trusted social support network by enabling unlimited groups of people to come together with the common goal of improving health and wellness. Social Solutioning™ also gives both users and professional healthcare providers control over the privacy of all content, including the ability to customize specific access to content they post on the site. "I see OneRecovery's Social Solutioning platform and their constant supportive connectivity as one of the greatest developments in addiction medicine treatment in the past twenty years," said Rick Zehr, Vice President, Ancillary Services for Proctor Hospital.

With 60 percent of e-patients (individuals who look online for health information), or 37 percent of U.S. adults, having completed at least one of 11 social media activities related to health and healthcare, OneRecovery captured these trends through real-time risk assessment and intervention algorithms; treatment collaboration tools for a continuum of care, multi-dimensional personal privacy settings; goal realization technology; reporting of ongoing comparative outcome data; interactive forums and blogs; live individual and



"OneRecovery features real-time mobile intervention that enables friends, colleagues, and professionals to proactively help when a person is most in need..."

group chat; and an up-to-date events and resources section, among other wellness tools (<http://www.pewinternet.org/Reports/2009/8-The-Social-Life-of-Health-Information/03-Social-Media-and-Health/2-60-of-epatients-access-social-media-related-to-health.aspx?r=1#content12>).

Health-related social technologies capture "the exchange of health information and personal stories in a way that transcends both medical textbooks and chatting with a friend on the phone—yet offers some of the benefits of both" (Sarasohn-Kahn, 2008). What's more, e-patients with mobile access to the Internet are more likely to contribute their comments and reviews to the online conversation, demonstrating that mobile technology is associated with deeper engagement in social media and an accelerated pace of information exchange. OneRecovery features real-time mobile intervention that

enables friends, colleagues, and professionals to proactively help when a person is most in need, thereby increasing recovery outcomes. For example, each time a user logs into the site, they are greeted with a simple question: "How Are You Feeling?" The user then has the option to select one of 27 "emoticons" ranging from "Afraid" to "Calm" to "Resentful". Selecting one of the "at-risk" emoticons ("Afraid" for example) automatically sends a text message to the user's pre-selected support circle of friends and professionals. This real-time intervention allows friends, colleagues, and professionals to proactively help and thereby increase outcomes.

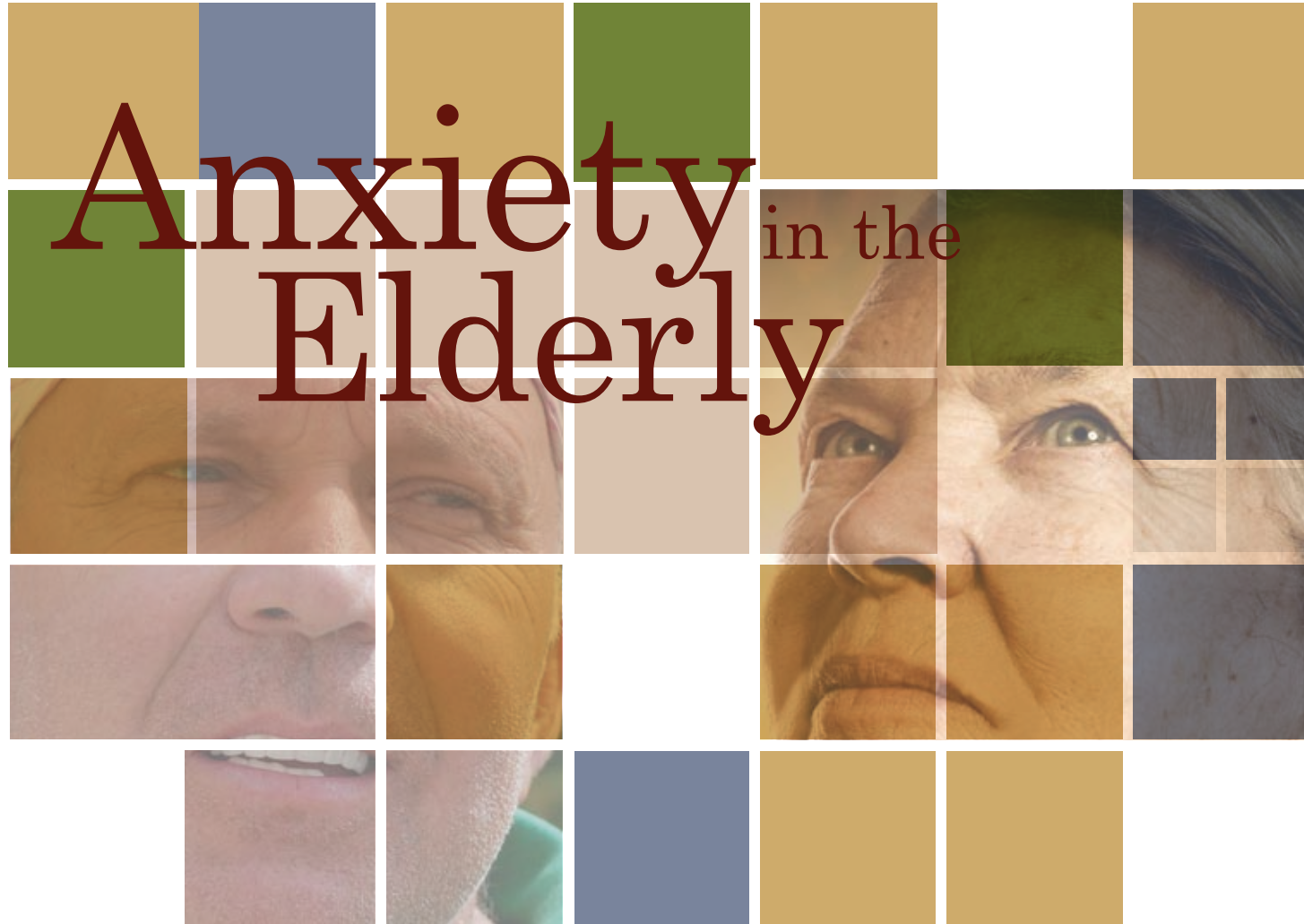
Founder and CEO, David Metzler, created OneRecovery out of his personal experience with addiction recovery and his desire to help people who suffer from addiction and other life-changing diseases. To ultimately achieve today's universal healthcare goals, OneRecovery believes healthcare providers must leverage widely accessible social-networking technology to extend proven clinical solutions to the greater population and connect them to the professional community—in a fun, interactive, and informative way. OneRecovery is a means to accomplish that solution. ▼

For more information contact Drew Paxton, Chief Marketing Officer for OneRecovery at (858) 947-6333 or email dpaxton@onerecovery.com.

References

Forrester, The Growth of Social Technology Adoption, 2008.
Lenhart, Amanda & Fox, Susannah. "Twitter and status updating." (Pew Internet Project: February 12, 2009). See: <http://www.pewinternet.org/Reports/2009/8-Twitter-and-status-updating.aspx>.
Nielson, Global Faces and Networked Places, March 2009.
Pew Internet & American Life Project's December 2008 tracking survey.
Pew Internet. "Social Media and Health." (Pew Internet Project: Retrieved September 10, 2009). See: <http://www.pewinternet.org/Reports/2009/8-The-Social-Life-of-Health-Information/03-Social-Media-and-Health/2-60-of-epatients-access-social-media-related-to-health.aspx?r=1#content12>.
Sarasohn-Kahn, Jane. "The Wisdom of Patients: Health Care Meets Online Social Media" (California HealthCare Foundation, April 22, 2008). See: Social Media and Health. <http://www.pewinternet.org/Reports/2009/8-The-Social-Life-of-Health-Information/03-Social-Media-and-Health/1-Many-seek-a-justintime-someonelikeme-but-few-post-their-own-stories.aspx?r=1>.





Anxiety in the Elderly

by Roberta Robinson, B.A., Jessica Calleo, Ph.D. and Melinda Stanley, Ph.D.

ANXIETY IS A NORMAL EMOTION THAT BECOMES A PROBLEM IF IT IS EXPERIENCED TOO INTENSELY OR TOO FREQUENTLY OR FEELS OUT OF CONTROL.

Introduction

The mental healthcare needs of older adults are understudied, and many older adults with mental health difficulties are never identified and do not receive adequate treatment. Research has now begun to address these issues to improve mental healthcare for older people. Of the mental health problems experienced in later life, anxiety is one of the most frequent. Anxiety is a normal emotion that becomes a problem if it is experienced too intensely or frequently, or feels out of control.

The prevalence of significant anxiety symptoms in older adults ranges from 15 percent to 52 percent in community settings (Bryant, Jackson & Ames, 2008). Collections of symptoms that meet criteria for an anxiety disorder under the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) occur in one to 15 percent of older adults. Increased anxiety is more frequent in homebound elders and nursing home residents, as well as older adults with chronic medical conditions, than in other older adults (Cully & Stanley, 2008). Persistent anxiety is associated with poor medical outcomes, such as coronary heart

disease, physical limitations, memory difficulties, higher levels of healthcare utilization, and even death (Cully & Stanley, 2008). Decreased quality of life and reduced life satisfaction are also associated with anxiety disorders in late life (Wetherell et al., 2004). Anxiety disorders and symptoms are not likely to remit on their own without treatment.

Although several anxiety disorders, including specific phobias, post-traumatic stress disorder, and panic disorder, appear in the elderly, generalized anxiety disorder (GAD) is the most frequent of the pervasive anxiety disorders and the most common seen in primary care clinics (Wetherell et al., 2002). Nevertheless, GAD is difficult to recognize and poses a significant public health concern. Thus, the remainder of this article will focus on the description, recognition, and treatment of late-life GAD.

Description of Generalized Anxiety Disorder

GAD is a complicated diagnosis, consisting of persistent worry and many physical symptoms of anxiety (e.g., muscle tension, sleep difficulties, difficulty concentrating) over a six-month period. Some

older people with GAD remember experiencing worries most of their lives and have been called “worry warts” or been told by family members or friends that they worry too much. Onset of GAD also can occur in later life after a major life change, such as retirement, death of a spouse, or diagnosis of a medical condition.

In contrast to younger adults who experience GAD, older adults tend to focus their experience of anxiety more on physiological (or somatic) symptoms and less on psychological symptoms. Older adults, in fact, often deny common psychiatric terms such as anxiety or worry and instead use words such as fret, concern, or think too much to describe their symptoms. Thoughts and worries in older adults may be related to concerns about aging, health, adult children or grandchildren, or being a burden on family members. Older adults with GAD find it hard to stop thinking about their concerns, even when they agree that their thoughts are excessive. GAD often produces behaviors such as procrastination, difficulty making decisions, safety checking (e.g., calling an adult child daily to be sure he/she is okay), and avoiding anxiety-producing situations. For example, some people with GAD refuse to go the doctor because they are afraid of having a medical condition. Others engage in medical “checking” behavior by calling or visiting the doctor too much because they worry about possible illness.

