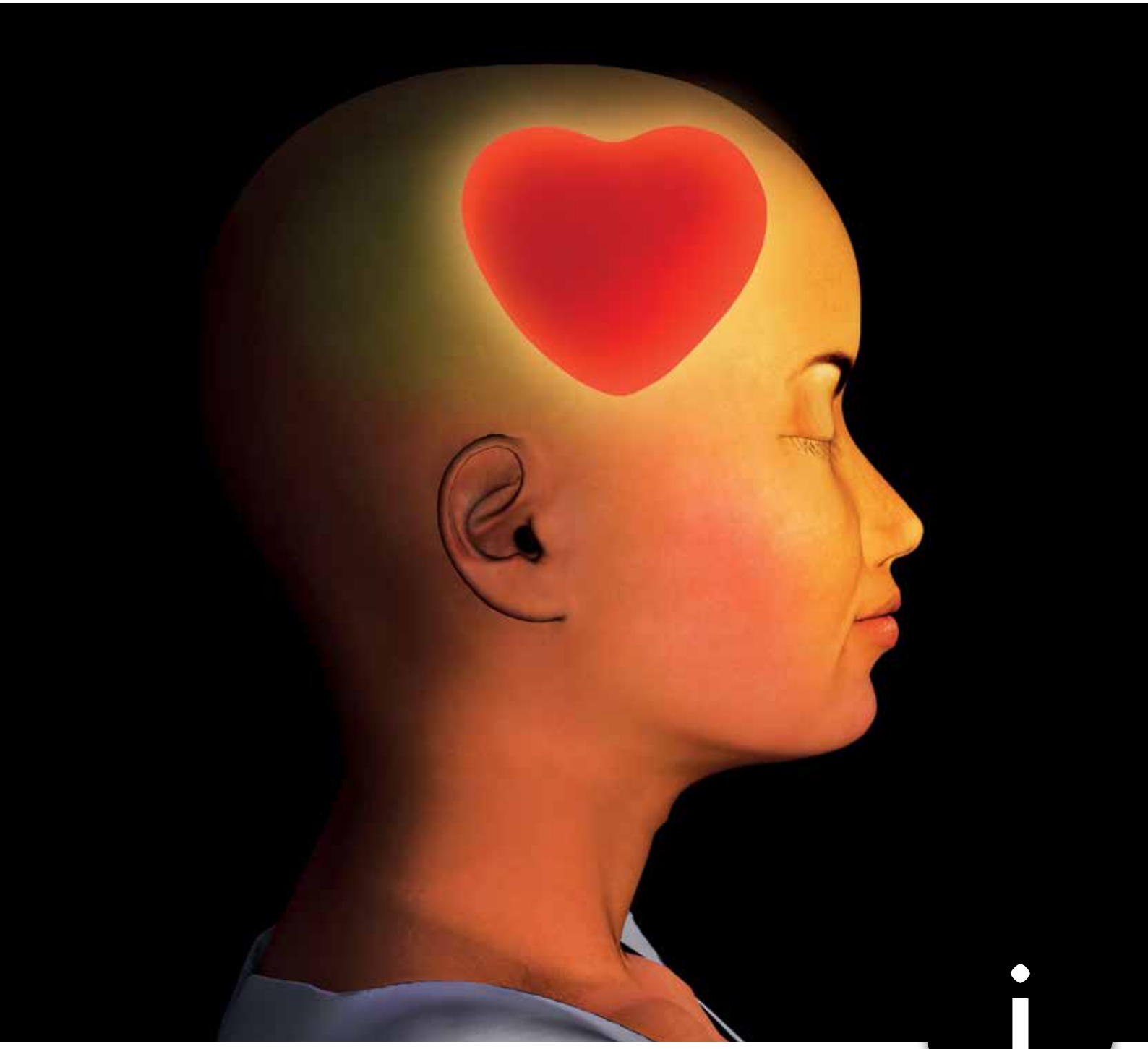
intervene

THE SEX AND LOVE ADDICTION ISSUE
ISSUE 154



NEWS, COMPREHENSIVE TREATMENT DIRECTORY, TRENDS, COMMENT, DIARY, BOOK REVIEWS, SELF HELP

THE RECOVERY MAGAZINE

This issue of Intervene appears on the eve of the United Kingdom's general election.

As we don't possess psychic powers we're hoping that the new parliamentary term sees more data transparency in order that the treatment system can be properly assessed, continuing joined up thinking in commissioning, greater commitment to abstinence based rehabs and treatment centres, a clear governmental definition of 'Recovery' and as a result a real increase in support for those suffering from addiction.

This is a bumper edition of Intervene, published to coincide with UKESAD International – the UK and Europe's biggest and most significant conference on addictive disorders. The event offers the global recovery community the opportunity to meet, discover the latest cutting edge approaches to the treatment of addiction and to share best practice.

As well as UKESAD's international attendees it's great to see so many of the UK's best known addiction treatment and recovery providers actively support the event, whether it's as individual exhibitors or as members of the Choices initiative, a collective which aims to bring rehabs together cohesively to work for improved and more appropriate options for their clients. In addition to this the calibre and variety of presenters, and the first time involvement of BACP and UKCP, has created one of the most exciting and varied menus in UKESAD's eleven year history.

As UKESAD International's media partner we'd like to say a big thanks to all of you!

This is also Intervene's Sex and Love issue with two compelling features about sex addiction and love addiction/love avoidance, we also have a fascinating article about gender specific treatment and much more. To make this rich content as available to you as possible we're redesigning our website (www.addictiontoday.org) - so, if you want to dip back into Intervene from your PC you'll be able to access it there.

In addition to traditional text-based articles we're also using digital technologies to create a fully multimedia experience for our readers and commercial partners - go to the app store on your tablet or mobile device and download Intervene for a quick taste of the future!

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INTERVENE'S MISSION IS TO:

- provide advice, support and guidance to anyone suffering from addiction/dependencies and to those involved in their care
- educate, teach and train professionals working with people with drug and alcohol problems in the methods and practices for prevention of and recovery from addiction/ dependency
- conduct and disseminate research into the care and treatment of people with addiction or dependency problems.

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ISSUE 154 2015

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DRUGSCOPE ANNOUNCES CLOSURE. THE FIELD PAYS TRIBUTE...

At the end of March, the charity Drugscope cited a lack of funding as leading to closure. Those involved in the charity spoke of their regret and sadness at this decision.

Edwin Richards, Chair of DrugScope, says:

'It is with a heavy heart that the Board has taken this extremely difficult decision. We are grateful to all of DrugScope's staff for their hard work, skill and commitment. I am saddened for DrugScope members whose support for the organisation has been at the heart of its work and governance. The focus going forward is on ensuring that the mission is carried on by other means.'

DrugScope was founded in 2000, the result of a merger between the Institute for the Study of Drug Dependence (ISDD) and the Standing Conference on Drug Abuse (SCODA). DrugScope's mission combined the aspirations of the founding charities; to provide drug information that was topical, non-judgmental and evidence-based, to be the voice for the drug and alcohol sector, to campaign for evidence-based treatment, promote good practice and challenge the discrimination and stigma experienced by some of the most vulnerable groups in society.

On hearing the news, a broad range of interested parties took to Twitter to pay tribute;

Alcohol Research UK @alcoresearchUK "We are all very sad and shocked to hear about the closure of @drugscope today. It is an enormous loss to the sector".

Alan Travis @alantravis40 "Closure of Drugscope leaves a huge hole in national drugs debate. Was an important and influential voice always based on evidence"

Revolving Doors @revdoors "We're very sad to hear @drugscope is closing – highly valued partners who prioritised evidenced & fought stigma"

Adfam @Adfam "All at Adfam saddened personally and professionally by news @drugscope..."
Alison Cowan @AlisonCowan " Just seen awful news about @drugscope ...Angry too. How many more vital charities must we lose?"

Steve Clare #SCADA @steveclare01 Drugscope was the reliable go-to place for credible info. Crushing that it is no more. Thank you for impartial guidance.

Action on Addiction @ActionAddiction "Really sad to hear @drugscope is closing. We wish everyone the best and will miss having their expertise"

Keith Humphreys @KeithNHumphreys "The closure of @drugscope is a big loss for the UK drug field. They did terrific, credible, widely-respected work for years.

Elsewhere, Lord Victor Adebowale wrote, "DrugScope's closure is a blow for civil society, not just social care" on the Guardian website. He continued, "DrugScope was a valuable organisation, representing providers from the smallest to the largest, and providing an evidence-based account of the moral, social and economic impacts of substance misuse. This was based on the experiences and expertise of service users and professionals, and DrugScope's position as a coalition allowed it to put forward robust arguments that withstood scrutiny at local and national level, and made many crucial contributions to the development of Whitehall policies".

His article ended with, "If DrugScope hadn't existed, then the sector would have had to invent it, and the challenge now is to create something that fulfils its function. However it is accomplished, the industry must find a means of providing itself with the information it needs, of informing policymakers, and moving itself towards the emerging public health agenda and the wider remit for substance misuse services this entails.

A vacuum is dangerous for everyone – if the role of DrugScope is not fulfilled by other means, then those who will suffer are the service users and the communities they live in. Providers will simply not have the evidence base they require to develop effective, good-value services".

We, at Intervene, would like to wish all the staff at DrugScope good luck for the future.

TWELVE

"Twelve" is a new multi-channel video installation by London-based visual artist, Melanie Manchot who spent two years talking to twelve people in early recovery and capturing their journeys in this major work. Using a diverse blend of cinematic techniques and tropes adapted by the artist, the work particularly shows the complex and non-linear nature of active addiction and recovery. Expect tragedy, pathos and humour! Twelve runs from 22 May to 26 July 2015, Peckham Platform, 89 Peckham High Street, London SE15 5RS (Telephone: 020 7358 9645). Free admission.
To learn more about Twelve, including details of UK tours, go to www.twelve.org.uk

Melanie Manchot, Twelve, Ferry

Melanie Manchot, Twelve, Car Wash

Melanie Manchot, Twelve, The Letter

NEWS IN BRIEF

DRUG RECOVERY SERVICE SAVES MONEY
One man referred to Cheshire East Substance Recovery in Macclesfield had cost services £500,000 in a single year – http://www.macclesfield-express.co.uk/news/local-news/drug-recorvery-service-saves-emergency-8964628

COST OF BINGE DRINKING REPORT
Researchers at the University of Bath have estimated the costs of binge drinking to the UK economy, and explored the potential impact of key policy options. It suggests while pricing policies in particular may be able to mitigate the costs to society, economic policies should not be used in isolation. Read the report at – http://www.bath.ac.uk/economics/research/working-papers/2015-papers/cost-binge-drinking.pdf

£17.8 MILLION AVAILABLE TO SUPPORT RECOVERY
Stoke-on-Trent City Council is looking to award contracts worth up to £17.8 million to provide services that will focus on recovery from substance abuse rather than 'maintenance'. Read more at – http://www.stokesentinel.co.uk/17-8-million-contracts-help-addicts-grabs/story-26286618-detail/story.html#ixzz3WqwLxD4r

ACTION ON ADDICTION AND CHILDREN OF ADDICTED PARENTS (COAP) ANNOUNCE MERGER
http://www.actiononaddiction.org.uk/News-Blog/News/Action-on-Addiction-merge-with-COAP-(Children-of-A.aspx

SCOTLAND'S METHADONE 'BLACK HOLE'
Dr Neil McKeganey, from the Centre for Drug Misuse Research, tells the BBC, that a lack of data prevents any impact analysis of methadone prescribing in Scotland. Read more at http://www.bbc.co.uk/news/uk-scotland-31943109

PREBIOTIC LINK TO REDUCED DEPRESSION
New research indicates that prebiotic intake reduces the waking cortisol response and alters emotional bias in healthy volunteers. Read the full report at – http://link.springer.com/article/10.1007/s00213-014-3810-0?wt_mc=Other.Other.1.CON417neurostarsment3