Factors Complicating Recognition

Older adults undergo changes in health, ranging from normal aging changes to chronic medical conditions, including hypertension, diabetes, and arthritis. Anxiety has many physical symptoms (sleep disturbances, fatigue, restlessness, difficulty concentrating) that overlap with those of a medical illness and/or the side-effects of medications taken to treat medical disease, complicating accurate recognition of anxiety. Complicating recognition further, most patients with anxiety emphasize vague physical symptoms, such as chest pain, headache, or sleep difficulties (Wetherell et al., 2002). Obtaining a timeline as to when the symptoms and medical illness/medications began can elucidate the relationship between anxiety symptoms and medical conditions. Ongoing collaboration between mental health and medical providers also is important. Older adults are more likely to discuss most physical and psychological distress with primary care providers than to seek help from a mental healthcare provider.

Recognizing anxiety in patients with dementia or cognitive impairment can also be a challenge. It is useful to obtain information from a caregiver or family member; however, reports between patients and caregivers are not always consistent. Several factors might bias the caregiver’s perception of the patient’s anxiety, including the quality of relationship and caregiver’s own anxiety. Some signs of anxiety may be visible through the patient’s behaviors, such as repeating concerns or fidgeting; but others are not directly observable. However, behavioral disturbances are common among patients with dementia, and differentiating between anxiety and progression of dementia can be difficult.

Overlap With Other Disorders

Anxiety and depression co-occur commonly in people of all ages, but this overlap is even more frequent in later life. Late-life anxiety disorders

and depression co-occur at a rate of 15 percent to 30 percent (Beekman et al., 2000), and as many as 85 percent of patients with depression have significant symptoms of anxiety (Lenze et al., 2001). Older adults with anxiety and depression use more services, experience reduced quality of life and increased disability, and have more severe somatic symptoms than patients with either set of symptoms alone. To determine an accurate diagnosis, it is helpful to understand whether anxiety or depression came first and which type of symptom is most severe. GAD often precedes an episode of depression, suggesting it may be a risk factor (Wetherell, Gatz & Pedersen, 2001) if not treated.

Treatment

Treatment for anxiety and anxiety symptoms includes pharmacological and counseling interventions. Older adults, in general, seek treatment for anxiety and other mental health problems from their primary care providers; so pharmacological treatment is most often used. Benzodiazepines (e.g., diazepam, chlordiazepoxide, alprazolam) are commonly prescribed anti-anxiety medications for older adults, with prevalence rates of ten percent to 20 percent (Gleason et al., 1998). These medications, however, can affect cognitive and psychomotor performance in ways that create significant consequences for life function in older adults, such as decreased ability to drive, increased risk of falls, and significant memory problems. Other medications demonstrated to be effective include antidepressants (venlafaxine, escitalopram) and other anti-anxiety medications (buspirone). However, many older adults are concerned that pharmacological therapy may cause dependency and produce unwanted side-effects; thus, they often are reluctant to add medications for anxiety. The cost and the stigma of psychiatric medications are also barriers to effective use in older generations. Moreover, older adults often state they prefer psychosocial interventions (Gum et al., 2006).

Psychosocial interventions provide an alternative to pharmacological treatment. This kind of intervention usually involves a mental health provider conducting either group or individual therapy in which skills are taught to help reduce symptoms of anxiety with or without depression. Among psychosocial interventions, cognitive-behavioral therapy (CBT) is helpful in reducing anxiety among younger adults; and interest in examining the effects of CBT among older adults has grown in recent years. The earliest trials in this area demonstrated positive outcomes with CBT in late life, even though response was less than to treatment with younger adults. However, results with longer treatment intervals for older adults suggest that response may improve with time, allowing equivalent response to that of younger adults at follow-up.

Common components of CBT include relaxation skills, coping self-statements, cognitive restructuring, problem solving, sleep-hygiene skills and behavior activation for anxiety and co-occurring depression.

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In contrast to younger adults who experience GAD, older adults tend to focus their experience of anxiety more on physiological (or somatic) symptoms and less on psychological symptoms.

Effectively treating anxiety would improve quality of life of patients, decrease healthcare utilization and even prevent diseases.

CBT has been offered in group format or individual meetings, although evidence suggests that the latter may be more beneficial with older adults (Thorp et al., 2009). Tailoring CBT to older adults can involve altering the pace of skills training, simplifying practice exercises and handouts, enlarging fonts on written materials, and varying the amount of time devoted to review of skills. It may also be helpful to include “booster” meetings or calls to help older adults practice and integrate the skills after treatment.

Future Directions

Because older adults most frequently discuss anxiety with primary care providers, recent research has examined the effectiveness of providing CBT in primary care clinics. The implementation of CBT for GAD in primary care patients has led to positive outcomes (Stanley, Wilson et al., 2009). Future areas of interest include cost-effective ways to integrate CBT for anxiety into primary care. One way to increase cost effectiveness and increase availability of professionals is to examine the usefulness of non-mental health expert counselors in providing anxiety treatment.

New ways to increase patient preference and provide flexibility in treatment for older adults are of current interest. One way to increase flexibility is to provide modular treatments that allow patients to choose a set of skills suited to their experience of anxiety (Wetherell, Ayers et al., 2009). Providing patients with the possibility of holding telephone sessions also can reduce the burden of travel and increase access for patients with financial or medical burdens.

Interest in studying the effectiveness of CBT in treating anxiety among patients with dementia has also grown, although it is still in preliminary stages. One difficulty in implementing CBT for these patients is that cognitive limitations may affect the patient’s ability to communicate, comprehend, and remember skills. To address these issues, a learning procedure known as spaced retrieval and reminder cues, such as reminder cards and calendars, can be helpful, as well as employing the help of a caregiver who can act as a “coach” to encourage patient practice and use of skills.

Conclusion

GAD is the most common pervasive anxiety disorder among older adults and, if not appropriately treated, it can have significant deleterious effects. Equally worrisome is the presence of persistent anxiety symptoms, which are even more common among older adults than in younger adults. Diagnosing anxiety is not always an easy task for providers, because common symptoms of anxiety overlap with normal aging and/or medical conditions common among the elderly. In addition, older adults tend to underreport psychological symptoms and emphasize physical symptoms. Once anxiety is diagnosed, pharmacological treatment and/or psychotherapeutic interventions can be implemented. CBT has consistently shown promising results among younger adults with anxiety, and interest in testing its efficacy among older patients has grown in recent years. Effectively treating anxiety would improve quality of life of patients, decrease healthcare utilization and even prevent diseases. ▼

Roberta Robinson is a counselor and research assistant on a project investigating the translational value of CBT for GAD in older adults in primary care at Baylor College of Medicine and the Houston Center for Quality of Care and Utilization Studies (HCQCUS), Michael E. DeBakey Veterans Affairs Medical Center.

Dr. Jessica S. Calleo is a clinical psychologist and research coordinator at Baylor College of Medicine and the Houston Center for Quality of Care and Utilization Studies (HCQCUS), Michael E. DeBakey Veterans Affairs Medical Center. Her current focus is on the identification and treatment of anxiety in older adults in primary care and treatment for anxiety in people with dementia.

Dr. Melinda Stanley is Professor and Head of the Division of Psychology in the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine. She is a clinical psychologist and senior mental health services researcher within the Houston Center for Quality of Care and Utilization Studies (HCQCUS), Michael E. DeBakey Veterans Affairs Medical Center, and an affiliate investigator for the South Central Mental Illness Research, Education, and Clinical Center (MIRECC). Dr. Stanley’s research interests involve the identification and treatment of anxiety and depressive disorders in older adults. Her current focus is on the provision of services in primary care and the development of treatment modifications to meet the needs of patients with dementia and those in community settings where the mental health needs of older patients often remain unrecognized and under treated. Dr. Stanley and her colleagues have been awarded ongoing funding from the National Institute of Mental Health (NIMH) for fourteen years to support her research in late-life anxiety. Dr. Stanley may be contacted by phone (713) 794-8841; email: mstanley@bcm.tmc.edu or visit the Web site www.bcm.edu/psychiatry/anxietycare/.

References

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders (IV-TR ed.)*. Washington, DC: APA.

Beekman, A., de Beurs, E., van Balkom, a., Deeg, D.J.H., van Dyck, R. & van Tilburg, W. (2000). Anxiety and depression in late life: co-occurrence and communality of risk factors. *Am. J. Psychiatry*, 157, 89-95.

Bryant, C., Jackson, H. & Ames, D. (2008). The prevalence of anxiety in older adults: Methodological issues and a review of the literature. *Journal of Affective Disorders*, 109, 233-250.

Cully, J. & Stanley, M.A. (2008). Assessment and treatment of anxiety in later life. In: Laidlaw, K. & Knight, B., eds. *The Handbook of Emotional Disorders in Late Life Assessment and Treatment*. Oxford: Oxford University Press: pp. 233-256.

Gleason, P.P., Schulz, R., Smith, N.L., Newson, J.T., Kroboth, P.D. & Kroboth, F.J. et al. (1998). Correlates and prevalence of benzodiazepine use in community-dwelling elderly. *Journal of General Internal Medicine*, 13, 243-250.

Gum, A.M., Areal, P.A., Hunkeler, E., Linggi, T., Katon, W. & Hitchcock, P. et al. (2006). Depression treatment preferences in older primary care patients. *The Gerontologist*, 46, 14-22.

Lenze, E.J., Rogers, J.C., Martire, L.M., Mulsant, B.H., Rollman, B.L. & Dew, M.A. et al. (2001). The association of late-life depression and anxiety with physical disability: A review of the literature and prospectus for future research. *American Journal of Geriatric Psychiatry*, 9, 113-135.

Stanley, M.A., Wilson, N.L., Novy, D.M., Rhoades, H.M., Wagener, P.D. & Greisinger, A.J., et al. (2009). Cognitive behavior therapy for generalized anxiety disorder among older adults in primary care: A randomized clinical trial. *Journal of the American Medical Association*, 14, 1460-7.

Thorp, S.R., Ayers, C.R., Nuevo, R., Stoddard, J.A., Sorrell, J.T. & Wetherell, J.L. (2009). Meta-analysis comparing different behavioral treatments for late-life anxiety. *American Journal of Geriatric Psychiatry*, 17, 105-15.

Wetherell, J.L., Ayers, C.R., Sorrell, J.T., Thorp, S.R., Nuevo, R. & Belding, W., Gray, E. & Stanley, M. (2009). Modular psychotherapy for anxiety in older primary care patients. *American Journal of Geriatric Psychiatry*, 17, 483-492.

Wetherell, J.L., Thorp, S.R., Patterson, T.L., Golshan, S., Jester, D.V. & Gatz, M. (2004). Quality of life in geriatric generalized anxiety disorder: A preliminary investigation. *Journal of Psychiatric Research*, 38, 305-312.

Wetherell, J.L., Gatz, M. & Pedersen, N.L. (2001). A longitudinal analysis of anxiety and depressive symptoms. *Psychology and Aging*, 16, 187-195.

Wetherell, J.L., Ayers, C.R., Sorrell, J.T., Thorp, S.R., Nuevo, R. & Belding, W., et al. (2002). Generalized anxiety and depression in primary care: Prevalence, recognition, and management. *Journal of Clinical Psychiatry*, 63 (Suppl), 824-34.