UK LAUNCH OF MENTAL HEALTH APPS LIBRARY
The NHS recently launched a Mental Health Apps directory accessible via the NHS England website. Resources available through this service are endorsed by the NHS. – http://apps.nhs.uk/apps/mental_health/?paged=all#

80% OF EVENING ARRESTS ARE DRINK RELATED
Metropolitan Police Commissioner calls for a reduction in the number of pubs in the UK. – http://www.telegraph.co.uk/news/uknews/crime/11468711/Britain-needs-fewer-pubs-top-cop-suggests.html

FORMER NEW YORK MAYOR, MICHAEL BLOOMBERG, FUNDS URUGUAY BATTLE AGAINST TOBACCO COMPANIES
In co-operation with the Bill and Melinda Gates Foundation, Mr Bloomberg has launched a multi-million dollar fund to help smaller countries fight legal battles with tobacco companies, among them the small South American country of Uruguay. – http://www.bbc.co.uk/news/world-latin-america-32199250

FRANCE MOVES TOWARDS BANNING ULTRATHIN FASHION MODELS
In an attempt to tackle anorexia, French lawmakers voted for laws to prevent excessively thin models from being hired in the fashion world. – http://www.wsj.com/articles/france-moves-to-ban-ultrathin-fashion-models-1428083804

IAN DUNCAN-SMITH'S COST-ANALYSIS OF RESIDENTIAL TREATMENT

The Department of Work and Pensions cost-analysis of residential treatment declared itself unable to conclude one way or the other due to inadequate data and questionable assumptions, yet did judge it "highly unlikely" that these treatments' 'extra' expense would be offset by extra savings. However, in February 2015, David Cameron stated that his government were, "committed to funding residential, abstinence-based rehabilitation, difficult though it may be in the current climate. Rather than maintaining people on substitutes like methadone, we have to help more people get off drugs and into work." Read more at http://findings.org.uk/PHP/dl.php?file=DWP_3.txt

BENEFIT CUTS UNDERMINE ADDICTION TREATMENT

A study by West Dunbartonshire Alcohol and Drug Partnership, found that one in five clients affected by welfare reforms had increased their alcohol or drug use. More than half did not have enough money to feed themselves and their families and 41% had borrowed money to survive.
http://www.heraldscotland.com/news/home-news/benefit-cuts-undermine-work-to-tackle-addiction-report-warns.121742613

FIGHTING STIGMA – GOODBYE HEADCLUTCHER!

When mental illness is portrayed visually, the image is usually posed with a person cradling their head in their hand. However, the stigma challenging organisation, Time for Change is leading a project to challenge this perception. The project, Get the Picture, is aimed at the media and has the backing of celebrities such as Stephen Fry. Get the Picture is asking members of the general public who have experienced mental illness to share their photographs on Twitter using the hashtag #goodbyeheadclutcher. Additionally, Time to Change have published a new set of media pictures which are free to download showing a less stigmatising view of mental illness. To find out more about this project, go to http://www.time-to-change.org.uk/getthepicture

NEWS IN BRIEF

SURVEY – LIFE IN RECOVERY
Action on Addiction, Sheffield Hallam University, and the Helen Kennedy Centre for Criminal Justice are currently running a survey to better understand life in recovery. To complete the survey, follow the link – https://www.surveymonkey.com/s/LifeinRecoverySurvey2015QHDDHVV

LIB DEM CARE MINISTER TALKS TO THE PRESS ABOUT HIS SON'S DRINK AND DRUG ADDICTION AND ANNOUNCES £1.25 BILLION INVESTMENT INTO MENTAL HEALTH SERVICES
Norman Lamb, MP for North Norfolk spoke about his family's experience of mental health issues in relation to his son Archie, who diagnosed with OCD at the age of 15. Addiction followed, but a blackmail threat from a former flatmate forced Lamb to speak publicly. Read more at – http://www.theguardian.com/politics/2015/mar/15/lib-dem-care-minister-noman-lamb-bring-mental-health-out-of-shadows

TOBACCO SMOKE STRENGTHENS SUPERBUGS
Laboratory research shows that exposure to tobacco smoke prompts methicillin-resistant MRSA bacteria to become more aggressive, and makes it harder for the immune system to fight the infection. Read more at – http://www.drugs.com/news/tobacco-smoke-strengthens-superbug-lab-research-finds-56308.html?utm_source=ddc&utm_medium=email&utm_campaign=Weekly+Drug+News+Round+Up+-+April+8%2C+2015&utm_content=Tobacco+Smoke+Strengthens+%27Superbug%2C%27+Lab+Research+Finds

PUPILS HAVE SATS PANIC ATTACKS
A study by the National Union of Teachers has found that primary school pupils in England are self-harming and having panic attacks over national tests. Read more at http://www.bbc.co.uk/news/education-32174569 . Meanwhile, the Department of Health has published a blueprint for counselling in schools. Download a copy at – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416326/Counselling_in_schools_-240315.pdf

US REGULATOR ALLOWS POWDERED ALCOHOL
Palcohol, already banned in several US states has been passed by the US Alcohol and Tobacco Tax and Trade Bureau. The makers say it should be widely available by the summer. Read more at – http://www.nbcnews.com/health/health-news/regulator-okays-powdered-alcohol-n322496

PRISONS AND AUTISM
Prisons are seeking help from the National Autistic Society to better support autistic prisoners. Read more at – https://www.gov.uk/government/news/prisons-seeking-national-autistic-society-help-to-improve-support-for-prisoners

$200 MILLION CUT TO ADDICTION TREATMENT BUDGET IN AUSTRALIA
The cuts will begin in June 2015. Experienced treatment staff are already leaving the services. Read more at – http://www.abc.net.au/news/2015-03-30/drug-alcohol-services-face-closure-after-health-funding-cuts/6357164

RUSSELL BRAND OPENS THE TREW ERA CAFÉ IN LONDON
http://www.theguardian.com/culture/2015/mar/26/russell-brand-donates-profits-book-hackney-cafe

THE UNITED NATION'S 58TH COMMISSION OF NARCOTIC DRUGS CONVENED IN VIENNA IN MARCH. FAY WATSON, SECRETARY GENERAL OF EURAD, REPORTS ON THIS PRESTIGIOUS EVENT.

In many ways, the work brought forward by EURAD at this year's Commission of Narcotic Drugs (CND) was the culmination of several years' work.

EURAD was the only non-government organisation to deliver a formal statement to the Commission this year and was one of a small number who were able to address the delegates as a panel speaker. EURAD also held well attended side events at the United Nations on the following topics:

1) Drug Policy and Human Rights: Sponsored by the EURAD, UNODC, ACTIS and San Patrignano (Wednesday 11th March)

This event was opened by Torbjørn Brekke of the Norwegian Ministry of Health and was facilitated by Stig-Erik Sorheim of ACTIS. Brekke opened the conference by referring to Norway's general support in the field of human rights. Gilberto Gerra, of UNDOC, then made a well-received presentation of how the UNODC condemns breeches of human rights. This was followed by a practical example by Monica Barzanti of San Patrignano, who demonstrated the Italian law which allows those committing drug-related offences (not for possession, but wider crimes committed by people with drug dependency) to enter rehabilitation programmes rather than go to prison. She demonstrated how in 2014 alone, the programme had converted 107 prison years into drug treatment, at a saving of €7.8 million for the Italian State. San Patrignano has itself converted 3,600 years of prison time into treatment, supporting over 3,800 people to receive drug treatment in lieu of prison time.

Fay Watson discussing Human Rights

2) A Public Health Approach To Drugs: Sponsored by EURAD, ACTIS, CADCA, Project SAM, with speakers from the World Health Organisation (WHO) (Thursday 13th March 2015)

Jens Guslund of the Norwegian Directorate of Health introduced this event, with Stig-Erik Sorheim of ACTIS facilitating. I presented a definition from the UK Faculty of Public Health which views public health as "the science and art of promoting and protecting health... through the organised efforts of society". I focused on the need for population-based measures and the role of the State in addressing underlying socio-economic and wider determinants of health as well as disease. I drew parallels with other areas of public health, namely the obesity epidemic, whereby I noted that obesity was rarely a personal choice but rather a product of an obesogenic environment, a sedentary lifestyle and linked to the affordability and accessibility of high-calorie food. I concluded by referring to the need to use a combination of population, targeted and individual measures to address drug demand.

Maria Renstrom, of World Health Organisation (WHO) followed. She stressed that the public health consequences of drug use disorders were increasing, quoting the increasing number of drug-related deaths on the global level. She also noted that compared to other public health problems, the disease burden attributable to drugs affected young people aged 25-29 years old disproportionately. She also noted the need for public health strategies to look at the harm to others, such as road traffic fatalities linked to drug use. She concluded by saying that "public health is the ultimate goal of drug control" and that "public health perspectives should be given greater consideration in drug control".

General Arthur Dean, of the Coalition of Anti-Drug Coalitions in America (CADCA) presented a public health model being rolled out by about 2,000 coalitions throughout the US.

Dr Kevin Sabet, founder of Smart Approaches To Marijuana (SAM) focused on the commercialisation of cannabis in Colorado. He concluded that a wider assessment of the public health impacts of legalisation needed to come to light.

3) Recovery: Policies, Research and Grass Roots Voices from Italy, Norway, UK, Sweden and the Balkans (Tuesday 10th March)

Public Health discussed.

EURAD Board Member and Chair of RUN, Boro Goic, providing the recovery voice at the UNCND.

EURAD and its Recovered Users Network (RUN) were delighted to be co-sponsors of this event, organised by member organisation San Patrignano. The side event involved EURAD's President Stig-Erik Sørheim, EURAD's Board Member Boro Goic and EURAD's Member Organisation RIO (Norway).

The event highlighted research carried out with EURAD's member organisations on recovery by Durham University and made policy recommendations for drug treatment services. The UK Home Office was also members of the panel at this event, to reflect on the UK drug strategy stated ambition towards recovery.

4) Eurobarometer Findings On The Situation On Drugs In Europe: Through The Eyes Of The European Youth Organisations (Tuesday 10th March 2015)

The event highlighted the results from the Eurobarometer results in terms of young people's attitudes to drug use as well as drug policy. During this event the results of the Eurobarometer were provided by Elsa Maia of the European Commission and members of Active provided feedback from their network on how best to reduce the demand for drugs. A presentation was also made by EURAD's member organisation, the Icelandic Centre for Social Research and Analysis who demonstrated the successful results of their prevention programme, which has now been rolled out across Europe. The event concluded by calling for further implementation of evidence-based prevention measures.

FIRST LEGAL HIGH IS CONTROLLED UNDER UN DRUG CONTROL CONVENTIONS: GOVERNMENTS ACROSS THE WORLD VOTE TO CONTROL MEPHEDRONE INTERNATIONALLY WITH NO OBJECTIONS

A UK-led proposal to internationally control the drug mephedrone was adopted by an almost unanimous (47 votes for and 1 abstention) decision was taken by Member States to control mephedrone under the UN Drug Control Conventions. Mephedrone is already controlled as a Class B substance in the UK. This international initiative is part of a concerted range of action taken by governments to respond to the challenges caused by New Psychoactive Substances (NPS) – known as 'legal highs'. This is the first time a New Psychoactive Substance (NPS) has been controlled by all United Nation members and the UK government said in their statement that it is, "therefore an important milestone in international action taken to combat the rise in dangerous and harmful NPS".

Contributors...

Inside information on the people who shared their knowledge, wisdom and talents to make this issue of Intervene possible

LAURA GRAHAM

Laura Graham is an independent consultant/ researcher working internationally in the addiction, mental health, and offender management fields. She worked as a Caseworker for life sentenced prisoners for three years, before moving into the development of suicide prevention and self-harm management policy in prisons. This was followed by a period of working on offender drug treatment strategy and the design of drug-free wings in prisons. She was also the Programme Manager for the pilot of Integrated Offender Management. Laura has written hundreds of articles about addiction and mental health. She had a regular column, "Laura Loves, Laura Loathes", in Addiction Today for three years. She is the author of "The State of Residential Treatment in England", published in 2011 and is the founder of Cure the NHS – Lambeth. (laurasmail@tiscali.co.uk

ELISABETH ESCOBAR

Elisabeth Escobar received her Masters Degree in Counselling Psychology from Columbia University in 1994. She has been working as a Mental Health Professional for 30 years. Elisabeth worked in an Adolescent Alcohol & Other Drug Treatment Programme in Oakland, California for several years and then moved over to the Adult Unit. She was also the School Counsellor for 8 years at several International Schools in Rome Italy. Elisabeth is a trained Interventionist for LoveFirst (www.lovefirst.net) and is presently offering Social Skills Coaching for Kids, Teens & Young Adults via Skype. She divides her time between New York City, NY, Miami, FL and Lisbon, Portugal. She can be reached at: jojoinoak@gmail.com

KATHRYN STARON

Kathryn Staron has a Masters degree in Clinical Psychology and is recognised by the State of Michigan as a Certified Advanced Alcohol and Drug Counsellor. She has worked in both inpatient and outpatient facilities specialising in dual diagnosis. Kathryn is also the Coordinator of the Addiction Studies Program at Madonna University and an Adjunct Assistant Professor in the Psychology Department.

BARBARA PAWSON

Barbara Pawson, psychotherapist with 18 years experience, was born and brought up in Brussels and is bi-lingual (French/English). She achieved her Masters (Addiction Psychology and Counselling) in London and gained further experience while training in Arizona with Pia Melody. She is a leading expert in Developmental Trauma, practising in Europe but mainly in London. She also has trained therapists in Holland and Bangladesh. Currently Barbara is concentrating on her private practice, as well as organising trauma workshops and CPD trainings.

LARRY ASHLEY

Larry Ashley Ed.S,LPC is Professor Emeritus of Counselling at the University of Nevada, Las Vegas. Professor Ashley has over 40 years experience as a researcher, therapist, and university professor in the areas of addiction and combat trauma. He has a special interest in the impact of war on soldiers worldwide. He has given presentations and trainings relative to combat trauma in many different countries.

TARA DAY

Tara Day is an Addiction, Trauma and Re-parenting Therapist. First-hand experience of adverse life events and symptoms of the manifestations of adaptive behaviour employed by way of coping mechanisms led to her interest and practice in process/ behavioural addictions. www.taraday.co.uk

Contributors...

Inside information on the people who shared their knowledge, wisdom and talents to make this issue of Intervene possible

DAVID BROWN

David Brown is a professional interventionist, mentor, coach, public speaker and educator. He was educated in Cumbria, England and has travelled the world extensively. He is a Licensed Addictions Counsellour and a Board Registered Interventionist. David and his wife own Avenues to Recovery, Inc. which provides substance abuse treatment, intervention and recovery mentoring services. His personal recovery dates from August 1, 1982. He is also the Clinical Outreach Consultant for Elements Behavioral Health for the UK.

ALASTAIR MORDEY

Alastair Mordey (BA Hons, RDAP) Alastair is the Programme Director and one of the founding members of The Cabin Addiction Services Group. Alastair developed the inpatient treatment programme and clinical framework of The Cabin Chiang Mai, a sixty bed residential addiction treatment centre located in northern Thailand, as well as The Cabin's Intensive Outpatient Programme in Hong Kong. Before founding The Cabin he worked for more than a decade in all four tiers of the UK's treatment system.

KARMEN K. BOEHLKE

holds a Master's Degree in Clinical Mental Health Counselling and a Graduate Certificate in Addiction Studies from the University of Nevada Las Vegas. She is currently pursuing a Ph.D. in Educational Psychology at UNLV.

JACQUI SINCLAIR

Jacqui Sinclair BSc.Hons, RYT500, LSSM Dip, Y12SR

An ex music industry account manager, Sports Studies graduate, LSSM (ISRM)

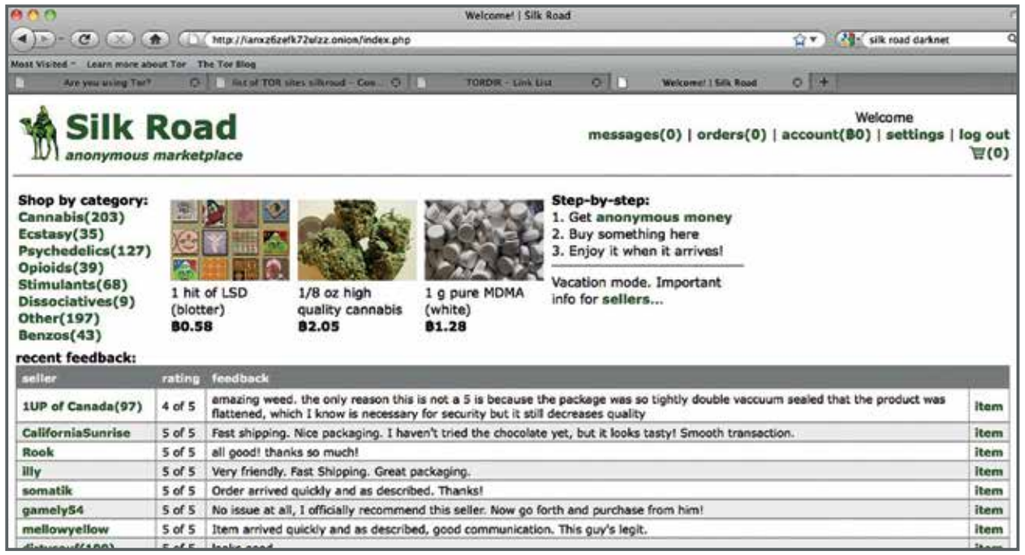
sports massage therapist, MFR and body worker, and Vinyasa Flow yoga teacher specialising in teaching addicts in treatment and recovery at Focus12. Based in Suffolk, daily life mainly revolves around moderating an infinite enthusiasm for living within the limitations of a 24 hr time frame. Music, yoga, meditation, reading and being in the company of like minded souls (and her dogs) all feature highly. Sleep also happens in there somewhere.

CHRIS JOHN

Chris John is a London based psychotherapist who is well known for his innovative and empathic style of therapy. Having trained extensively with Pia Melody Chris is one of Europe's leading trauma reduction specialists. An expert in issues relating from developmental and attachment trauma he draws on his years of experience and a rich combination of theories to provide the most effective therapeutic outcome for clients who have struggled with relational issues, including co-dependency, betrayal, sex and love addiction and low self-esteem. Chris also trains and supervises professionals in Trauma & re-parenting and working with love addiction.

CHULA GOONEWARDENE

Chula Goonewardene MBACP has worked with over 500 clients in community-based treatment and moved into Treatment Management and Training in 2010. Alongside his private practice, he currently manages a team of twelve to deliver a group-based Recovery Programme in North Westminster and still finds time to play the drums in two bands.



SILK ROAD

The mastermind of the internet drug dealing website, Silk Road was found guilty of several federal charges in March at his trial in New York. Thirty year-old Texan Ross Ulbricht, who used an online alias Dread Pirate Roberts, was convicted on three drug offences including distributing or aiding and abetting the distribution of narcotics with an additional charge of undertaking this activity over the internet, and conspiracy to violate narcotic laws. Other charges included conspiracy to run a criminal enterprise, computer hacking, distributing false identification documents and money laundering.

Silk Road was launched in 2011, on the 'dark web' and was described as the 'Amazon.com of illegal drugs'. The site used an anonymising tool 'Tor' to protect the identities of sellers, buyers and the site's administrators. It was used by several thousand drug dealers with over 100,000 customers who traded with Bitcoins with an estimated value of 1.2 billion dollars.

Ulbricht's San Fransico home was being watched by police when he was followed to his local public library. He was arrested after using his laptop at the library, virtually handing all the evidence of his online activity, (including passwords, transactions, financial details and staff), to the investigators.

On Ulbricht's conviction, US Attorney Preet Bharara warned, "The supposed anonymity of the dark web is not a protective shield from arrest and prosecution". Ulbricht is due to be sentenced on 15th May with a minimum mandatory sentence of 20 years but it is anticipated that he will receive a life sentence.

In another turn on the Silk Road, two former US special agents have been charged with stealing an estimated $1 million in Bitcoins whilst they were investigating the Silk Road.

The US Department of Justice alleges that Secret Service agent, Shaun Bridges stole large amounts of the digital currency, whilst 46 year-old, Carl Force, who served as an undercover agent during the Silk Road investigation, has been charged with money laundering and on-line fraud.

The Department of Justice claims that, "without authority", Force developed additional on-line personas and engaged in a "broad range of illegal activities calculated to bring him personal financial gain".

It is alleged that Bridges transferred more than $800,000 Bitcoins into an account at MtGox, a Japanese digital currency exchange which filed for bankruptcy in February. He then allegedly wired funds into one of his personal investment accounts in America days before he sought a $2.1 million seizure warrant for MtGox's accounts.

A second dark web drugs bazaar mysteriously ceased trading in March. The Evolution site administrators have reportedly closed the site, taking an estimated £8 million in the almost untraceable Bitcoins with them.

Who's who... *at recent events*

THE CITY OF CARDIFF BAND

The City of Cardiff Band played their final concert of the 2014/15 academic season in March. Highly acclaimed for their musical performances, the band have been supporting Recovery Cymru by raising in excess of £1,000. During the interval of this performance, the Cardiff University Music Hall removed alcohol from the bar and served a selection of hot drinks and cakes to an appreciative crowd. During the performance, every band member wore a Recovery Cymru badge or wristband..

DOUBLE IMPACT 'SPIRIT OF RECOVERY AWARDS 2014'

Double Impact hosted the first 'Spirit of Recovery Awards' [when?] in recognition of the contributions that individuals and organisations have made to the recovery agenda across Nottinghamshire and the life-changing impact their efforts have had across the community.

Over 150 Spirit of Recovery nominations were received across the 12 Award categories. A judging panel, made up of staff from across Double Impact, including ex-service users, awarded the following;

- Rosemary Pearson - Lifetime Achievement Award
- Andy Downs - Volunteer of the Year
- Ann Collins Mentor of the Year County
- Nigel Reeve Mentor of the Year City
- Colin Metcalf Exceptional Achievement (Male)
- Louise Wightman Exceptional Achievement (Female)
- SUMO Team - Creative Award
- Hetty's Family Services - Recovery Team Awards
- Studio House - Social Impact Award
- Primark - Outstanding Employer
- Geri Griffin - Exceptional Recovery Worker
- Graham King - Going the Extra Mile

The awards event was attended by staff, volunteers, service users and many local supporters, including the Sheriff of Nottingham Councillor Jackie Norris. Since its conception in 1998, Double Impact services have been designed to integrate volunteers from within the service to assist in the ongoing delivery of the various services provided. Integral to the effectiveness and sustainability of Double Impact has been the effort and commitment of these volunteers; The Spirit of Recovery awards celebrate individuals making an outstanding contribution to Double Impact and the wider recovery community through their work or volunteering.

Pictured right are some of the award winners with the CEO of Double Impact Graham Miller (far left) and The Sheriff of Nottingham Councillor Jackie Morris (centre).

INTERVENE WAS AT THE ATMOSPHERIC HOUSE OF BARNABAS,

in London's Soho, for the launch of Mark Dempster's latest book, and second installment of his story, 'The Ongoing Path'.

Pictures by Tom Jones

▲ **JOHN BIRD AND MARK DEMPSTER**
Getting down to the big issues

◀ **OUTREACH FOR ARSENAL FOOTBALL CLUB, JOHN KEYES AND PSYCHOTHERAPIST NICK MERCER**
Staying within reach

▲ **JOHN BIRD AND PHIL RYAN**
Founders of the Big Issue

▲ **JIM MULLAN**
Big Issue giant CEO Jim Mullan

◀ **MARK DEMPSTER AND AMY DANIELS**
Mark chats to TV producer Amy Daniels

Cascade Coffee Shop – the Story of Community Recovery & Asset Based Development.