AMERICAN INDIAN LIFE SKILLS

A Community-Driven Model for Suicide Prevention

by **Teresa D. LaFromboise, Ph.D.**

When Diana Jetty, a sixteen-year-old member of the Spirit Lake Tribe in North Dakota, stood to address the United State Senate Select Committee on Indian Affairs, she told the devastating story about the November 3, 2008, day when her fourteen-year-old sister, Jami, took her life by hanging from a bunk bed with a belt. Despite Jami’s struggles with depression, she had been an outgoing teenager, surrounded by family and friends who loved her. Their mother took Jami to doctors and to mental health professionals for evaluation. Nevertheless, Jami fell through the cracks, leaving those around her feeling lost, lonely, and angry (http://indian.senate.gov/public/_files/DanaJettytestimony.pdf).

Prevalence of Suicide Among American Indian/Alaska Native Youth

The pain of suicide has not only been felt by Jami's family but by countless American Indian/Alaska Native (AI/AN) families within tribes that are experiencing alarming rates of adolescent suicide. It is not unusual in "Indian Country" to hear of accounts such as that of the Jettys or the suicide cluster that occurred last spring on the Standing Rock Reservation, located on the border between North and South Dakota, when four teens took their lives by suicide within a two-week period of time (C. Naasz, personal communication, May, 11, 2009). Compared to the mainstream youth population, death by suicide is more common within the AI/AN youth population (Indian Health Service, 2000). Among AI/AN ten- to fourteen-year-olds, suicide is the third-leading cause of death and the second-leading cause of death among fifteen- to twenty-four-year-olds (Centers for Disease Control, 2005). Suicidal behaviors (i.e., suicidal ideation, suicide plans, and suicide attempts) increase with age in this population until age twenty-five when the rate begins to resemble that of the general U.S. population (Goldsmith, Pellmar, Kleinman & Bunney, 2002). Suicidal ideation, an important antecedent to attempted and completed suicide, has ranged from 14 to 81 percent among AI/AN adolescent participants in studies of suicidal behavior (Dinges & Duong-Tran, 1993; LaFromboise, Medoff, Lee & Harris, 2007; Manson, Beals, Dick & Duclos, 1989; Novins, Beals, Roberts & Manson, 1999).

Unique Risk Factors

Beyond the usual suspected risk factors of depression and substance abuse, AI/AN youth experience unique risk factors for suicide that may give them the propensity to take their own lives. The following suicide risk factors must be considered when prevention interventions are selected or designed with AI/AN communities' goals of strengthening the existing protective factors of cultural continuity and social connectedness in addition to the typical targeted goals of individual self-regulation and reduction of aggressive social behavior.

Beginning in the early 1700s and continuing through the 1960s, the U.S. government enacted the boarding school experiment—one of the most devastating policies specific to American Indians. It was thought that if AI/AN children were reared away from home in residential schools, they would learn to be self-sufficient participants in the larger society. At these boarding schools, children were often severely punished for speaking their language or practicing their tribal customs. Most tragically, children were denied opportunities to be nurtured through traditional child rearing practices or ongoing contact with their loved ones. The major impact of the boarding school experiment can be seen in the high rates of out-of-home placement among AI/AN children today (Evans-Campbell, 2006).

Trauma associated with intergenerational distress due to disruption in family continuity, loss of land, restrictions on cultural practices, and extinction of native languages has been labeled "historical trauma." One would predict higher levels of suicidal behavior within a population that experiences historical trauma compared to one that does not. Symptoms of historical trauma include poor emotional tolerance, psychic numbing, substance abuse, depression, and an identification with death (Yellow Horse Brave Heart & DeBruyn, 1998). While few empirical studies have specifically examined the

role of historical trauma in suicidal behavior, numerous authors have identified it as a probable risk factor specific to AI/AN suicides (Muchlenkamp, Maronne, Gray & Brown, 2008).

In addition to experiencing historical trauma, AI/AN adolescents must also deal with a number of pervasive stressors, which contribute to cumulative vulnerability and disease. AI/AN youth are subject to acculturation stress, a psycho-cultural stress experienced during the process of encountering cultural differences between a host culture and an incoming culture. The impact of acculturation stress is shown in reduction in the physical and mental health status of individuals or groups expected to undergo change imposed upon them by a dominant culture (Nwadiora & McAdoo, 1996). Depression, anxiety, feelings of marginality and alienation, heightened psychosomatic symptoms, and identity confusion are emotions and behaviors that can stem from acculturation stress. Lifetime cumulative exposure to both distant and recent adversity predicts the risk of subsequent drug dependence, which is shown to be one of the risk factors for youth suicide (Turner & Lloyd, 2003). Other unique risk factors associated with suicide ideation among AI/ANs include: erosion of social support, cultural discontinuity, weak cultural identity, and perceived discrimination (Chandler & Prouix, 2006; Howard-Pitney, LaFromboise, Basil, September & Johnson, 1992; Yoder, Whitbeck, Hoyt & LaFromboise, 2006).

American Indian Life Skills Development Curriculum

Comprehensive prevention interventions that address both unique and common risk factors for multiple problems (e.g., smoking, substance use, unprotected sex) are a promising avenue for prevention with AI/AN adolescents. The *American Indian Life Skills (AILS)* curriculum (LaFromboise, 1996) is an evidence-based, suicide prevention intervention for AI/AN youth that has been found to reduce suicidal thoughts and feelings of hopelessness while increasing problem-solving skills and suicide-prevention skills (LaFromboise & Howard-Pitney, 1995). From a social cognitive perspective (Bandura, 1986) which underlies the *AILS*, suicidal behavior is attributed to direct learning or modeling influences (e.g., peer or community suicide attempts/deaths by suicide) in conjunction with certain contextual sources (e.g., historical trauma, acculturation stress, geographical isolation) and individual characteristics (e.g., depression, PTSD) that mediate decisions related to suicidal behavior. The *AILS* emphasizes pro-social skills and values through the use of social-cognitive therapeutic activities interspersed with cultural tenets for coping and resilience. It focuses upon helping adolescents learn how to inhibit impulsive behavior, to plan, to regulate emotions, and to foster acceptance of others. Beyond emphasizing risk and protective factors specific to AI/AN youth, the *AILS* provides details concerning how behaviors witnessed within AI/AN communities might be related to an increased risk of suicidal behavior (Alcantara & Gone, 2008). It importantly utilizes cultural teachings to enhance Cognitive Behavior Therapy (CBT) and social skills development procedures.

A unique quality and strength of the *AILS* is that it was designed to be compatible with the AI/AN communities with which it was first developed (LaFromboise & Lewis, 2008). Extensive input was solicited from AI/AN elders, parents, and youth to examine key aspects of helping and problem solving within their communities and to establish grassroots support for the intervention. Regional trainings of the *AILS* have taken place in many areas of the United

States, including Wolf Point, Montana; Anchorage, Alaska; Rosebud, South Dakota; Oklahoma City, Oklahoma; Spokane, Washington; and Phoenix, Arizona. These training sessions prepared community leaders from over forty reservations to plan for implementation of the *AILS* in their academic, after-school, and youth development programs. A team of researchers from Johns Hopkins University School of Public Health is currently modifying the *AILS* for a home visitation program with suicide attempters and their families on the White Mountain Apache reservation. The Montana/Wyoming Tribal Leadership Program has offered *AILS* training to promote psychological resilience in children and adolescents in tribal colleges within both states. The *AILS* continues to be used to train adolescent "natural helpers" in a comprehensive suicide prevention program on a reservation in the Southwest following a public health approach (May, Serna, Hurt & DeBruyn, 2005).

A recent National Research Council and Institute of Medicine report, entitled *Preventing Mental, Emotional, and Behavioral Disorders Among Young People* (National Research Council and Institute of Medicine, 2009) featured the *AILS* as a program that embodies generic principles of health behavior change and an appropriate level of cultural sensitivity. Inclusion in this report was based upon an evaluation of the *AILS* with youth from the pueblo of Zuni (LaFromboise & Howard-Pitney, 1995) and an analysis conducted by the National Center for AI/AN Mental Health Research, which verified the reversal of a twenty-year suicide rate at Sequoyah High School in Tahlequah, Oklahoma, with zero completions noted since implementation of the *AILS* in the late 1980s. Greenberg, Domitrovich, and Bumbarger (2001) featured the *AILS* as a promising program in their review of prevention interventions for mental disorders in school-aged children. Although they noted there were many aspects of students' functioning, such as efficacy for stress management, that were not shown to have been affected by the intervention, the target problem of suicide ideation was reduced. The *AILS* is listed in the National Registry of Effective Programs and recognized as a SAMHSA Program of Excellence by the Department of Health and Human Services. Finally, the First Nations Behavioral Health Association have recognized the *AILS* as an Effective Practice and Model for Children, Adolescents, and Families in Communities of Color.

Work is underway for AI/AN children, youth, and families to have access to the best available evidence-based preventive interventions delivered in AI/AN communities in a culturally competent and non-stigmatizing manner. In the case of the *AILS*, a new middle school version has been field tested on the Omaha reservation in Macy, Nebraska, and the Puyallup reservation in Tacoma, Washington. Feedback on this *AILS*-middle school version was received from interventionists in those settings and from clinical psychologists at the Oklahoma University Health Sciences Child Trauma Center, known for its work in culturally adapting CBT to Trauma Focused Therapy. During the 2010-2011 academic year, the *AILS*-middle school version will be evaluated with AI/AN youth attending middle schools on reservations in the Midwest and Southwest areas of the country. It is imperative that more effectiveness trials of the *AILS* be conducted. However, given the legacy of historical trauma and past injustices on the part of some researchers working with AI/AN communities, scholarly collaborations with tribes that require adherence to randomized controlled trial procedures take much

time to negotiate, extensive resources, and the respectful goodwill of all involved. ▼