The Cascade Coffee Shop launched in February 2015. ***Pete Davies***, Founder of Cascade Creative Recovery, talks us through this incredible journey.

In 2012, a group of service users and people who had recently existed treatment delivered the biggest recovery orientated event that year, the 4th UK Recovery Walk, the first of its kind in Brighton & Hove. The event took a year to organise with zero funding, one laptop between half a dozen of us and no prior experience of organising a national event through to delivering a highly visible celebration of recovery with almost 3,000 people walking through the streets of the city followed by an afternoon and evening of music and dancing in the early autumn sun…,Job done!

The success of the event was dependent on belief, faith, collective willpower and assets. These assets were buried under the rubble of active drug addiction and alcoholism, undiscovered by key workers or care coordinators or during therapeutic sessions. When you're sifting through a lifetime of wreckage there isn't much chance to find out what, in recovery, you are capable of.

Eventually, some financial investment from,CRI (a national treatment provider), the Government and Brighton & Hove City Council, the hustling instincts of a group of people who survived horrendous self-destruction, the event not only happened but was an incredible success, demonstrating to local services exactly what recovery, (as opposed to harm reduction), was all about. Social networks, camaraderie, using the tools recently learned and rediscovering abilities and skills that had always existed made it all possible!

As the result of that success we sat down, reflected and asked ourselves what next… Our lived experience told us that there was a need for a place, independent of traditional services, peer-led, where all of the recovery community, including family, friends and people in recovery, can connect and mutually support each other. Somewhere that was not specifically fellowship or Service based, but community based, visible and easily accessible. A place where recovery capital could be rapidly accrued through meaningful, esteem building creative projects (Brighton & Hove has a very vibrant arts scene so we identified that as a local asset that could be accessed.)

In March 2013, we submitted an application to become a Charitable Incorporated Organisation, having identified that configuration as the correct one to carry out our aims. Our application was accepted in September 2013. While waiting for the application to be processed we joined an umbrella organisation for groups, social enterprises and smaller charities called Community Works, thus placing ourselves firmly in the third/voluntary sector and less dependent on service providers. We recruited trustees who had particular skills, sourced appropriate training, set up a recovery choir, organised social events, attended and delivered workshops at conferences and symposiums in order to build our profile while networking and learning.

Our biggest challenge was realising our dream of the Cascade Coffee Shop. Once again, we found ourselves in the position of challenging the misconceptions which surround people who have or are working their way from drug addiction and alcohol issues. Our experience is that those outside of the 'recovery bubble', (the Police, council officers, local business people, landlords etc) are deaf to the term RECOVERING addict or RECOVERING alcoholic. They only hear the latter part. However, the Manager of a local women's project, Oasis, pointed us in the direction of an understanding landlord and after a year of looking for an appropriate premises, we signed a lease in April 2014.

We accessed some capital funding from Public Health England and employed a builder to start on the structural work needed for the Cascade Coffee Shop to open. During this work, we continued to build our presence in the city. It became apparent after the initial work that if we continued using a professional building company we would run out of money with only half the job done. We took another leap of faith and took on the build ourselves, reaching out to the recovery community to provide the skills while we sourced the

materials. We asked and they came! Sourcing free or at cost materials from builders merchants, we delivered a high specification coffee shop and upstairs creative/meeting space in mid-February.

We are now open for business! We have created an 'out of hours' safe space, we are running our choir and theatre group from the premises, and we are providing an affordable space for a variety of mutual aid groups to hold meetings. By connecting, creating, and empowering, we have created an asset for the recovery community and we are working hard to source an appropriate level of funding to nurture and sustain this asset.

If you find yourself in Brighton, come and see us!

Cascade Coffee, 24 Baker Street, Brighton BN1 4JN

Since finding recovery 7 years ago, Pete Davies has set up award winning exhibitions as part of the Brighton Fringe Festival. He project managed the 4th nation UK Recovery Walk and is the Founder and Manager of Cascade Creative Recovery.

Combat Trauma, Traumatic Brain Injury, & Addictive Disorders

Larry L. Ashley, Ed.S., LCADC, CPGC & Karmen K. Boehlke, M.S.
provide a fascinating insight into the experiences of American veterans returning from recent conflicts in Iraq and Afganistan.

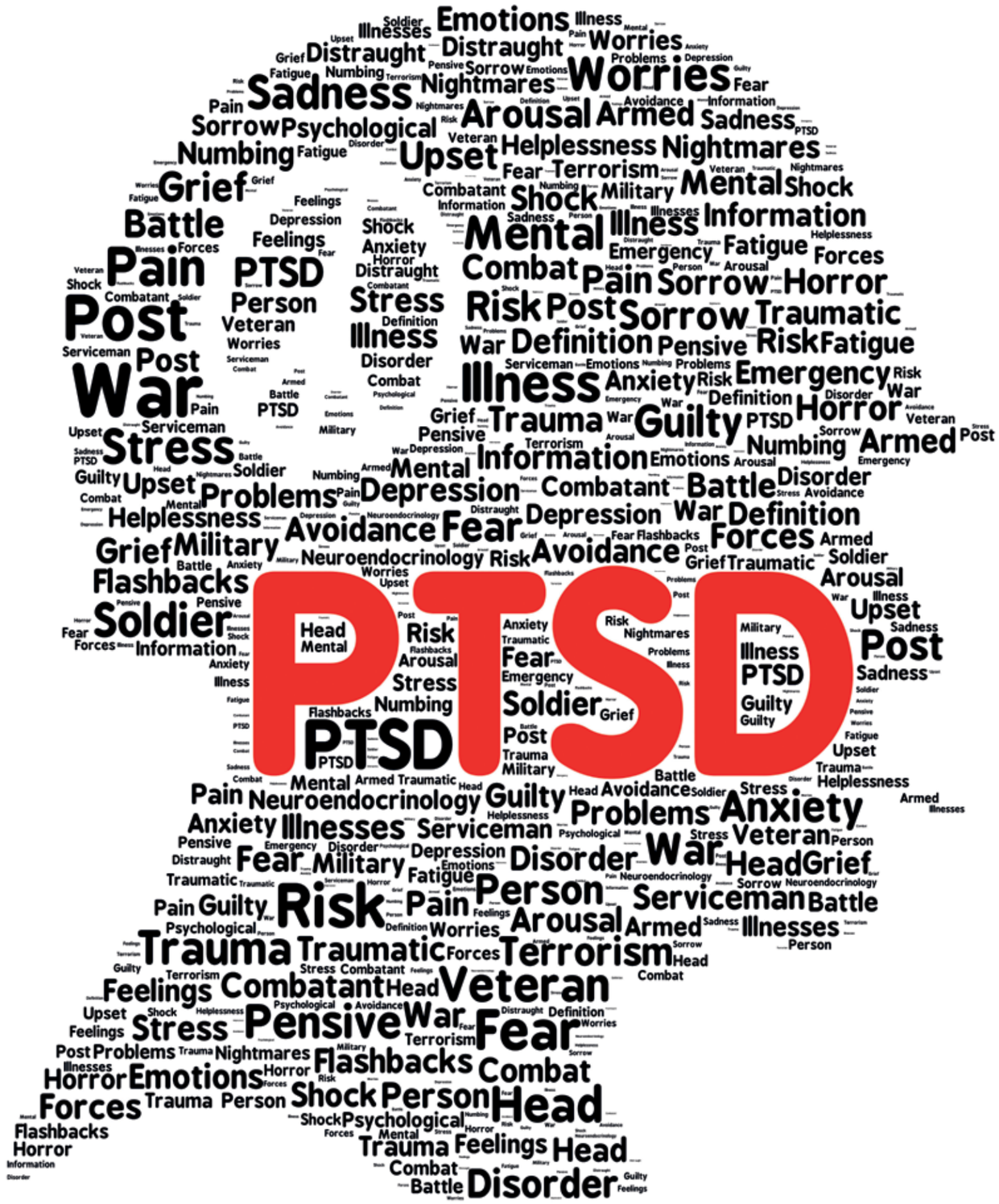
Whether anticipating, engaging in, or experiencing the aftermath of battle, historical accounts indicate that war has always had severe psychological impacts on soldiers in immediate and enduring ways. For example, three thousand years ago, an Egyptian combat veteran named Hori wrote about the feelings he experienced before going into battle: "You determine to go forward…Shuddering seizes you, the hair on your head stands on end, your soul lies in your hand." Herodotus, the Greek historian, writing of the battle of Marathon in 490 B.C., cited an Athenian warrior who went permanently blind when the soldier standing next to him was killed, although the blinded soldier "was wounded in no part of his body." In a different account referencing the battle of Thermopylae Pass in 480 B.C., Herodotus wrote of another soldier, Aristodemus, who was so shaken by battle that he was nicknamed "the Trembler." Aristodemus later hanged himself in shame (Bentley, 2005; p. 1).

Employing the term "Nostalgia" in 1678, Swiss military physicians were among the first to identify and name the constellation of symptoms that comprised acute combat reactions (Bentley, 2005). Since then, the moniker has undergone several revisions. Transitioning from "soldier's heart" during the Civil War, to "shell shock" during World War I, to "combat exhaustion" or "combat fatigue" during World War II and the Korean War (Hunter, 2009) to "combat stress reaction" during the Vietnam War (Johnson, 2010), posttraumatic stress disorder (PTSD), as it is currently classified today, officially debuted in 1980 when it was included in the in third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Symptoms of PTSD include sleep disorders, avoidance, numbing, detachment, re-experiencing, hyper-arousal, and hyper-vigilance (Reckess, Chen, & Vasterling, 2012).

While epidemiological data suggest that the majority of adults (69%-90%) have experienced at least one potentially traumatic event (Dedert et al., 2009), PTSD rates are more than twice as high in veterans than civilians (Back et al., 2014). According to a reexamination of the National Vietnam Veterans Readjustment Study, approximately 19% of male Vietnam theatre veterans developed PTSD (Dohrenwend et al., 2006). Hoge et al. (2004) found PTSD rates in veterans returning from the Iraq and Afghanistan wars to range between 11% and 17%.

Traumatic brain injury (TBI) often occurs during some type of trauma, such as an accident, blast, or a fall. A disruption of normal brain function occurs when the skull is struck, suddenly thrust out of position, penetrated or struck by blast pressure waves. While the initial trauma tears, shears, or destroys brain tissue, the effects from the incipient wound may cause a second injury cascade in the brain resulting in edema, internal bleeding, and oxygen deprivation. Symptoms associated with TBI, many of which overlap with the common reactions following trauma, occur in the physical, cognitive, and affective domains and range from headaches to memory problems to changes in mood and personality (Center for Substance Abuse Treatment, 2010).

The conflicts in Iraq and Afghanistan (OIF/OEF) have resulted in increased numbers of veterans presenting with TBI. While 12% of the combat wounds incurred during the Vietnam War were



related to TBI, the Department of Defense and the Defense and Veteran's Brain Injury Center estimate that 22% of all OIF/OEF combat wounds are brain injuries. Additionally, symptomatology in veterans appears to extend beyond what is experienced in the civilian population. Studies show that most veterans who experience a TBI will suffer symptoms 18-24 months following the initial injury (U.S. Department of Veterans Affairs, 2014).

While the stresses of military service, combat, and reintegration have the potential to place individuals at an elevated risk for experiencing PTSD and TBI, these variables have also been identified as risk factors associated with the development of other emotional and behavioral disorders, including depression, generalized anxiety disorder, and addictive disorders (Biddle et al., 2005). The rates of PTSD among individuals presenting for substance use disorder (SUD) treatment have been reported to fall between 30-59% (Stewart et al., 2000). According to the National Research Council (1996), individuals presenting with trauma histories are 1.5 to 5.5 times more likely to abuse chemical substances than those without a trauma history. To complicate matters further, as many as 82% of individuals presenting with a comorbid PTSD-SUD diagnosis experience additional non-substance use Axis I disorders (Cacciola et al., 2001).

Current prevalence rates of SUDs in veterans aged 18-53 is nearly five times that of the general population (SAMHSA, 2007). The most commonly abused drug among active duty military and veterans is alcohol. Approximately 27% of Army soldiers were found to meet criteria for referral to treatment when screened within 3-4 months after returning home from service in Iraq (NIDA, 2011).

There is also evidence indicating that prescription drug misuse rates in the military also exceed civilian rates. The Department of Defense (2009) reported an 11.7% prescription drug abuse rate among military personnel compared to that of 4.4% in the civilian population. Not only are the abuse rates higher in the military, they are also escalating at a more rapid pace: statistics indicate that prescription misuse by military personnel doubled from 2002 to 2005, and then nearly tripled between 2005 and 2008 (NIDA, 2011).

Additionally, differences exist between the military population and the general population with respect to gambling. According to the National Council on Problem Gambling, anywhere between 1 to 3 percent of the general population experience a gambling problem within a given year. However, 10 percent of veterans utilizing VA treatment services have been

diagnosed with a gambling disorder (Hall, 2013).

In general, comorbid disorders tend to complicate treatment. Comorbidity is associated with increased symptom severity and poorer treatment outcomes (Brown & Wolfe, 1994). Individuals presenting with comorbid disorders tend to experience more psychiatric symptoms and interpersonal distress than clients presenting with either a PTSD or SUD disorder alone (Najavits et al., 1998). Additionally, individuals diagnosed with comorbid PTSD-SUD tend to relapse sooner (Brown, Stout, & Mueller, 1996) and engage in more frequent inpatient treatments than individuals presenting with an SUD alone (Brown, Recupero, & Stout, 1995).

Moreover, military personnel face unique factors that may interfere with treatment-seeking endeavors. Concerns related to the potential stigma attached to utilizing mental health services appears to be disproportionately high in the military population compared to that found in the civilian population. A particular concern relates to how a soldier will be perceived by his/her peers and leadership. There is also concern that treatment-seeking may prove harmful to career aspirations or result in disciplinary actions (Hoge et al., 2004).

Despite advances in classification, recognition, and public awareness, misunderstanding and denial continue to exist regarding the lingering effects of combat trauma. A particularly poignant portrayal of denial was demonstrated a number of years ago by the actor George C. Scott wherein he played the role of General Patton in the movie Patton. In one scene, Patton visited an aid station behind front lines and came upon a soldier sitting on the edge of his hospital bed. Seeing no visible signs of wounds, Patton asked, "What's wrong with you, son?" Uncertain how to respond and awed by the presence of the general, the soldier simply stammered. Impatient, Patton raised his voice and repeated the question. Informed by the attending nurse that the soldier was suffering from combat fatigue, Patton became incensed, launched into a litany of obscenities, disparaged the soldier, and called him a coward. Before storming out of the aid station, Patton hit the soldier with his gloves (Johnson, 2010).

The tirade cost Patton his command. However, the scene illustrates a lingering attitude: If there is no blood, there is no harm. And, while helmets and body armor can provide some protection against penetrating head injury, the psyche remains vulnerable to the invisible wounds that result from combat (Johnson, 2010).

"While the stresses of military service, combat, and reintegration have the potential to place individuals at an elevated risk for experiencing PTSD and TBI, these variables have also been identified as risk factors associated with the development of other emotional and behavioral disorders, including depression, generalized anxiety disorder, and addictive disorders."

Veterans are exceptionally susceptible to experiencing PTSD and TBI. As a consequence, especially if left untreated, some will become homeless; others may engage in domestic violence and criminal behaviors that will result in subsequent incarceration. Many will develop other debilitating psychological problems as a result of their struggles with PTSD, including depression, anxiety, and addictive disorders; tragically, some will see suicide as the only way to escape their pain (Hurley, 2010). There is little doubt that the current rate of mental health problems amongst military personnel and veterans present enormous economic challenges to both the U.S. military's medical system and the communities into which soldiers reintegrate upon return from combat. However, those bearing the preponderance of the painful costs associated with war are the soldiers and their families who live first-hand with the psychological wounds of battle (Hurley, 2010). And, while the needs of veterans are complex and the systems though which they receive care can be complex, services must promote the care, healing, and recovery of afflicted members of the veteran population. The health and the well-being of our veterans depend on it, as do the health and well-being of our nation.

Addiction is a Disease, but this doesn't Reduce Treatment to a Medical Model.

Alastair Mordey explains how successful recovery from addiction engages self-directed neuro-plasticity through psycho-social treatments such as CBT, 12 Steps & Mindfulness, and that these approaches are particularly effective when combined into an integrative model

As practitioners we often seem to debate two issues over and over again. Firstly whether addiction is a disease or not, and secondly, how should it be treated? I would like to combine these two areas of debate into one, and explain that for me, seeing addiction as a disease doesn't reduce its treatment options down to a medical model. Quite the opposite. The way that addiction develops gives us vital clues as to which methods we need to employ, and these interventions are predominantly psycho/social and spiritual in nature. We now have an understanding of the human brain as a highly plastic (changeable) organ, and due to this principle of plasticity our psychology can significantly affect our biology. Three of the most effective treatments which achieve this in my view are; 12 Steps, CBT and Mindfulness, and when combined, they complement each other enormously, especially if we understand why they do what they do.

Addiction professionals often talk informally about the similarities between Cognitive Behavioural approaches and 12 Steps in treating addiction, in particular REBT's focus on disputing irrational thought and gaining unconditional acceptance of self, others and the world. Analogous 12 step practices would be checking your thinking with others and handing over pathological controllingness (self-will) to a higher power, support group or sponsor. These similarities first presented themselves to me quite naturally (as I'm sure they did too many other people) whilst learning the ABCs used in Beck and Ellis' therapeutic models. I remember thinking "wow", this is a lot like a Step 4 resentment inventory.

Quite simply put, a Step 4 resentment inventory requires us to know who we are resentful with? What they did? How this threatened us? What was our part in it, and what are we going to do about it? This is exactly analogous to a CBT approach where we might ask, A - What activated us? B - What do we believe about it? C - What are the consequences - how are we behaving? D - Dispute our thinking - or see our part, and E - do something 'effective' to resolve it like making an amend.

This revelation (which is actually fairly obvious) started me on a journey of hybridizing the two approaches for work with addicted clients. Along the way I realized many practitioners were already doing the same thing, but at that point an unexpected event occurred. I moved to Thailand, started running a treatment centre (The Cabin Chiang Mai) and crucially, I was introduced to Mindfulness.

Mindfulness is a meditation practice which can be completely secular, but which evolved from the Theravada Buddhist tradition. You've probably heard of it before. Its local name in South East Asia where I practice is Vipassana (which literally means 'insight'). Rather like 12 steps, and Ellis style REBT, it focuses on gaining acceptance over things as opposed to trying to get on top of them, or conquer them.

The more I looked the more I realized that the connection between 12 steps and Mindfulness is well documented, as are the similarities between CBT and Mindfulness. But the combination of all three is so much more powerful than the sum of its parts and to understand this we need to go back to the basis of what addiction actually is.

According to The American Society of Addiction Medicine, addiction is a "primary, chronic and progressive brain illness" (ASAM, 2011). As a disease, the 'broken' bit is the brain's reward system, and specifically the way dopamine, the brain's pleasure - reward chemical, is functioning. In essence addiction is reward deficit, triggered by stress or what we would now refer to as trauma. Reward deficit leaves sufferers with a broken 'sense' of pleasure and a broken

sense of pleasure is pretty serious in the same way a broken sense of sight is pretty serious, and it throws up recognizable symptoms namely; lack of reward, meaning and purpose, restlessness, irritability and discontentedness. These symptoms often present in adolescence before an individual even begins using or drinking and the symptoms will certainly persist after cessation of using if treatment is not consistent because the illness is chronic (incurable). We have a name for the return of symptoms during sobriety - 'dry drunk' - and dry drunk is a collection of the un-medicated symptoms of poor dopamine function.

Whilst The National Institute on Drug Abuse (US) estimate that 40-60% of the vulnerability to addiction is genetically inherited this does not mean that addiction can only be seen through the lens of the medical/biological model. Environment plays a big part too, because our brains are highly plastic and changeable, especially when we are young. Stressful or traumatic environments can down-regulate (lower) dopamine function over time, creating a reward deficient brain. So environment often 'triggers' the illness as ASAM have also noted. It is apparent that dopamine's role in addiction is central and that this neurotransmitter is a common denominator behind all addictive drugs and processes, but how does it do this, and what does that then tell us about how we need to treat the illness in our clients?

Dopamine's much vaunted role as a 'pleasure' chemical is slightly misleading. The actual role it plays in providing pleasure feelings is via the meaning or purpose it confers on that pleasure or reward (in this case the drug). This is a subtle difference. It is wanting more than liking. Due to genetically inherited or environmentally created reward deficiency (poorly functioning dopamine receptor sites and other related phenomena) addicts brains' can't interpret the dopamine signal that's being produced, and can't experience the meaning or pleasure in ordinary rewards which 'normal' people take for granted. Dopamine helps us understand the purpose of rewards… "oh this is good….this is useful….I want it." Drugs, alcohol and highly rewarding processes like novel sex or gambling provide a 'louder' signal which reward deficient addicts can 'hear', and recruit the meaning they need.

For this reason, meaning and purpose is central to addiction, but it is also central to recovery from addiction. In my view this is precisely why addiction is instinctively felt to be a 'spiritual' illness. What is more spiritual than meaning and purpose? If you think about it, we are not so focused on providing reward and pleasure for clients in their early recovery (to replace their reward deficit) but rather we are trying to instill in them a sense of meaning and purpose. Addiction is a social illness, as well as a biological/psychological illness, and meaning for human beings comes down to being social. Gaining interconnectedness with others (fellowship) has meaning. Service work with others (Step 12) has meaning. The altruism involved in service gives recovering addicts a sense of purpose and cuts right to the heart of our intrinsic nature as social animals. We are apes…not cats!!

The meaning and purpose that 12 Steps provide is much more central to the sustainable, manageable feelings which clients need than mere thrills or substitute rewards would be, otherwise we could just send our clients skydiving, or teach them how to win

more, and then they would recover via the pleasure and reward feelings they were recruiting. No, holistic dopamine reinforcement is provided through purpose and meaning. Recovery through the Steps is in effect, a slow release and long acting method of dopamine reinforcement, rather than a nasty, spiky dopamine boost which is procured through drugs, alcohol, novel sex, money and anything which has strong addiction potential.

Whilst the 12 Steps play a very central role in correctly medicating the illness by implementing meaningful and purposeful feeling states, Mindfulness and CBT's role comes more into play in treating the part of the illness that affects the front of the brain. Denial, or hypo-frontality (low functioning of the forebrain) impairs sensible decision making in addiction sufferers. As ASAM noted in their 2011 definition; addiction is an illness of "reward, memory, motivation…and related (brain) circuitry". Many a loving, but addicted parent has neglected to attend that crucial case conference to regain custody of their child in favour of sitting at home in their bedsit injecting heroin. The addict has no choice; it's not complicated, it's a brain thing! Addicts' brains are also more sensitized to cravings than non-addicted peoples brains are. They seem to have a genetic talent for it.

But if we can stop clients from acting on their addiction by slowing down their stress - craving - drug-seeking neural pathway, then we have time to challenge (dispute) their reasoning, both in one to one work and even more effectively in group. The relationship of CBT and Mindfulness here is circular. The microscopically slow movements of a Vipassana prostration practice, or the acknowledgement of uncomfortable sensations such as itches during a sitting meditation, are ideal behavioural practices for dealing with cravings and urges. The Buddhist perspective of impermanence teaches the client that unpleasant things like cravings are just as impermanent as anything else. Pleasure is impermanent – cravings are impermanent.