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References

- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Centers for Disease Control. (2005). *Deaths, percent of total deaths, and death rates for the 15 leading cause of death in 5-year age groups, by race and sex: United States, 2002*. Retrieved June 6, 2006, from <http://www.cdc.gov/nchs/data/nvsr/nvsr53-17.pdf>.
- Chandler, M. & Prouix, T. (2006). Changing selves in changing worlds: Youth suicide on the fault-lines of colliding cultures. *Archives of Suicide Research*, 10, 125-140.
- Dinges, N.G. & Duong-Tran, Q. (1993). Stressful life events and co-occurring depression, substance abuse and suicidality among American Indian and Alaska Native adolescents. *Culture, Medicine, and Psychiatry*, 16, 487-502.
- Evans-Campbell, T. (2006). Indian child welfare practice within urban American Indian /Alaska Native communities. In T.M. Witko (Ed.), *Mental health care for urban Indians* (pp. 33-53). Washington, DC: American Psychological Association.
- Goldsmith, S.K., Pellmar, T.C., Kleinman, A.M. & Bunney, W.E. (Eds.). (2002). *Reducing suicide: A national imperative*. Washington, DC: The National Academies Press.
- Greenberg, M.T., Domitrovich, C. & Bumbarger, B. (2001). The prevention of mental disorders in school-aged children: Current state of the field. *Prevention and Treatment*, 4(1).
- Howard-Pitney, B., LaFromboise, T.D., Basil, M., September, B. & Johnson, M. (1992). Psychological and social indicators of suicide ideation and suicide attempts in Zuni adolescents. *Journal of Consulting and Clinical Psychology*, 60, 473-476.
- Indian Health Service. (2000). *Regional differences in Indian health 1998-1999*. Rockville, MD: Department of Health and Human Services, Public Health Services. Available online at [www.ihs.gov/PublicInfo/Publications/trends 98/region98.asp](http://www.ihs.gov/PublicInfo/Publications/trends%2098/region98.asp).
- LaFromboise, T.D. (1996). *American Indian Life Skills Development Curriculum*. Madison, WI: University of Wisconsin Press.
- LaFromboise, T.D. & Howard-Pitney, B. (1995). The Zuni Life Skills Development Curriculum: Description and evaluation of a suicide prevention program. *Journal of Counseling Psychology*, 42, 479-486.
- LaFromboise, T.D. & Lewis, H. (2008). The Zuni Life Skills Development Program: A school/community-based suicide prevention intervention. *Suicide and Life-Threatening Behavior*, 38, 343-353.
- LaFromboise, T.D., Medoff, L., Lee, C.C. & Harris, A. (2007). Psychosocial and cultural correlates of suicidal ideation among American Indian early adolescents on a Northern Plains reservation. *Journal of Research and Human Development*, 41, 119-143.
- Manson, S.M., Beals, J., Dick, R.W. & Duclos, C. (1989). Risk factors among Indian adolescents at a boarding school. *Public Health Reports*, 104, 609-614.
- May, P.A., Serna, P., Hurt, L. & DeBruyn, L.M. (2005). Outcome evaluation of a public health approach to suicide prevention in an American Indian tribal nation. *American Journal of Public Health*, 95, 1238-1244.
- Muehlenkamp, J.J., Marrone, S., Gray, J.S. & Brown, D.L. (2009). A college suicide prevention model for American Indian students. *Professional Psychology: Research and Practice*, 40, 134-140.
- National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Committee on Prevention of Mental Disorders and Substance Abuse among Children, Youth and Young Adults: Research Advances and Promising Interventions. M.E. O'Connell, T. Boat & K.E. Warner (Eds.) Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.
- Novins, D.K., Beals, J., Roberts, R.E. & Manson, S.M. (1999). Factors associated with suicide ideation among American Indian adolescents: Does culture matter? *Suicide and Life-Threatening Behavior*, 29, 332-346.
- Nwadiora, E. & McAdoo, H. (1996). Acculturation stress among Amerasian refugees: Gender and racial differences. *Adolescence*, 31(122), 477-487.
- Turner, R.J. & Lloyd, D.A. (2003). Cumulative adversity and drug dependence in young adults: Racial/ethnic contrasts. *Addiction*, 98, 305-315.
- Yellow Horse Brave Heart, M. & DeBruyn, L. (1998). The American Indian holocaust: Healing historical unresolved grief. *Journal of the National Center for American Indian Alaska Native Mental Health Research*, 8(2), 56-78.
- Yoder, K., Whitbeck, L.B., Hoyt, D.R. & LaFromboise, T.D. (2006). Suicidal ideation among American Indian youth. *Archives of Suicide Research*, 10, 177-190.

by Mary Tramontin, Psy.D.

Bearing the Brunt of WAR



The Unique Challenges Faced by Military Families

In considering the impact of war, the focus is often on the individual—the brave man or woman on the frontline. Yet, those closest to these soldiers, sailors, and marines are also deeply affected by their service, often in unexpected and unacknowledged ways. Military families are experiencing the emotional trauma of deployment, and, often, multiple re-deployments, on an unprecedented scale (Hutchinson & Banks-Williams, 2006). Especially for reservists and guardsmen whose families do not have the support of a military base—including those where medical or emotional/behavioral problems preexist—the departure of a spouse during a time of war can be destabilizing, creating a significant ordeal for a marriage and the family. This article looks at the nature of this shared impact.

★ Immediate Impact: The Deployment Cycle

Deployment is defined as a soldier's activation to serve in a particular mission. Career soldiers and reservists alike can be called upon to bear arms for their country in a duty station far away from home. *The Deployment Cycle* is the term used to connote the three broad phases of this process: pre-deployment, deployment and post-deployment. Each phase is proposed to have unique characteristics and challenges.

Pre-deployment includes notification and preparation. It is the "ramping up" period that can last anywhere from two weeks to two months. Deployment comprises departure, separation, and sustainment. During this phase, those activated work in dangerous and stressful environments and are apart from their loved ones from seven to fifteen months. The post-deployment phase includes the return home, a time of reunion and reintegration. In the past, this was seen as the terminal phase of the cycle. However, today, many contend with the stress of re-deployment soon after a reunion. And as we have to come realize, reintegration post-deployment is a process that can span years.

★ Pre-Deployment

New stresses begin with the first notification of impending deployment. Often there is very little notice and too little information about length and destination. The departing service member begins to psychologically be more focused on the mission ahead and his or her comrades rather than the needs of the family, often becoming preoccupied with preparations to mobilize. During pre-deployment, couples prepare both practically and emotionally. Practically, they must review wills, financial plans, and powers of attorney. Emergency contact procedures are established and contingency childcare arrangements devised. Emotionally, they must begin to consider

a range of unexpected outcomes but still move forward with faith in the mission and trust that the soldier will be protected. A 2004 Department of Defense Survey indicated that over 80 percent of the Army's enlisted are under thirty-five with a mean age of twenty-seven (Military Family Resource Center, 2006). Fifty-one percent of their children were under the age of seven, with half under three years old. Thus, those contending with these stressors are often very young. They are at a point in their family life cycle when they are still forging their roles and lives together but must begin to discuss what life would be like if the deployed service member is killed or seriously injured in the line of duty.

★ Deployment

At the heart of the story of the deployment phase are the combat experience and the family separation. Understanding the experience of the service member is key to understanding military families. Tough realities of war include: that combat is harsh and demanding; that combat impacts every soldier mentally and emotionally and has lasting mental health effects; that combat poses moral/ethical challenges; that fear in combat is ubiquitous; and that unit members will be injured and killed. All family members, adult and children, know these realities and they need to live with the uncertainties that these bring before, during, and after a deployment.

Each of these challenges implies certain individual and family tasks that must be mastered. A family's ability to stay strong and healthy relies on flexibly being able to shift roles, maintain family functioning and, if necessary, being able to accommodate changes in the military parent's health status.

Deployments are identified as the top challenge by Army spouses (Booth, Segal & Bell, 2007). And for the service member, difficulty balancing duty and family demands are the most frequent reason for leaving the Army (Hoge, Auchterlonie & Milliken, 2006). Currently, those in the Army are facing more frequent and less predictable deployments. One can imagine the tension this creates within a family; studies have indicated that family members become less satisfied as length, frequency, and unpredictability of deployments increase (Milliken, Auchterlonie & Hoge, 2007). In a survey of Army spouses, 85 percent reported loneliness (Riggs, 2008). They listed missing companionship and intimacy, and the absence of those deployed during significant family occasions, as stressors.

Moreover, the reserve component of the military may experience additional burdens. Many lose income and have an increase in

childcare needs and expenses (Milliken, Auchterlonie & Hoge, 2007). For single parents who are deployed, this may entail a significant disruption in a child's life as they may be dislocated and separated from their routines and possibly even their siblings. When a mother is deployed, children are separated from their most significant attachment figure, often at critical times in their development.

The Center for Deployment Psychology, based in Washington, D.C., and created in 2005 to provide expertise in deployment behavioral health issues, has found increased rates of child neglect and abuse during wartime (Riggs, 2008). Though these episodes are comprised of much less noxious events than typical in child abuse or neglect cases, they suggested decreased parental availability to young children linked at least temporally with wartime. Many of these cases included young military families—young wives with small children who lacked resources and who were struggling with combat deployments. The data suggest that wartime deployment may be most difficult for families who have greater vulnerability prior to deployment and who were tipped into dysfunction because of an inability to call upon needed resources.

★ Coming Home

The "typical" course of reintegration attests to the resilience of deployed families in that most manage the ensuing changes. Still, reunion is stressful. Most practitioners readily assume that the service member will be changed by their combat zone experience but may overlook that families are also strained and changed by the absence of their loved ones (Kessler, 2000). The spouse who remained on the home front has taken on new roles and responsibilities as a result of being placed in charge of the home, finances, and children. Because decisions could no longer be made jointly, they have developed new routines, rituals, and ways of being on their own. As noted earlier, they have had to deal with both missing their loved one *and* the possibility that they may not return. All of this often leads to an increased sense of capability and a newfound independence. Changed soldiers return home to changed families and the expectations of returning soldiers and their loved ones are often perceived as mutually confusing (Mikulincer, Florian & Solomon, 1995). In a 2004 through 2005 U.S. Army Community and Family Support Center (CFSC) Survey, the following were the top sources of post-deployment adjustment difficulties noted by families: changes in spouses, handling children, re-establishing roles, communication, household routines, decision-making, children's expectations, and marital intimacy (Riggs, 2008). Spouses are altered by what they each have had to face separately.

And, the excitement of homecoming can promote unrealistic beliefs about reunion. Couples unexpectedly discover that they require time to re-establish physical and emotional intimacy, leading to a sense of disappointment or disillusionment. In many instances, a traumatized soldier is greeting a traumatized spouse and neither is "recognizing" the other (Hoshmand & Hoshmand, 2007). Many soldiers are finding that neither they nor their spouses are able to cope with the changes in their relationships. Those returning from a war zone find it difficult, if not impossible, to share their experiences with those closest to them. Typically, they choose not to share details about what they have been through with loved ones, thus causing further estrangement as those closest to them cannot put such experiences into context.

Service members are recognized to return from deployment with a "battlefield mindset." Emotional steeliness, mission focus, hyper-vigilance and distrust work well in war but not at home. Returning

soldiers feel as if they are still "in country"—closer to the military mission and those with whom they served than to their spouse and children. For them, nothing else may seem so important for awhile. Couples and families expect to resume where they have left off, but each will need to appreciate what the other has been through as they "reinvent" their family together again. This is a period of transition with accompanying mixed and unsteady emotions—joy, resentment, relief, anxiety—that takes individual and collective effort as well as the passage of time.

★ Long-term Impact: The Legacy of Trauma

In terms of more serious outcomes, contending with significant physical and mental health consequences poses a special hardship for a family (Hutchinson & Banks-Williams, 2006). For example, notification of physical injury intensifies activity. While a spouse leaves to be with the injured service member, children are left under the supervision of others or brought to a hospital. This may result in school absences and being in a new environment that is not conducive to meeting a child's needs. The disruption injury causes can be quite severe. If the injured is of active duty status and now can no longer serve, the whole family may lose its military way of life. Disruptions in the family constellation and roles may ensue as a result of loss of functional capacity. And injury can alter disciplinary styles and emotional availability and generate deeper changes in personality.

Traumatic brain injury (TBI), often called the "signature wound" of the current conflict, is linked to persistent headaches, short-term memory problems, concentration difficulties, and trouble with balance. According to a 2008 RAND Corporation study, approximately 320,000 soldiers have experienced some form of traumatic brain injury (Pentagon's Defense Manpower Data Center, 2006). Improvements in armor and medical treatment allow soldiers to survive explosions and then suffer their delayed effects. These brain injuries range from mild to severe; for those in the mild to moderate continuum, they represent invisible wounds, as real as missing a limb but with no obvious damage to visibly "explain" the notable impairments.