Active addiction itself is a short term way of medicating reward deficient symptoms but it is really just a 'quick fix'. Eventually it becomes counter-productive by lowering dopamine functioning overall and exacerbating the addiction. Engaging recovery activities such 12 Steps, CBT exercises and Mindfulness, works across the reward system by raising dopamine tone in a slow release, long acting manner, and 'coaching' the frontal lobe through delaying gratification and challenging impaired thinking. This starts to fix the problem long term. The more our clients implement these behaviours into their life, the more the structure and chemistry of their brain will change. At The Cabin, we integrate these three approaches into one model.

So it's a brain illness! Problem is, even when we agree with that intellectually, we often don't in reality practice addiction treatment that way. For me, the disease model of addiction is anything but a dry, reductionist view of the etiology of addiction. It actually promotes and re-emphasizes the importance of behavioural, psychological and social treatments in conjunction with medical interventions, and what's more it explains to a considerable extent why they work. We humans have an amazing capacity to change the structure and function of our own brains, by repeatedly talking, feeling and behaving in a particular way. For me the teachings of the 12 step movement and pioneers such as Albert Ellis are clearly vindicated through an understanding of the principles of the brain's plasticity. Recovery is self (and other) directed neuro-plasticity.

Alastair Mordey is the Programme Director of The Cabin Addiction Services Group which has centres in Northern Thailand, Hong Kong, Singapore & Sydney. www.thecabinchiangmai.com

50 Shades of Shame

Tara Day is an Addiction, Trauma and Re-parenting Therapist. First-hand experience of adverse life events and symptoms of the manifestations of adaptive behaviour employed by way of coping mechanisms led to her interest and practice in process/behavioural addictions.

We are all touched by addiction in some way, whether personally, within our close circle of family and friends, colleagues or in the wider community. Sex and Love Addiction (SLA) is a progressive, insidious and debilitating disease for those directly and indirectly affected and I have long wanted to change its public perception: from the misapprehension that it is only a condition of prominent individuals caught doing something untoward and committing themselves to treatment in a last ditch attempt to save their relationship and/or career, to the reality that is an every day commonplace practice.

LABELS

Sex and Love Addicts (SLAs) are people who have been distressed by and adapted to the things that have happened to them. Whilst the label represents unhealed suffering, society can lead them to believe there is something fundamentally wrong with them. This of course makes no rational sense. We don't label those who were never taught to play the piano as having piano deficiency disorder. Yet the same is true of SLAs for they have suffered major disturbances of their primary care-giving relationship and have not been taught how to be autonomous human beings, let alone intimate and relational (Spring, 2015). Ask SLAs for their definition of intimacy as they experience it and what they will often describe and present with are the manifestations of intensity.

INTRODUCTION

A child can experience lack of appropriate physical and emotional nurture from a primary caregiver as more traumatic than extreme forms of abuse. Both abuse and trauma are instances of profound shamelessness and powerlessness for the caregiver and child respectively. SLA is a creative adaptation to this dysfunctional childhood environment: a coping strategy for surviving otherwise unendurable traumas. It is the brains way of managing the trauma. The brain reacted right; the abuse and trauma was wrong (Melody, 1993 & Spring, 2015).

Theoretical Position

My theoretical position is based upon the bio-psycho-social model of addiction, comprising of a genetic predisposition, compounded by features within the environment. I submit that addiction is an intergenerational dis-ease and that addicts are born and raised! And so perhaps unsurprisingly a SLAs journey begins with the attachment relationship, since our emotions and our ability to manage them are intrinsically linked to the early bond with our primary caregivers (Bowlby, 1951).

ATTACHMENT

The attachment relationship is crucial to an infant's physical and emotional survival. Attachment includes literal proximity, the infant's expectation of the caregiver's availability and felt-security. The infant therefore must adapt to the caregiver's behaviour and patterns of behaviour elicit patterns of responses. In other words, does the infant elicit help and support by showing or suppressing emotion and how does this impact their later adult relationships? (Bowlby, 1951 & Spring, 2015)

ETIOLOGY

We are meant to grow from childhood into adulthood and become interdependent individuals; however, abuse skews our sense of boundaries and teaches us that we do not have any real sense of ownership or control over ourselves and our lives (Bowlby, 1951, Melody, 1993 & Spring, 2015).

SLAs have been parented within dysfunctional family systems, the behavioural patterns of which can mirror that of eating disorders, in terms of operating in the extreme by compulsively bingeing/avoiding sex and love as they define it in a way that is self-destructive and harmful. Since we are attracted to what is familiar/familial, SLAs are drawn to individuals who reflect their primary care-giving template, whether abandoning or enmeshing, thereby repeating the cycle (Melody, 1993).

Love Addiction (Compulsive Overindulging) – Overt fear of abandonment and covert fear of intimacy

Love Addicts (LADs) can be categorised as individuals who are immobilised by romantic or sexual obsession created about another through the use of fantasy and denial, mistaking this for love rather than objectification.

LADs have been parented from behind a wall for a personal boundary. A wall is un-relational, creates distance and if solid is abandoning; if occasionally neglectful. This connection is an act of abuse because it fails to provide a child with what they need, shames them and undermines their confidence in their ability to take care of the self.

Having been abandoned/neglected and shamed by their primary caregiver, the elicited response is for the child to adapt to who the caregiver needs them to be: a Lost Child who is seemingly good/perfect and needless/wantless rather than their authentic self. These children spend a great deal of time on their own, engaging in fantasy to relieve the boredom, fear and pain of not being attended to.

In adulthood these children become too needy, vulnerable and dependent. Lack of boundaries and lack of inherent self-worth, compounded by an overt fear of abandonment, compels them to look for another to take care of them, attaching emotionally and sexually without first knowing who the other person really is (objectification and fantasy).

LADs are drawn to individuals who appear seductive, walled-off and powerful. These individuals are Love Avoidant (LAV). The seduction of the LAV triggers a fantasy in the LAD who gains value form it: finding someone to right the wrongs of childhood, feel connected and belong or relief from the feeling they didn't matter.

LADs will oscillate between being boundary-less (enmeshing) and walled-off (abandoning), use

emotional and sexual involvement to control/manipulate the other and create intensity inside of the relationship because they perceive it critical to their survival. Since their identity is tied to another they can move into collapse if they do not feel close enough relationally.

Having entered the relationship in a haze of fantasy, the LAD becomes obsessed with the other to maintain the euphoria and uses denial to ignore any evidence of distancing, lessen feelings of abandonment and protect the fantasy. An event occurs that disrupts the denial and co-addicted cycle from relational compulsivity. The LAD enters into a state of emotional withdrawal from the fantasy in the form of extreme emotional pain, anger, fear and shame which can result in suicide, homicide, panic and shame attacks respectively. Therefore, the LAD will look for means (obsession) to return to the fantasy, medicate their painful reality, get back /even with the other and either return to the fantasy or move onto a new relationship thus repeating the cycle.

NB: anyone who has experienced a caregiver in active addiction has experienced a walled-off caregiver.

Love Avoidance (Compulsive Avoiding) – Overt fear of intimacy and covert fear of abandonment

LAVs can be categorised as individuals who are phobic to love, intimacy and compulsively avoid being vulnerable from all intimate involvement through the use of relational walls.

LAVs have been parented without personal boundaries. Enmeshment gives the appearance of bonding and of the caregiver being present but

enmeshment is abandonment, not care-giving. This connection is an act of abuse as the caregiver uses the child to take care of their needs over and above that of the child's. This causes a child to shut down, adapt to the situation and care-take the caregiver, resulting in a loss of spontaneity and diminished sense of self. The more a child adapts the emptier they will feel.

Having been enmeshed, abandoned and shamed by their primary caregiver, the elicited response is for the child to adapt and be who the caregiver needs them to be and depending on their relational wound will be a: Heroic Avoidant who is good/perfect and anti-dependent; or a Scapegoat Avoidant who is bad/rebellious and too dependent, rather than their authentic self. Relational trauma creates a phobia around love and the child associates it with duty and feeling suffocated and drained.

In adulthood these children will either become very good at being good or very good at being bad respectively. Similarly to the LAD, a LAV also has few healthy boundaries and lack of inherent self-worth, compounded by an overt fear of intimacy. LAVs feel compelled to care-take needy individuals in order to either obtain a sense of value or to alleviate their guilt if they were not to do so.

LAVs connect through a wall of seduction that impedes intimacy in an attempt to avoid being controlled and meet the need of the other without feeling vulnerable. Initially, LAVs gain a sense of value from the adulation they receive for caretaking the LAD. However, they soon begin to feel overwhelmed by the LADs neediness and stand in judgment of their dependency. As historic family of origin engulfment issues surface and because walls drain energy, LAVs resent having to care-take from behind a wall for self-preservation and move from a wall of seduction to a wall of anger to create the distance they need.

Loss of spontaneity from care-taking their primary caregiver creates a need to seek intensity, usually in the form of risk taking behaviours, in order to relieve the suffocation and emptiness, distance themselves from the other and alleviate intensity within the relationship. Heroic Avoidants will do this seductively and covertly, whilst the Scapegoat will do so negatively and overtly, as a means to justify seeking relief from being on relational duty. If the LAV feels guilty for their distancing/risk taking behaviour and/or fears of abandonment, they may return to the relationship or connect to a new relationship, all whilst behind a relational wall.

HOW THE TWO LAV ROLES COMPARE:

Heroic Avoidant

- Falsely empowered
- Learn their value by bringing honour to the family through their behaviour
- Will spend a great deal of time being seductive, caretaking their partners and make them feel special in order to feel good about themselves
- Is passive aggressive when they drop down behind their wall of anger.
- Keep their means of creating intensity hidden.
- Returns to the relationship to alleviate their guilt

Scapegoat Avoidants

- Falsely empowered/disempowered
- Learn their value by being very good at being very bad, having been used to discharge negative emotional energy and ideas.
- Spends little time being seductive
- Is aggressive when they drop down behind their wall of anger.
- Does not hide how they create intensity
- Usually only returns to the relationship if their fear of abandonment is triggered, which can be displayed as LAD symptoms.

CONCLUSION

All three roles share commonalities in terms of a fear of abandonment, intimacy and are dissociative states that drive a compulsional relational cycle. If an individual has been abandoned and enmeshed by their primary caregiver(s) they will oscillate between some or all three roles, depending on their relational wound and are known as User Friendly because they are so adapted and will be responsive to who they are presented with.

Most parenting is done in earnest. Functional parenting affirms, nurtures and set limits for a child so they are able to esteem, self-care and contain themselves. Dysfunctional parenting, most of which is unconscious and unintentional, relationally traumatises a child: its destructive effects are as a consequence of not understanding how to parent appropriately.

SLA is not a dirty word: it is a banner for someone who was abused, neglected and shamed as a child, rather than loved, irrespective of socio-demographic status. Undiagnosed, such individuals are persecuted rather than seen as survivors and supported for having been relationally traumatised and living in perpetual trauma reaction.

SLAs need not be victims of their own internal working model. "Our wounds serve to remind us where we have been, they need not dictate where we are going" (Davis & Dunkle, 2009).

This article is inspired by and based upon the work of Pia Mellody and Carolyn Spring.

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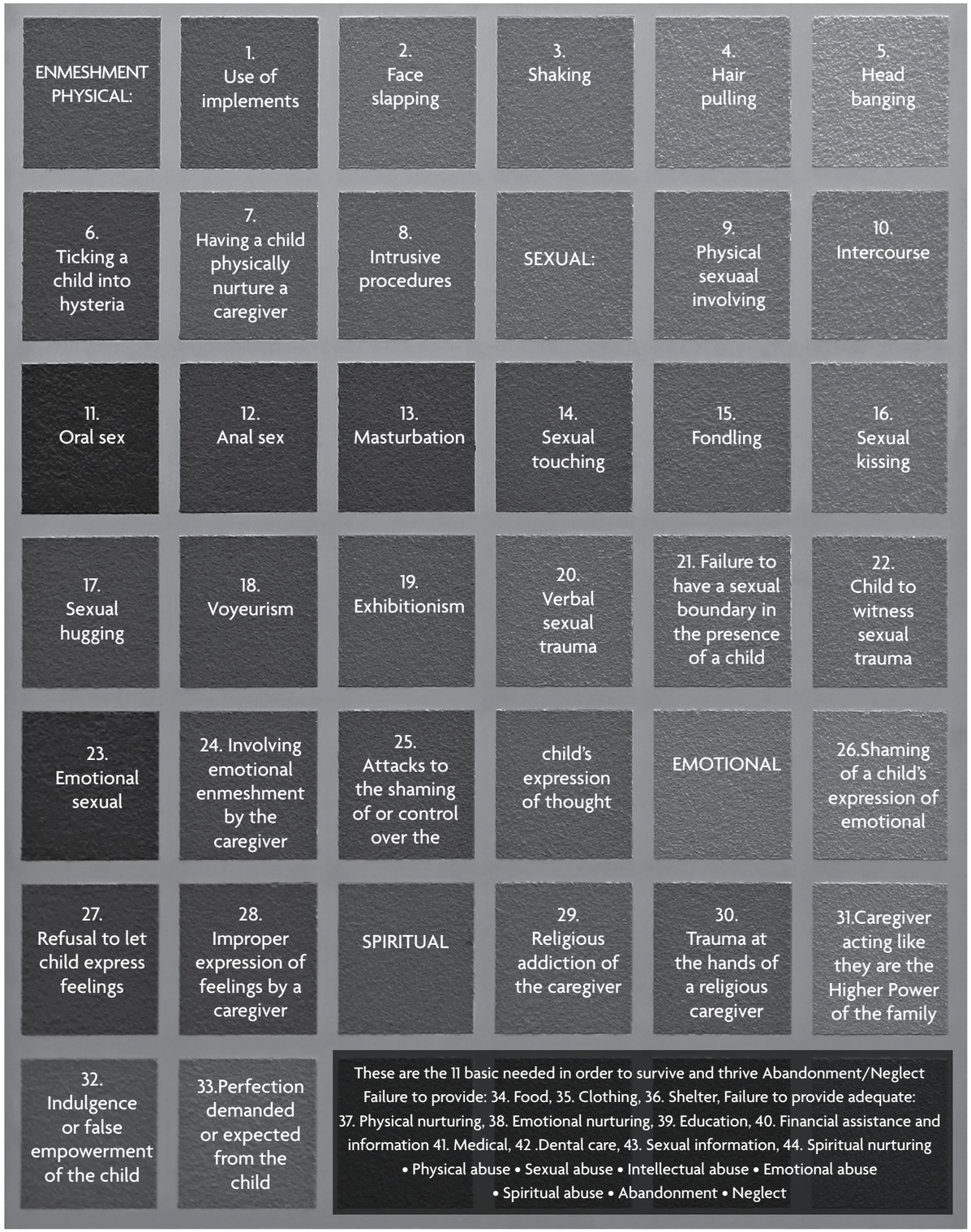


CARERS ACT

The new Carers Act 2014 came into force in April 2015. The Act gives local authorities a legal duty to assess a carer's needs for support, replacing the previous law which said that the carer had to be providing a substantial amount of care on a regular basis in order to qualify for an assessment. To be eligible, the carer (who must be over the age of eighteen), and the person they care for, must reside in the same local authority area. For the first time, carer's of people in their local prison may also be eligible for support.

Under the new Act, local authorities will assess and identify whether a carer has support needs and consider the impact of being a carer has on the carer. The assessment will also consider the ambitions of the carer such as whether they work or want to go to work, whether they wish to undertake training or education, and whether they would like to develop their social life.

Following assessment, the local authority and the carer will agree a support plan. Consideration will be given to whether a carer is "willing and able" to provide elements of care, replacing former assumptions about what a carer will do. The support plan might include assistance with housework, or money for a laptop or it could include the provision for replacement care to allow the carer time to undertake the carers chosen activities.

In recognition of the valuable contribution carers

make, it is unlikely that carers will be charged for the support they receive. However, any local authority charges will be means tested with a financial assessment of the carer. Where replacement care is required, the means test will only apply to the person being cared for. The Act is very clear on this point.

In most cases, carers will receive a personal budget as part of their support plan. This statement will highlight how much the carer will contribute and how much the local authority will pay.

Carers have the right to request that the local authority meets some or all of such needs by giving them a direct payment which will give them control over how their support is provided.

For more information: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm

NEW POWERS FOR FAMILIES OF MISSING PEOPLE

A new law will help families deal with the fall out of a loved one going missing.

On top of the trauma of someone going missing, families have faced the uncertainty and confusion of not knowing what will happen to their absent loved one's property and financial affairs, and have been powerless to do anything about it.

The new legal powers will mean families can step in, take control, and safeguard their loved one's assets in their absence – for example being able to suspend direct debits for mobile phone and utility bills or to make mortgage payments.

Justice Minister Lord Faulks said:

The provisional proposals were developed by the Ministry of Justice with the help of the leading charity in this field, Missing People, and their pro bono lawyers, Clifford Chance LLP.

The key features of the proposed scheme will be:

• a guardian will be appointed by a court on application by a person with a sufficient interest in the property and affairs of the missing person

• the appointment can be made if it seems likely that a decision will need to be made regarding the property and affairs of the missing person

• a guardian will be required to act in the best interests of the missing person and in this respect will be subject to duties similar to those of a trustee

• the guardian will be supervised by the Office of the Public Guardian and will be required to file accounts in much the same way as a deputy appointed under the Mental Capacity Act 2005

• the appointment will be for a period of up to 4 years with the possibility of applying for an extension for up to another 4 years

This follows the introduction of certificates of presumed death which are equivalent to death certificates and allow families to resolve a loved one's affairs when he or she is thought have died. The certificates were introduced on 1 October 2014 and can be applied for by relatives.

I Love You But:

the "Dance" of Love Addiction (and Love Avoidance)

by Barbara Pawson and Chris John.

Since the dawn of time love addiction and love avoidance have been written about. In the biblical story, Adam is master of all and wants for nothing, yet his existential loneliness prompts God to create a helper and companion, Eve. His love for Eve is his weakness; Adam is seduced by her and eats the forbidden fruit, getting them both kicked out of the Garden of Eden, something that Eve has been blamed for ever since. In more modern tales, Prince Charming is hit with such intensity and appears to become so love addicted that he resorts to getting women of all shapes and sizes to try on a glass slipper. Once he finds Cinderella he whisks her away to live happily ever after.

Although there's a place for such fairy tales in a child's belief system, for people with attachment issues or dysfunctional boundaries theses stories can embed a belief that the answer to loneliness is fixed externally and only Mr or Miss Right can heal an aching heart. Very quickly the search for the perfect partner begins. The love addict is attracted to the fantasy of a relationship and the love avoidant feels he/she is able to rescue the addict. The dance, or the pas de deux, has begun….

Such relationships are built on intensity and fantasy. They are the "if only" relationships - "If only he talked more… If only she talked less… If only he took me out at night… If only she didn't nag".

Scratch the surface of a sex addict and the wound is most often that of a love addict. The lonely alcoholic is alone because "love" was too painful. The "chem sex" crowd are lost and looking for love.

Love addiction/avoidance is often the underlying addiction in many lives. Looking at the stories that have been passed down over the centuries and how they're still promoted in today's digital age it should come as no surprise that so many people live with cold or broken hearts.

WHAT IS LOVE ADDICTION?

Love addiction is defined as a coping mechanism whereby "an individual is obsessed with a fantasy he/she has created about another person, believing he/she is 'loving' the other but in fact objectifying the other person through the use of the fantasy." (Pia Mellody)

This is usually created in childhood by a major care giver who, incapable of being relational with their child, parents behind an emotional wall. As it's psychologically impossible for the child to believe that it's the parent's issue, the child has no choice but to take the blame him/herself and start feeling 'less than'.

Although in the vast majority of cases no parent wishes to act in such a way, the consequence is a child lacking in confidence in his/her ability to look after the self. In adulthood the person believes that, if nobody takes care of them, they will not only be alone but won't be able to survive. As a result, the love addict has very little, if indeed any, personal boundaries, becoming resentful and creating intensity in a relationship in order to "keep it alive".

Love addicts live in a chaotic world of desperate need and emotional despair. Fearful of being alone or rejected, love addicts endlessly search for that special someone – the person that will make them feel whole. Ironically, love addicts often have had numerous opportunities to experience the true intimacy they think they want. But they are much more strongly attracted to the intense experience of "falling in love" than they are to the peaceful intimacy of a healthy relationship. As such, they spend much of their time hunting for "the one." They base nearly all of their life choices on the desire and search for this perfect relationship – everything from wardrobe choices to endless hours at the gym, from engaging in hobbies and activities that may or may not interest them to the way they involve others in conversations and social interactions.

WHAT IS A LOVE AVOIDANT?

The definition of a love avoidant is "the systematic use of relational walls during intimate contact in order to prevent feeling overwhelmed by the other person. The love avoidant associates 'love' with duty or work." This coping mechanism is usually the result of a child being parented by an adult with no personal boundaries, making the child "responsible" for the major care giver's happiness or, sometimes, their survival. As a result, the child loses all sense of self and starts believing that esteem is directly related to how much he/she takes care of other people.

For the love avoidant, being relational involves making sure that walls are in place to reduce the intensity within a relationship, as the risk of showing vulnerability is simply inconceivable.

Unlike love addiction, which is widely talked about, love avoidance is often brushed to one side.

WHAT ARE THE SIGNS OF A LOVE AVOIDANT PERSONALITY?

1: Fear of intimacy and emotional closeness

For an avoidant, intimacy equals the risk of being hurt. Although in a healthy relationship emotional intimacy is essential and sought after, emotional closeness is the love avoidant's ultimate fear. For the avoidant, intimacy is identical to, amongst other things, suffocation and being controlled. The love avoidant therefore use walls as boundaries to make intimacy more or less impossible.

2: What you see is not what you get…

After a while in the relationship the love avoidant seems to change from a hero to a cold, unavailable or unreliable partner. Indeed, the love avoidant cannot continue the charade and starts using certain coping mechanisms that allow him not to get closer!

These stratagems usually come across as not being "committed" to the relationship. From being suddenly super busy at work or volunteering an extravagant number of hours to a charity, to creating drama through arguments or simply avoiding physical intimacy - the love avoidant will do anything to avoid risking intimacy.

3: The presence of an addiction or a compulsive problem

This is a typical characteristic of the love avoidant. Undeniably there is nothing better than an addiction to keep people away! From substance abuse to behavioural addiction, the avoidant person may use sex or work to escape connection.

4: Narcissism

Often the love avoidant displays a number of narcissistic features. Although it may not be a full-blown case of narcissism, there is a sense of entitlement, the two faced personality - from "Mr Nice Guy" in public to "it's all about me" in private. Becoming defensive at any challenge, to having major difficulty with admitting a mistake, the love avoidant can very often be mistaken for a person with narcissist personality disorder.

5: Resistant to help

Finally, and this may explain why we often hear much more about the addiction part of this illness than the avoidance aspect, the love avoidant is highly resistant to asking for professional help, either for themselves or their relationship. Indeed asking for help from anyone, let alone a professional, would require the ability to open oneself up to vulnerability and connection…. and of course emotional connection is what the love avoidant fears most. Being in a relationship with a love avoidant is more to do with a fake emotional interweave than being in an intimate relationship.

However let's not forget that the love addict and love avoidant will inevitably find each other. The love addict, having experienced childhood emotional and/or physical abandonment, will look for someone who can "save" them. The love avoidant, having experienced childhood emotional and/or physical enmeshment, will look for someone to "rescue". This interplay is what we refer to as "the dance".

WHAT DOES A LOVE ADDICT/AVOIDANT RELATIONSHIP LOOK LIKE?

1. While the love addict is responsive to the avoidant's seductiveness and enters the relationship in a haze of fantasy, the love avoidant feels compelled to take care of a person who presents as needy.

Addict: "I am SOOOOO happy…I met this man and he's everything I've always wanted…he has a fantastic job, loves travelling and loves children. We're trying to see each other every day and we text each other at least 50 times a day…."