It is widely accepted that soldiers exposed to combat may suffer psychological injury: these other "invisible wounds" include post-traumatic stress disorder (PTSD), depression, and additional emotional problems. Twenty percent of combat exposed veterans endorse symptoms consistent with PTSD, depression or other mental health problems (United States Department of Defense, 2006). Left untreated, psychiatric illness disrupts healthy parenting and family functioning and impairs a child's development. These illnesses can also cause families to avoid community contact so that they do not seek out and or accept help.

According to the Pentagon's Defense Manpower Data Center, a total of 3,325 Army officers' marriages ended in divorce in 2004, representing 6 percent of all marriages among officers including enlisted personnel. This was understood to represent a 78 percent increase from 2003 when approximately 1,866 marriages ended in divorce (Pentagon's Defense Manpower Data Center, 2006). Generally, research has indicated that divorce rates for veterans is 62 percent higher than for civilians.

PTSD can deeply affect families in terms of relationships with spouses and the psychological adjustment and well-being of their children. Research has identified PTSD as mediating the effect of veterans' combat experience on the family (Gavaloski & Lyons,

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Bought out and SPENT

by Terrence Daryl Shulman, J.D., L.M.S.W., A.C.S.W., C.A.A.C., C.P.C.

We all have money issues and, with the current economy, now more than ever. The bubble has burst as individuals, families, companies, and governments come to terms with overspending and living beyond our means. We were given easy credit, no money down, and promised “The American Dream.” Look at what’s happened.

Americans work longer hours, take less vacation time, have more health issues such as lack of sleep, depression, anxiety, obesity, and report less overall satisfaction with life. As we continue to emulate and chase the lifestyles of the “rich and famous,” we pay a devastating toll—individually and collectively.

Yet, it is strange that in our capitalist culture money is also taboo—perhaps more than sex. We talk fairly openly about sex. But when was the last time we told even a close family member or friend *exactly* how much we earn per year, how much we spend, how much we owe? Do we even know ourselves? Presumably, we know just as little about the financial details of others who are close to us. Why is this? Is there fear? Is there shame?

Something is going on. You’ve probably noticed a growing trend over the last decade or so. We see it from Suze Orman to Dave Ramsey, from Oprah’s *Debt Diet* to A&E TV’s *Big Spender*. Books, articles, television and radio shows—calls near and far—are sounding the alarm about our individual and collective problems with debt and spending. A dangerous mindset has taken root: spend now and worry later, or worse, don’t worry at all! The easy access of the Internet and Home Shopping TV make shopping and spending as addictive as crack cocaine.

Mixed messages are all around us. We still have the hyper-consumerism best illustrated by the blossoming of magazines and TV shows pushing the lure of haute couture and mocking—tongue-in-cheek—the excesses of shopping and spending—from *Sex and the City* to the *Confessions of a Shopaholic* novella, which was released as a major motion picture earlier this year. We were prodded to shop after 9/11 and we are still being encouraged to shop and spend to help the overall economy. But if we do not shop wisely, don’t save, don’t invest, and don’t buy good health insurance and have enough left over for the kids’ college and our own retirement—that’s not good for the economy or us.

In the addiction/recovery field, it has long been noted that many addicts seem to have money manageability issues. Many relapses also occur when money stresses pile up. Yet, we have been slow to assess and treat shopping and spending behaviors as part of a good overall recovery foundation. In fact, the notion that shopping and spending can be addictive behaviors has only recently gained some acceptance.

In 2006, a landmark Stanford University study concluded that something else may better describe the phenomenon that is growing among millions of people. It is called “compulsive buying disorder.” For simplicity’s sake, I will be using a preferred term: “compulsive spending.” The term is controversial—there is a tendency to call it poor money management—but it opens a new window towards prevention and treatment of people whose spending may not be helpable through conventional approaches such as trying to follow a financial advisor’s counsel. Assessing spending as an addiction or compulsion is similar to assessing any other: look for loss of control, increased tolerance, negative consequences, withdrawal symptoms such as preoccupation, denial and lying.

Consider the following statistics:

- According to a 2006 Stanford University study, 17 million Americans (roughly 6 percent of the population) are compulsive spenders; and nearly 50 percent of all compulsive spenders are men (<http://ajp.psychiatryonline.org/cgi/content/abstract/163/10/1806>).
- A 2009 Money Smart Life article cites money issues, spending/debt as “one of the top reasons for divorce” (<http://moneysmartlife.com/debt-and-marriage-what-you-should-know-before-the-wedding/>).

We have all heard the cliché: “You can’t solve issues with money or things.” Most of us have experienced this lesson. We see how “the rich and famous” still have problems. We have heard the stories of lottery winners who spend their money all too quickly, fall into depression or addictions, or who end up saying they wish they had never won. Yet, millions of us still buy into the fantasy that more money and more things will make us happy. As with any addiction, nobody starts off planning to lose control. Nobody starts off intending to get into debt, hide purchases, or become obsessed with shopping or spending. The

shame for most compulsive spenders occurs when they fear being revealed as irresponsible, superficial, or materialistic—cracks in an otherwise common facade of perfection and order. But compulsive spending tends to happen a little at a time. It is insidious. Our culture conspires to create “super consumers.”

Several factors make assessment, treatment and recovery more challenging for most compulsive spenders: 1) the behavior is legal; 2) most if not all people shop/spend; 3) it’s an activity that is greatly encouraged by advertising and social culture; 4) it’s easily accessible even from home; and 5) complete abstinence is unrealistic and not the primary goal. As with eating disorders, sexual addiction, and codependency, the client who overspends needs to learn to have a healthy relationship with money and credit so that his or her spending comes from a place of choice, balance and appropriateness rather than from a place of emotional need, escape, or emptiness.

The following scale can be useful in assessing problem shopping or spending. It is modeled after the Debtors Anonymous 15 Question scale. Most compulsive spenders will answer yes to at least seven of The Shulman Center for Compulsive Theft & Spending’s 20 Question Assessment.

- 1) Have you ever lost time from work or school due to shopping/spending?
- 2) Has shopping/spending ever created problems in your relationships?
- 3) Has shopping/spending ever affected your reputation or people’s opinion of you?
- 4) Have you ever felt guilt, shame, or remorse after shopping/spending?
- 5) Do you have trouble with debt or paying your bills?
- 6) Did shopping/spending ever cause a decrease in your ambition or efficiency?
- 7) Did you ever experience a “high” or “rush” of excitement when you shop or spend?
- 8) Have you ever shopped/spent to escape worries?
- 9) Has shopping/spending caused you to have difficulty eating or sleeping?
- 10) Do arguments, disappointments or frustrations create an urge to shop or spend?
- 11) Have you noticed you began shopping or spending more frequently over time?
- 12) Have you ever considered self-destruction or suicide as a result of your shopping/spending?
- 13) Upon stopping over-shopping or overspending did you continue to be tempted/preoccupied by it?
- 14) Have you kept your shopping/spending a secret from most of those you are close to?
- 15) Have you told yourself “this is my last time” and still over-shopped or overspent?
- 16) Have you continued to shop or spend despite having had legal issues such as bankruptcy or divorce?
- 17) Do you often feel a need for control or tend toward perfectionism?
- 18) Do you have issues with clutter or hoarding the items you’ve purchased?
- 19) Have you purchased items that you’ve never if rarely even used?
- 20) Do you have trouble speaking up for yourself, asking for help, or saying “no”?

A simplified 6-item 2008 test for “compulsive buying” was administered along with a survey that revealed that nearly 9 percent of a sample of 550 university staff members, mostly women, would be considered compulsive buyers. Nancy Ridgway and Monika Kukar-Kinney of the University of Richmond, and Kent Monroe of the University of Illinois at Urbana-Champaign developed the test.

This test includes six statements, for which individuals answer on a 7-point scale from strongly disagree to strongly agree:

- My closet has unopened shopping bags in it.
- Others might consider me a “shopaholic.”
- Much of my life centers around buying things.
- I buy things I don’t need.
- I buy things I did not plan to buy.
- I consider myself an impulse purchaser.

Respondents who score 25 or higher would be considered compulsive buyers.

“We are living in a consumption-oriented society and have been spending ourselves into serious difficulty,” according to Monroe. “Compulsive buying is an addiction that can be harmful to the individual, families, and relationships. It is not just something that only afflicts low-income people.” As marketing researchers, Monroe and his colleagues found compulsive buying was linked to materialism, depression, anxiety, and reduced self-esteem. Compulsive shoppers had positive feelings associated with buying, and they also tended to hide purchases, return items, have more family arguments about purchases and have more maxed-out credit cards. For compulsive shoppers with higher incomes, money matters could be non-existent. A dwindling bank account is just one of the upshots of shopping until you drop. Others include family conflicts, stress, depression and loss of self-esteem.

Through my research and my work with clients, I have distilled some of the most common psychological reasons people compulsively shop or spend. These are similar with most other addictions as well. The Shulman Center for Compulsive Theft & Spending cites the following:

TOP TEN REASONS PEOPLE OVERSPEND

- 1) Grief and Loss: *to fill the void*
- 2) Anger/Life is Unfair: *to get back/make life right*
- 3) Depression: *to get a lift*
- 4) Anxiety: *to comfort*
- 5) Acceptance/Competition: *to fit in*
- 6) Power/Control: *to counteract feeling lost/powerless*
- 7) Boredom/Excitement: *to live on the edge*
- 8) Shame/Low Self-Esteem: *to be good at something*
- 9) Entitlement/Reward: *to compensate for over-giving*
- 10) Rebellion/Initiation: *to break into own identity*

Some other sub-categories of compulsive spenders include the following:

Compulsive Shoppers

The classic compulsive shopper tends to shop to avoid or suppress a core of pain—usually from trauma or loss. The compulsive shopper may shop fairly consistently or become triggered by something recent and then go shopping as an automatic response to distract from painful or uncomfortable emotions.

Understanding Youth Street Gangs

Youth gang violence continues to rise dramatically with more and more of our youth deciding to join gangs each day. It was once thought that gangs only convened in selected areas, which left churches, schools, and hospitals as “neutral” territory. Unfortunately, this is a fallacy. Gang violence has poured into the schools, community centers, churches, and hospitals. Youth gangs are even a problem in the military. Throughout the country in urban, suburban, and rural communities, mental health professionals are constantly being challenged by intramural shootings between rival gang members on a daily basis, whether it is out in the community or in a school setting, as first-hand witnesses of youth gang violence. Youth gang violence has continued its upward trend nationwide according to the Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP, 2008). Furthermore, youth gangs have been identified in every single state (OJJDP, 2008). Nationwide there are 24,500 gangs with a gang membership of over 750,000, while the ethnic composition of these gangs include 47 percent Latino, 31 percent African American, 13 percent Caucasian, 7 percent Asian, and 2 percent Mixed Ethnicities (OJJDP, 2008). As a result of the proliferation of youth gangs in our communities, it is imperative that mental health professionals, social workers, educators, and others involved with direct therapeutic care become aware of the signs and symptoms of youth gang activity. At the conclusion of this article, readers should be able to define a youth gang, know the different typologies of youth gangs, understand various motivations to join a youth gang, and finally know some signs and symptoms of possible youth gang involvement.

What is a Youth Gang?

Before we get started talking about youth gangs, we must first define what is a youth gang. A youth gang, often referred to as a criminal street gang must be ongoing, meaning that the gang associates on a continuous or regular basis. The youth gang could be formal or informal. Moreover, the youth gang must consist of at least three members and have a name, and hand sign or symbol, which is identifiable. The final element that defines a youth gang is that one of the primary objectives of the gang must be criminal activity. Not to get confused with various social groups such as fraternities, sororities, or social clubs, what differentiates a youth gang from other groups is its criminal activity (Akiyama, 1997; Leet, Rush & Smith, 2000; Valdez, 2005).

Gang Membership

In all of the 24,500 youth gangs with over 750,000 gang members across the nation, there are various types of gang members ranging from hardcore to “wannabe” members. The most plentiful type of gang member is the active/regular gang member making up

between 40-50 percent of the gang (Akiyama, 1997; Leet, Rush & Smith 2000; Valdez, 2005). Regular gang members self admit that they are in a gang when asked. They also have gang-related tattoos, are involved in gang related crimes, and have a past history of gang activity. Associate/affiliate gang members make up 20-30 percent of the gang (Akiyama, 1997; Leet, Rush & Smith, 2000; Valdez, 2005). Associate and regular gang members also use hand signs to communicate to each other and other rival gangs. Associate and regular gang members also write gang graffiti, wear gang-related clothing (colors), associate with known gang members, and are included in gang photos. What sets associates apart from regular members is that they are able to freely come and go in and out of the gang as they see fit making them great informants for law enforcement. The hardcore gang members known, as an “OG” (original gangster), make up 10-20 percent of the gang and are the primary leadership arm of the gang group (Akiyama, 1997; Valdez, 2005). Hardcore gang members fit into all of the criteria listed for regular and associate members, but they are also involved in narcotics distribution. Furthermore, hardcore gang members are involved in violent gang activity from assaults, shootings, and robberies, to murder. Wannabes are the last group of gang member types. Wannabes make up less than 10 percent of the gang; however, they are extremely dangerous (Akiyama, 1997; Valdez, 2005). One should not presume that the other gang member types are not dangerous; they all have the potential to be extremely dangerous. The dangerousness of the wannabes lies in their motivation to join the gang. The wannabes need to prove that they are “down” and have “heart” (dedication) for the gang because in the gang hierarchy, wannabes are at the bottom (Akiyama, 1997; Valdez, 2005). In order to be dedicated to the gang, the wannabes are instructed by the OG to prove that they have heart for the gang by performing a gang-related crime such as killing of a rival gang member or committing a robbery or property crime such as burglary (Akiyama, 1997; Valdez, 2005). In determining a gang member typology, it is important to use the strongest of initial criteria to classify a suspected gang member. For example, if an individual is documented for writing gang graffiti, wearing gang colors, and admits that he/she is a gang member; this gang member should be classified as a regular member. To list a person as a hardcore gang member, only one of the criteria for hardcore members needs to be met. These criteria imply heavy gang involvement which should be documented thoroughly.

Gang Structure

In addition to the various types of gang membership typologies, there are different types of gang structures from turf gangs to philosophical gangs. The most common type of gang structure is the turf gang,

otherwise known as the territorial gang. They are often known as a traditional gang, as they claim a “turf” or neighborhood to exist. An example would be African American and Latino gangs. The next type of gang structure is the crime-for-profit gang. The crime-for-profit gang is characterized as being extremely mobile, meaning that they are able to move from one area to the next easily because they are not bound by a specific neighborhood to exist. Committing crime for profit is the main motivational factor for membership and activity. One could argue that all gangs are crime-for-profit gangs; however, the Asian gang stands out as being the largest crime-for-profit gang and fits all of the criteria for a crime-for-profit gang, namely that they are mobile. The final gang structure type is the philosophical gang. The philosophical gang is based on a belief system instead of “lifestyle.” This belief system may be political or religious and as a result, the membership and activity would be motivated solely by the belief system. Motivation for committing crime is solely based on the philosophy of the group. An example of this gang would be a skinhead gang.

Why Are Our Children in Gangs?

Why would someone want to join a youth street gang? The following reasons include some but not all the reasons someone would want to join a gang:

- Identity or Recognition: This allows the gang member to achieve a level or status he feels impossible outside the gang culture. Most gang members visualize themselves as warriors or soldiers protecting their neighborhood from what they perceive to be a hostile outside world.
- Protection: Many members join because they live in the gang area and are, therefore, subject to violence by rival gangs. Joining guarantees support in case of attack and retaliation for transgressions.
- Fellowship and Brotherhood: To the majority of gang members, the gang is a substitute for a family cohesiveness lacking in the gang member's home environment. Many older brothers and relatives belong to or have belonged to the gang.
- Intimidation: Some members are forced into joining by their peer group. Intimidation ranges from extorting lunch money to beatings. If a particularly violent war is in progress, the recruitment tactics used by the gang can be extremely violent, even to the point of murdering one to cause others to conform.

Some additional motivational factors in joining a gang include the need to make money; narcotics distribution; control over the environment; racial and cultural similarities; acceptance by peers; loyalty and reward of just being part of the gang; recruitment; control of turf or territorial neighborhood; and having common enemies. However, the most pervasive motivational factor for joining a youth gang is a sense of finally belonging to a group that respects them. This sense of belonging, a sense of family, a sense of safety, a sense of identity, is so emotionally powerful that many gang members will do anything to become accepted and respected by the gang, even if it means using violence.

Possible Warning Signs of Gang Involvement

Mental health professionals should be aware and take appropriate action if a child exhibits one or more of these warning signs. Although we should exercise caution, we need to determine the degree (if any)

of a child's involvement in the gang. We could assume that a child has some level of involvement with a gang if he/she:

- Openly admits that they are involved in any manner with a gang
- Is obsessed with a particular clothing color (i.e.: Red=Bloods, Blue=Crips, Grey=TRG, Black/Gold=Latin Kings)
- Wears jewelry with distinguishing designs or wears it only on one side of the body
- Requests a particular logo or brand of clothing over others such as British Knights (BK)—known as “Blood Killer” or Calvin Klein (CK)—known as “Crip Killer” in some areas
- Is obsessed with gangster music or videos
- Begins using hand signs with friends
- Has paint or permanent marker stains on his/her hands or clothes. Or, is in possession of graffiti paraphernalia such as markers, etching tools, spray paint, and starch cans
- Shows evidence of physical injuries and lies about how they were received
- Displays unusual drawings or text on school books or displays graffiti in their bedrooms and on items such as books and posters

None of these warning signs alone is sufficient for predicting gang involvement, aggression, or tendencies toward violence. Also, it can be detrimental to use these signs as a checklist against which to measure children.

Early warning signs are just that, indicators that a child may need our help and guidance. These are behavioral and emotional signs that, when considered in context, could signal a distraught child. Early warning signs provide us with a means to examine our concerns and address the child's needs. Early warning signs allow us to get help for the child before problems escalate.

Conclusion

As we have seen in this article, youth gang violence is a problem that affects us all, regardless of race, gender, or socioeconomic status. We can all assist with the suppression, intervention, and prevention of gang violence. However, we first need to realize that there is a problem before we could act to resolve it. Most importantly when dealing with these young people and their families is to remember that they are in trouble and in pain.▼

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References

- Akiyama, C., Comparini, S.O. & Nepomuceno, J. (1997). Youth Gang Violence: A New High Risk Biopsychosocial Emergency. *Mind and Human Interaction*, 8:3, 186-194.
- Leet, D.A., Rush, G.E. & Smith, A.M. (2000). *Gangs, Graffiti, and Violence: A Realistic Guide To The Scope and Nature in Gangs in America*. Copperhouse Publishing Company, Incline Village, NV.
- Office of Juvenile Justice and Delinquency Prevention (2008). *Fact Sheet: Highlights of the 2005 National Youth Gang Surveys*. US Department of Justice, Washington, DC.
- Valdez, A. (2005). *Gangs: A Guide to Understanding Street Gangs*. Law Tech Publishing Company, San Clemente, CA.

Trophy Shoppers

Trophy shoppers tend to need to be the best at everything and, thus, to have the best of everything. The trophy shopper—regardless of income level—seeks the perfect accessory for outfits or high end items—be they art, furniture, etc.—and the more rare or hard to find, the better.

Image Shoppers

Image shoppers are similar to trophy shoppers on the surface because they tend to buy nice things, too, but their motivation is different. The image shopper buys things less for the inherent value of the items themselves and more for the image those items project to others. The image shopper needs to impress others more than the trophy shopper does.

Bargain Shoppers

Bargain shoppers are driven by the need to get a good deal—regardless of income level. It boosts their mood, their self-esteem and symbolically soothes their pervasive feeling of being shortchanged in some area of their lives. They often buy things they don't need but feel are too hard to pass up.

Codependent Shoppers

Codependent shoppers primarily buy things for other people to gain love and approval and to keep others from leaving or abandoning them. They feel their primary worth or value is what they can give to others.

Bulimic Shoppers

Bulimic shoppers are sometimes referred to as “binge shoppers.” They may have relatively short or episodic outbursts of excessive shopping—usually during times of stress. Bulimic shoppers—like bulimic eaters—may also engage in a pattern of “bingeing and purging:” shopping and then returning the items almost immediately after purchase; the initial buying is cathartic, but then guilt or ambivalence sets in so the returning also brings relief.

Collector Shoppers

Collector shoppers are similar to trophy shoppers in that they typically are focused more on attaining or accumulating items for personal satisfaction rather than to impress others. Unlike trophy shoppers, collector shoppers do not necessarily have to possess the best or hard to find items; rather, the collector shopper typically becomes obsessed with having complete sets of something to feel empowered or in control. Collector shoppers are often hoarders.

Overspenders

There are people who are less concerned with “things” than experiences. They may make occasional—rather than frequent—purchases that are financially excessive. Overspenders may splurge on dining out, vacations, theater and concerts, hosting parties, weddings, or gatherings, or may exceed their budget on cars, homes, an engagement ring, or other “lifestyle” purchases.

Deprivation vs. Overindulgence

One quick, relatively effective way to understand why many people overspend is to explore early childhood upbringing patterns. I have found that most compulsive spenders fall into two basic groups: those who were brought up spoiled or overindulged (materially and/or emotionally) and those who were brought up neglected or deprived (materially and/or emotionally). The first group

essentially continues the behaviors/lifestyle they were modeled; the second group attempts to “make up for” what was not given, what they wanted or felt they were owed. There may also be a mixed group—those who were showered materially but neglected emotionally and so shopping or spending developed to fill an endless emotional void.

Thus, while no parent is perfect, we have seen a trend in the last decade or so of parents spoiling and overindulging their children—creating a culture of entitlement. What would it be like if we actually taught children about money at an early age? Why not teach them about saving and responsible spending? Further, when working with families and couples, all of the key dynamics play themselves out in the financial arena. People's shopping/spending may be related to issues of power and control, trust and mistrust, commitment, belonging, and caring.

While our current economic downturn may have slowed, it has created financial and emotional stress with less disposable income and harder-to-obtain credit, which have exacerbated the addiction for many more. Fortunately, now is a great time to examine and reset our spending habits as there is a new frugality that is in vogue.

We each need to stop, take a breath, and calm ourselves in the sea of endless consumption. Either we can try to satisfy all our desires in a rush and then burst or we can learn to spread out our desires and enjoy life for real. As mental health professionals, we need to learn about our own money and consumerist tendencies and assist our clients in prevention and treatment of this growing problem.

Treatment for compulsive spending may include: specialized counseling, support group attendance, trigger avoidance/management and new hobby/goal development. Also, the medications Naltrexone and Celexa have been studied and used.

Compulsive spending is a serious disorder that requires sensitive and aggressive treatment. The good news is that, like with other addictions, people can learn why they are really spending and make healthier choices that help them live their best lives, financially and emotionally.▼

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References

- Ridgway, N., Kukar-Kinney, M. & Monroe, K. (2008). An expanded conceptualization and a new measure of compulsive buying. *Journal of Consumer Research* 35:4, 622-639. <http://www.sciencedaily.com/releases/2008/09/080915165830.htm>.
- Monroe, K. (September 22, 2008). New test show if you are a shopaholic. *LiveScience.com*. Retrieved August 10, 2009 from <http://www.livescience.com/culture/080922-shopaholic-test.html>.
- Money Smart Life (May 2009). What you should know before the wedding. Retrieved August 10, 2009 from <http://moneysmartlife.com/debt-and-marriage-what-you-should-know-before-the-wedding/>.
- Shulman, Terrence, D. (2008). *Bought Out and Spent! Recovery from Compulsive Shopping and Spending*. Infinity Publishing, Haverford, PA.

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by Alan Cohen, M.A.

Good News for Crackpots



An elderly Chinese woman brought two large pots to a stream to fetch water for her household each day. The pots hung at two ends of a stick she carried on her shoulders. One of the pots was perfect, but the other one had a crack in it.

At the end of the long walk from the stream to the house, the cracked pot arrived only half full. For a long time this went on, with the woman bringing home only one and a half pots of water each day.

The perfect pot was proud of its accomplishments. But the poor cracked pot was ashamed of its imperfection, miserable that it could only perform half of what it had been created to do.

After two years of what it perceived to be bitter failure, one day the pot spoke to the woman by the stream: “I am embarrassed because this crack in my side causes water to leak out all the way back to your house.”

The old woman smiled and answered, “Did you notice that there are flowers on your side of the path, but not on the other pot's side? That's because I have always known about your flaw, so I planted flower seeds on your side of the path, and every day while we walk back, you water them. For two years I have been able to pick these beautiful flowers to decorate the table. Without you being just the way you are, there would not be this beauty to grace the house.”

While you may criticize yourself for your flaws, they may serve a purpose. What you perceive as your shortcomings give you character, and may endear you to others, as well as serve them. Be not hasty to put yourself down for your foibles. What you think is wrong with you may be what is right with you, and your worst characteristic or experience might be the best.

I do a lot of work with people in 12-Step programs, mostly members of Alcoholics Anonymous. I find them to be among the most honest, dedicated, and faithful teachers I know. They have a lot of compassion and heart, and sincerely seek to help others where they can. They have been tempered by the agony of their experience, and parlayed their growth into a powerful asset to uplift their lives and the world. While their addiction was once an albatross around their neck, it has been transformed into a gift. The most difficult part of their life paved the way for one far better.

Beware of people who are well-adjusted. The question is, “Well-adjusted to what?” If you are well-adjusted to being nice to everyone and doing what people expect you to do, you are probably pretty bored and boring. If you are somewhat maladjusted, you are probably making a bigger difference in the world and having more fun.

One of my favorite actors is Sean Penn, who has had a longtime reputation as a “bad boy.” He was married to Madonna, got into drunken fistfights, and is seen as a loose canon. Yet Sean has also directed his energy and passion toward positive social causes. He has chosen some excellent roles championing the causes of the downtrodden, such as a developmentally disabled man in *I am Sam*, a prisoner in *Dead Man Walking*, and a gay politician in *Milk*. The red hot passion that has gotten him into trouble has also uplifted many when directed meaningfully. If Sean Penn were well-adjusted, he would not be, well, Sean Penn.

If you have felt like a misfit in this world, you may have more company than you know. You may be a part of a very large group (perhaps over 50 million in the U.S.) called “cultural creatives,” a term coined by sociologist Paul H. Ray and psychologist Sherry Ruth Anderson to describe people who are disenchanted with traditional religion and societal roles, hold visionary values, and seek a lifestyle unlike the masses.

If you are not normal (and who is? Stephen Wright asks, “How do you feel to know that half of the people you know are below average?”) one of your major life lessons may be to find and claim your right place in the great web of life. If you have felt weird for being spiritual, gay, not interested in climbing the corporate ladder, bored with television, unwilling to sell your soul for a mortgage, or bashful about revealing your psychic experiences, you may be closer to home than you know. You may be living exactly the life you came to live, and you simply need confidence to claim it without apology or compromise.

In the film *The Lake House*, one character feels lost and confused and does not know where to go. A friend advises her, “Go where you feel most like yourself.” So, too, you must go to the place and be with the people where you feel most like yourself. You don't need to attend family gatherings, church services, or business meetings where you don't belong. They may be right for others, but if they are not right for you, you must seek people who match you at your core. Those who truly belong to you will greet you with open arms, and you will feel like you have come home after a long trek in the wilderness. Then your jigsaw piece will fit and you will realize, like the cracked pot that created a long row of beautiful flowers, that the universe has a place for you.▼

Alan Cohen is the author of many popular inspirational books, including *The Dragon Doesn't Live Here Anymore* and *I Had it All the Time*. Join Alan for his *Life Coaching Training Program* beginning January 6, 2010. For more information on this program, Alan's free inspirational quote program, or his daily Wisdom for Today lessons via email visit www.alancohen.com; email info@alancohen.com or phone 1 (800) 568-3079.

EARLY WARNING SOFT SIGNS OF UNCARING CHILDREN

by Norman E. Hoffman, Ph.D., Ed.D., L.M.H.C., L.M.F.T., NCC

Although there are many cases of “Bad Parents” who raise children in a dysfunctional environment, and produce offspring that cause serious interpersonal, social, and legal problems, we rarely notice “good parents” whose children behave in a similar manner. Society’s first reaction is to blame the parents for their child’s behavior, assuming they must always be at fault. Taking this approach, society has bought the incorrect belief that “there are no bad children, only bad parents.”

Most “good parents” are very much aware of early troublesome signs; however, they are not usually cognizant of those “soft signs” that may lead to later problematic or even dangerous behavior as they develop. *The case of Eric Smith offers such evidence:*

In 1994, Eric Smith was 13 years old. He murdered a four-year-old boy, Derrick Robie.

Smith grew up in a small town of 970 people in New York. It was reported that he was terribly bullied and teased, and had “no friends.” He was found guilty of murder and was sentenced to the maximum of nine years in prison.

Although there is a tremendous amount of controversy raised with regard to whether or not he has served enough time, or should serve more time, the real focus should be on the many “red flags” or “soft signs” that were screaming during his childhood.

It was obvious that he was horribly teased and bullied, which resulted in his becoming a loner without any friends. He was observed by family members expressing a great deal of rage without any significant rationale for such behavior.

It is tragically sad, that if the family members of Eric Smith had the advantage of being able to identify and recognize his early “soft signs” of the “Uncaring Child Syndrome” (UCS) and appropriate intervention was initiated; this horrific crime may have been prevented.

Uncaring Child Syndrome

Kids who give “nothing back” to their parents, in spite of being provided all of their needs, love, and affection should be considered “Uncaring Children.” This is not to say, however, that they can’t be reached and changed. To get the child to change this uncaring behavior, the parents must first, change the playing field. The parents must get their “power” back and make the child experience “discomfort” while the parents “feel fine” or “comfortable.” This task is accomplished by setting up clear and consistent objectives, i.e., take out the trash every Tuesday and Friday before 6:30 p.m. If the chore is not performed, the parents will enact the effective and powerful technique, “Over-correction.” This technique is a catastrophic intelligent response to the child’s lack of cooperation. The child must complete five chores while grounded in a 24-hour period. If the chores are not accomplished, the grounding continues until satisfactory completion.

We must avoid the wasteful blame-the-parents game and instead make it imperative to provide parents and educators concrete behaviors and symptoms of the “Uncaring Child Syndrome”—children who lack a sense of guilt and remorse and often blame others for their problems and behavior. Behaviors that can lead to teenage violence and tragedy.

Early Warning Signs of the “Uncaring Child Syndrome”

Birth—1 Year

- Easily bored
- Difficulty in play
- Resists being held
- Lacks desire to explore toys or objects

1—2 Years

- Easily distracted by noises or people
- Sudden mood swings
- Difficulty playing in competitive games
- Difficulty engaging with other children in cooperative play

2—3 Years

- Reacts badly to being told “no”
- Lacks usual inquiry or interest in what-and-why questions
- Easily frustrated at not being understood

- Lacks even mild anxiety about strangers
- Overly ingratiating

3—4 Years

- Difficulty in self-play
- Will not assist others at home with chores

4—5 Years

- Lacks interest in what-and-why questions
- Lacks the desire for exploration
- Resistance with adult directions
- Easily bored

Four Profiles of the “Uncaring Child Syndrome”

The Chameleon

These individuals who, like lizards that are capable of changing their color, are able to change their dispositions and habits. Their whole relationships lack genuineness and authenticity. Although they appear to be making a good adjustment to life, they take on the personality of others, and copy their ideas and ideals.

The Operators

These children are charming and ingratiating, while being experts at wheeling, dealing, and conning parents and others.

The Hellbenders

Hellbenders are children who behave a little more daringly than their peers. They appear to take unnecessary risks and are accident-prone. They are the proverbial accident waiting to happen.

The Transformer

These children are initially seen as the “good child.” However, at about the time of pubescent and adolescents occur, there is a sudden and markedly different child emerging who becomes uncaring and disobedient. The change occurs because of a genetic pre-disposition resulting in a child who is easily influenced and dominated by another of higher dominance, charisma, and psychopathic personality traits.

Identifying ‘Soft Signs’ (Red Flags of UCS)

Debunking the knee-jerk “blame the parent” philosophy exposes the mental illnesses and/or genetic traits that may push kids into antisocial and even violent behavior. By learning to identify and interpret these early warning signs helps pinpoint the real culprit of bad behavior. Then a straightforward, step-by-step assessment and training program can teach parents how to transform their children’s behavior. *The following is a list of red flag warning signs of tween or teen behavior (soft signs) that stipulate help for families:*

- Lies or makes up stories to get out of trouble
- Does not listen to parents or teachers
- Is impulsive
- Has no attachment to personal belongings or to people
- Fails to learn from experience
- Lacks guilt or remorse when such a reaction is appropriate
- Blames or informs on others to avoid punishment
- Has little or no regard for the rights of others
- Is unreliable
- Is oppositional

- Has sudden mood swings
- Uses poor judgment
- Have superficial or poor interpersonal relationships
- Has been in trouble with the law, police or a juvenile officer
- Has made threats

Scores of 3 or more of the above behaviors are evidence of warning signs of the “Uncaring Child Syndrome.”

Transformation and Improvement Program

The Improvement Program applies behavioral techniques to provide children with freedom as a privilege and reward, not an obligation of the parents. This program teaches parents how to use “discomfort” in positive ways to keep kids in check. *These include:*

- Know your kid. Don’t judge your kids’ freedom by what others are getting. Some kids are better off with more limits and somewhere deep inside, they even know it.
- Give them numbers. Instead of be back early, tell them 9 p.m. Instead of letting them drive in town, tell them no farther than three miles.
- Encourage kids into activities that create their own parameters. A job for 10 hours per week that rewards your kid with a salary will limit the loose hours in which lots of kids get into trouble.

Conclusion

As with any therapeutic work with the young child, it is paramount to fully delineate serious symptoms from behavioral traits. For example, if a child complains of depression and fear, and may isolate from others, this child is suffering from significant psychological symptoms. They must be treated, and the child, therefore, becomes the significant focus of the treatment.

However, if the child behavior is bothering others, at home and at school, and he does not complain of symptoms, these may be considered behavioral traits. In most cases, the child will not comply with therapeutic intervention, regardless of the skills and personality of the therapist.

Therefore, the only way this child will change his maladaptive and antisocial behavior is to create a sufficiently strong discomfort level resulting in his desire to change. A child who fails to experience subjective anxiety rarely will understand or appreciate family pain and the need for cooperation and change. Subjective anxiety is pervasive and will usually last until issues are mediated and resolved. Because subjective anxiety is usually painful and unwanted, the uncaring child will maintain and nurture any position necessary to avoid it. This is why, at the hands of skillful parents, it becomes the most effective and powerful tool in the armamentarium. ▼

Dr. Norman E. Hoffman is a licensed mental health counselor, marriage and family therapist and is certified by the National Board for Clinical Counselors as a National Certified Counselor (NCC). He is the clinical director of the Counseling and Psychotherapy Center in Ormond Beach, FL and the President and Founder of the National Board of Forensic Evaluators, Inc. Dr. Hoffman is the author of *Bad Children Can Happen to Good Parents* (2007, VG Press), a child development expert, an expert witness in the field of forensic mental health evaluations, child custody disputes, and competency assessments throughout the United States. He also conducts workshops that enhance the forensic skills of mental health professionals. You may contact Dr. Hoffman by email drnorm@drnorm.com or visit the Web site www.drnorm.com.

2004). Core symptoms of this disorder—reexperiencing, avoidance, and hyperarousal—significantly impact interpersonal relatedness. Numbing/arousal symptoms in service members have been found to be especially predictive of family distress (Riggs, Byrne, Weathers & Litz, 1998). The crucial role that emotional expression plays in developing and maintaining close and intimate relationships has long been emphasized. This finding is consistent with the general literature on marital and couples' functioning citing the ability of the marital dyad to engage in communication as integral to overall satisfaction. Constricted intimacy and expressiveness, limited emotional sharing, and lack of self-disclosure add to marital discord and thwarts full integration into the family structure. PTSD avoidance spurs withdrawal and isolation, and induces the serious functional loss of a parent and spouse from everyday life, precluding communication and interfering with conflict resolution. The veterans' drive to avoid irritating stimuli is confusing and draining for the family. Even normal developmental tensions and strains within the family can be experienced by the PTSD impacted veteran as intolerable. These interpersonal impairments may directly interrupt the development of a positive parent-child relationship.

Previous study within other trauma populations such as Holocaust survivors' families has conceptualized the negative impact of an individual's traumatic stress on family members as "secondary traumatization" (Figley, 1988). This term generally refers to the distress induced by being in close proximity with others who have been traumatized. Researchers have generally concluded that there is clear and consistent evidence for an intergenerational transmission of trauma in war veterans' children (Rosenheck & Fontana, 1998a). Parental traumatic experiences may be transmitted to children in one of three ways. First, a child can be directly traumatized by the parent's behavior (such as through erratic actions or violence). Second, the transmission may occur as children identify with the affected parent. And, third, the impact of the parental trauma may occur indirectly as a result of the subsequent dysfunction within the family.

★ Helping Military Families

Awareness and support of both the soldier and his or her family has grown as reflected in the military's efforts to provide psychological preparation before, during, and post deployment. Each branch of service has several dedicated Web sites. MILITARY ONESOURCE (www.militaryonesource.com) serves as a "one-stop shopping center" for military families. Sponsored by the Department of Defense (DoD), its services are free and confidential, and offer a wide range of practical and psychological support. Another example from the military is the Army Reserves Yellow Ribbon Reintegration Program that supports families through all phases of the deployment cycle and holds thirty-, sixty-, and ninety-day post deployment gatherings. Beyond the military, other agencies have offered their expertise to help military families. Sesame Street has developed the *Talk, Listen, Connect* DVD series (free to the public) that includes modules on *Preparing for Deployment*, *Homecoming Family Routines*, and *Coping with Changes* that are hosted by Muppets, real-life members of service and their families, and celebrities. The American Red Cross's Services to Armed Forces (SAF) division has developed a four-hour course for military spouses and children entitled, *Coping with Deployments: Psychological First Aid for Military Families*. This course is offered on military bases for both active duty and reservist families.

When a soldier, sailor or marine is deployed, so are his or her loved ones. No one goes through traumatic experiences alone. This perspective underscores the importance of addressing the needs of military family members and considering them as potential central

figures in treatment planning when working with returning members of service. For the community-based mental health practitioner, perhaps first and foremost is appreciating the impact of combat exposure and the deployment cycle on spouses, children, and loved ones. A service member's spouse and family is perhaps his or her most valuable asset. Next, it is important to become educated about what a soldier and his or her family undergoes. It is vital to become familiar with military culture, deployment cycle stress, and combat PTSD. Toward this end, there are many online resources as well as professional trainings. The next challenge is to incorporate this in practice. Because most treatment remains centered on the individual service member, research is needed on effective intervention paradigms for military families. Until evidenced-based methods are developed, practitioners can include family functioning in their assessment when working with a service member or veteran, and consider holding spousal and family sessions to provide support, education, and acknowledgement of the often unrecognized impact of war on the family's well-being. ▼

Dr. Mary Tramontin is a psychologist at the Traumatic Stress Studies Program/PTSD Clinic at the James J. Peters Veterans Administration Medical Center in New York City where she provides supervision and treatment in state-of-the art post-traumatic stress disorder therapies. Dr. Tramontin has served on the Disaster Mental Health Leadership Committee of the Greater New York Chapter of the American Red Cross for over a decade. She has been instrumental in organizing New York City's Red Cross mental health response to disasters, including that of the World Trade Center Attack. In addition to her expertise in the management of traumatic stress, Dr. Tramontin is also a forensic psychologist and has worked for the New York City Police Department, the Department of Justice-Federal Bureau of Prisons and the United States Secret Service's National Threat Assessment Center. She is the co-author of *Disaster Mental Health: Theory and Practice* (2007), Thomson Books/Cole Publishers. You may contact Dr. Tramontin by email Mary.Tramontin2@VA.GOV.

References

Booth, B., Segal, M.W. & Bell, D.B. (2007). What We Know About Military Families: A 2007 Update. Prepared by the DoD United States Army Family and Morale, Welfare and Recreation Command.

Figley, C.R. (1988). A five-phase treatment of post-traumatic stress disorder in families. *Journal of Traumatic Stress*, 1, 127-141.

Gavaloski, T. & Lyons, J.A. (2004). Psychological sequelae of combat violence: A review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior*, 9, 477-501.

Hoge, C.W., Auchterlonie, J.L. & Milliken, C.S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *JAMA*, Vol. 295(9), 1023-1032.

Hoshmand, L.T. & Hoshmand, A.L. (2007). Support for military families and communities. *Journal of Community Psychology*, 35(2), 171-180.

Hutchinson, J. & Banks-Williams, L. (2006). Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan. *Primary Psychiatry*, Vol. 13(3), 66-71.

Kessler, R.C. (2000). Post-traumatic stress disorder: The burden to the individual and to society. *Journal of Clinical Psychiatry*, Vol. 61, Suppl. 5, 4-14.

Mikulincer, M., Florian, V. & Solomon, Z. (1995). Marital intimacy, family support, and secondary traumatization: A study of wives of veterans with combat stress reaction. *Anxiety, Stress and Coping: An International Journal*, Vol. 8(3), 203-213.

Military Family Resource Center. (2006). *Profile of the military community, 2006 demographics*. Arlington, VA: Author. Retrieved August 18, 2009 from <https://cs.mhf.dod.mil/content/dam/mhf/QOL-Library/Project%20Documents/MilitaryHOMEFRONT/Reports/2006%20Demographics.Pdf>.

Milliken, C.S., Auchterlonie, J.L. & Hoge, C.W. (2007). Longitudinal assessment of mental health problems among Active and Reserve Component soldiers returning from the Iraq War. *Journal of the American Medical Association*, Vol. 298(18), 2141-2148.

Pentagon's Defense Manpower Data Center (DMDC) cited in Hutchinson, J. & Banks-Williams, L. (2006). Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan. *Primary Psychiatry*, Vol. 13(3), 66-71.

Riggs, D. (2008). *Stress Through the Deployment Cycle: Impact on Military Personnel and their Families*. Presentation at SUNY New Paltz, April, 2008. Retrieved February, 15, 2009, from https://blackboard.newpaltz.edu/.../Microsoft%20PowerPoint%20-%20Riggs_KEYNOTE_DeploymentCycle.pdf.

Riggs, D.S., Byrne, C.A., Weathers, F.W. & Litz, B.T. (1998). The quality of the intimate relationships of male Vietnam veterans: Problems associated with post-traumatic stress disorder. *Journal of Traumatic Stress*, 11, 87-101.

Rosenheck, R., & Fontana, A. (1998a). Warrior fathers and warrior sons: Intergenerational aspects of trauma. In Y. Danielli (Ed.), *International handbook of multigenerational legacies of trauma* (225-242). New York: Plenum.

United States Department of Defense. *Post-Deployment Health Reassessment, 2006*. As of January 28, 2009: <http://www.pdhealth.mil/dcs/pdhra.asp>.



ILLINOIS INSTITUTE FOR ADDICTION RECOVERY 2010 TRAINING AND WORKSHOP SCHEDULE

MARCH 3RD–5TH & 8TH, 9TH

Problem and Compulsive Gambling: Counselor Training

Presented by the Staff of the IAR

Training held on the campus of Proctor Hospital

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 Illinois Institute for Addiction Recovery (IAR) will be providing the training. The IAR 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.

MARCH 18TH–20TH

Family Meeting Approach Intervention Training

Phil Scherer, CSADC, PCGC, MISA-II, BRI-II

Training held on the campus of Proctor Hospital

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 Sight Manager for the Illinois Institute for Addiction Recovery. Mr. Scherer is certified through the Illinois Alcohol and Other Drug Abuse Professional Certification Association at the supervisor level. Mr. Scherer is a certified Problem and Compulsive Gambling Counselor as well as a Mental Illness and Substance Abuse II professional. 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.

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 Web site www.addictionrecov.org. Refreshments will be provided, but lunch will be on your own for all workshops. For future dates of our trainings, please refer to *Paradigm* magazine or visit www.addictionrecov.org.

Continuing Education Units

New! 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. Please visit our Web site at www.addictionrecov.org to obtain your continuing education credits.

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



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