Avoidant: "I met this girl, I'm not too sure, but she's nice, I mean… I may as well give it a try…."

2. As the love addict uses denial to protect the fantasy, not wanting to look at the distancing happening, the love avoidant, in order not to be controlled and to fulfil his duty, appears to be relational behind a wall of seduction.

Addict: "It's great, I mean, he's working a lot - weekends included - and with his busy social life we don't spend a lot of time together but that's OK... Guess what? He's invited me for a weekend away in five weeks' time..."

Avoidant: "OK…I'd better organise something or she's really going to feel bad….I'm going to send her flowers and book a weekend away…."

3. An incident happens that crushes the denial of the love addict, who enters an emotional withdrawal from the fantasy. This may take the form of an overwhelming sense of pain, shame, rage or panic. At the same time, the love avoidant starts to feel invaded and the wall of seduction becomes a wall of anger.

Addict: "You'll never believe it…first he said he'd phone me and didn't. Then, at the last minute, he cancelled the weekend away because he needed to work… I feel awful... I don't know how I can get through this: I feel like dying…"

Avoidant: "I can't believe she's so angry…I mean, one of us has to work. Where does she think the money comes from for all those restaurants, flowers etc?… you know what?… it's never good enough…."

4. To return to the fantasy, and avoid feeling this sense of helplessness and hopelessness, the love addict either medicates and obsesses or starts getting even. It triggers a need in the love avoidant to create distance and an intensity outside of the relationship, often manifesting itself in risk taking, with money or life threatening activities such as alcohol, drugs or sexual acting out.

Addict: "That's it, I can't take it anymore….I know I'm useless and that you don't love me any more… what am I going to do on my own?…..maybe if I change, if I go on a diet ..."

Avoidant: "I can't breathe any more…I need some space…I need to relax, let off some steam… it's OK, it was just a one off (affair)..."

5. The final part of the dance is for the love addict to return to the fantasy with the same partner or a new one...and for the love avoidant either to return to the relationship out of guilt and a fear of being abandoned or, like the love addict, move on to a new partner.

Addict: "He called me, it's fantastic! He has asked me to marry him!" or "You won't believe it, I met a new guy, he just split up with someone…"

Avoidant: "If I ask her to marry me, she'll forgive me for my affair…" or "I can't handle her anymore…and I met this girl last night…"

SO WHY DO THE LOVE ADDICT AND LOVE AVOIDANT FIND EACH OTHER?

The love addict has a conscious fear of being abandoned and a subconscious fear of being controlled. In contrast, the love avoidant has a conscious fear of being controlled and a subconscious one of being abandoned. They are one in the same - two sides of the same coin, two ends of the continuum. Both have childhood trauma, both need to learn about healthy intimacy.

TREATMENT

The love addict usually only seeks help when there's a break in the fantasy and he or she is in withdrawal. "I looked at my therapist and thought I was going to die, the pain in my chest was so real." The love addict feels the loss, pain and anger associated with the relationship, and this allows them to connect with their own vulnerability.

Although as a therapist it may be tempting to concentrate solely on the pain and anguish the client displays, it is also the best moment to help the client identify the cycle of love addiction. Talking about the fantasy of the relationship will often highlight how the client's denial has been maintained. It will also help the client to see how and where these fantasies were created in their history. "My therapist asked me to write down ten reasons why I wouldn't go back to my ex – I wrote over 40. Three months later, when I was back in fantasy, my therapist handed me the list."

Another important aspect of working with love addiction is to help the client to understand how they have been in a relationship that did not respect or promote good protection or containment boundaries. Reflect on how they tolerated abusive and neglectful behaviours as a result of their own upbringing, when they were taught, "this is how to be in a relationship". Explore and coach them in boundary work on other relationships.

It doesn't matter if it's Adam and Eve, Adam and Steve, or Eve and Eve, love addiction is real. Love addiction, like all addictions, does not discriminate by race, gender, sexual orientation or religion. As with other addictions the consequences are – at best – destructive and – at worst – fatal. It is therefore essential for professionals to recognise both the symptoms and the causes of love addiction. Only then can the client truly be helped to break the perpetual cycle of love addiction.

Barbara and Chris, in addition to each running their own very successful practice, offer trauma reduction workshops and a set of CPD trainings around trauma and love addiction. For more information please visit www.twlondon.co.uk

Yoga has the potential to play a key part in the recovery process

Jacqui Sinclair, yoga teacher, explains Y12SR, a system that combines yogic and Twelve Step principles.

One of the main tenets of yoga is the recognition that we start from where we are, in the present moment, and 'practice' from wherever that is on the spectrum of our experience. This inclusive philosophy prevents procrastination or excuses whilst we wait for optimum conditions based on pre-conceived ideas of readiness. Yoga is for everyone and at any time.

After attending a charity fund raising event for a Focus 12, treatment centre local to me, I offered to run a weekly yoga class as a donation to the cause. Initially, attendance to the class was voluntary, but the affects were viewed positively enough for yoga to become integrated into the rehabilitation programme.
With an interest in trauma and PTSD, in July 2013, I travelled from the UK to Richmond, Virginia to study with Nikki Myers in order to learn more about yoga and recovery via the Y12SR format.
Y12SR is a framework for addiction recovery that combines the twelve-step programme, the trauma healing approach of Somatic Experiencing and the body-based 'entry points' of awareness offered by yoga and mindfulness practices. It explores the combination of cognitive and somatic approaches in supporting changes in brain patterning (could do with some sources of research here). Y12SR seeks to combine cognitive work with physical yoga (asana) practice to consolidate and enhance the efficacy of each to support awareness, mindfulness and balance. Y12SR places a great emphasis on the need to look after the self in order to be able to serve others. Seva (service) is a strong tenet within all yoga practice which mirrors Step 12 of the Twelve Steps.

Addictive behaviours separate and disconnect us from ourselves and others. Conversely, yoga means union, integration and balance, within ourselves and with everything around us. Yoga practice teaches the art of integrating our multi-dimensional lives within the complex ever changing world we live in. Rather than separating and sub-dividing further into the specifics of what people have been or their specific addiction, Y12SR seeks to reflect the concept of yoga union and integration into the collective itself. A yoga class provides a non-judgemental and non-competitive environment.
The class structure of Y12SR is unique as it is part meeting and part yoga practice. Following brief shares during the opening session of each class, movement and breath awareness within a mindfulness structure is explored. Through the usual parabolic energy of a flow-based class, students gain a greater understanding of how the cognitive process has a direct connection to the physical body in a stress response.

"Yoga emphasises the importance of acceptance with a starting point of 'where we are' and working from there on."

The yoga practice is a basic slow Vinyasa (means to place in a meaningful way), with the sequencing of asanas (postures) designed to illicit responses that deepen awareness of key focal points and balance the central nervous system. This flow teaches the importance of constant vigilance with transitions; as the asanas are moved into the practice becomes a moving meditation rather than a series of individual end points. Through the practice, the fluctuation and waves of experience in expansion and contraction, ebb and flow, inhale and exhale, intensity and release, left and right, strength and flexibility, dynamic and restorative, attraction and aversion, and the individual and a Higher Power are explored to find a perfect point of balance through an awareness of a perpetual present moment.

The physical benefits of yoga practice are wide ranging. Improvements in strength are well documented, as are increased flexibility. Yoga also improves cardio vascular fitness, and can elevate mood. Yoga practice also serves to facilitate a greater understanding of gratitude, self-awareness, and stress and anxiety control. Yoga enhances relaxation which enables students to rest and re-charge helping participants to maximise their gains from co-existing therapeutic interventions and meetings. Poor sleep is common in early recovery and is a known risk factor to relapse. The accentuated depth of relaxation students experience in yoga practice improves sleep quality.

Yoga emphasises the importance of acceptance with a starting point of 'where we are' and working from there on. Through yoga practice and breath awareness, the ability to control the stress response and inclination to react to feelings of discomfort is explored, felt and developed by combining inner and outer peace. Each practice provides a reminder to the student to let go of any expectation of the practice or of yourself, and instead, set the intention to engage with present moment fully in order to feel the ebb and flow of the sequence and of the breath. This increases an individual's ability to hone control of the self through breath and the depth of awareness which allows the urge to seek control of anything else to fall away. In this aspect, yoga is the felt experience of the serenity prayer in action. You cognitively understand it, you somatically feel it, and through the breath and connection to a Higher Power, you experience that knowing. With enough repetition, it becomes easier to incorporate this into your daily lives and your interactions with everyone and everything around us.

The influence of the stress response is part of Y12SR. The effects on posture and longer term anatomical changes often lead to biochemical inefficiencies in the body, pain and discomfort. Much of the tension in the body is as a result of stress or allostatic load (alongside somatic storing of trauma). This can be released and reversed through greater awareness and understanding of the underlying links and with regular mindfulness practice. Your biography becomes your biology – and a body distorted by stress houses a mind whose perception becomes distorted by stress.

For more information about Y12SR, go to: www.Y12SR.com. For Jacqui Sinclair's work: www.yogaattheboilerhouse.com

FACING BEREAVEMENT IN RECOVERY

Chula Goonewardene writes about the unparalleled pain of losing his father within the context of his own recovery

In early February, my Father passed away, quite unexpectedly, and the emotional pain I have felt is like nothing else I have ever felt before. I spent many years of active addiction being numb to my feelings, getting clean was like having my skin peeled off in a bath of salt, and recovery has been a rediscovery of what it truly feels like to be human and face life on life's terms. I remember hearing people share about staying clean through the emotional turbulence of bereavement and I remember in my early days thinking; 'if that happened to me I'd surely relapse', but thankfully, it doesn't feel like an option today.

My surprise at this has caused me to wonder why it is that the compulsion to use has not come to me at this difficult time and what exactly caused this constantly nagging craving to disappear from the moment I started working a programme of recovery. I am aware that this is not everybody's experience, but it is mine, and it is the same for many of those in the fellowship that I know.

I was lucky enough to kick-start my recovery with a stay in 12-Step treatment and it is here that I laid the foundations of the last eleven-and-a-half years of my life of total abstinence. I learned that honesty, open-mindedness and willingness would guide me in the right direction, I learned that taking the courage to 'trust, risk and share' in a therapeutic environment would bring healing, and most importantly; I learned that I had the 'dis-ease' of addiction, that I wasn't morally deficient, and that I could arrest my illness to find freedom, if I followed at least some of the suggestions on offer, and didn't pick up another drink or drug.

So this is what I did, and life began to happen, I started feeling my emotions; the good, the bad, and the ugly, and I used the tools at my disposal to process what came up for me. My programme became a reality-filter for every experience, chastening my tendency for negative projection and self-pity. The fellowships gave me a safe space to share my vulnerabilities, a sense of positive identity, provided a secure attachment, and immediate access to the wisdom of those in successful, long-term recovery. The therapeutic work that took place gave me great insight into myself, in a way that I had never managed to achieve through any other medium, and this raising of self-awareness led to me seeking 1:1 therapy, at two years clean, to work on my deeper underlying issues. A true acceptance of my condition, and the necessities involved in maintaining my recovery, followed accordingly, and as my personal life developed, so my professional career blossomed, bringing me in a decade, to where I am today; a qualified and experienced treatment manager and BACP registered therapist.

I am so pleased that my Father was able to witness this incline, after having to endure my spiralling decline into heroin addiction, and we have parted ways with only good feelings between us, which would not have been the case, had he died twelve years ago. I owed him countless amends, for incredibly selfish and down-right nasty behaviour, during my severely blinkered quests for the next fix, and it is thanks to my programme of recovery, that we had managed to find resolution in our relationship, and precious emotional intimacy between us.

I remember feeling extremely guilty about the way I had treated him, as soon as my detox had finished it came flooding in, and I apologised profusely when he came to visit me in rehab, only to learn that I was actually being driven by an unconscious desire to relieve my own conscience, and that true amends meant actions, not words, motivated by a sincere

> *"Being the Buddhist scholar that he was, he clearly stated; 'This is Dukkha, death is as much a part of life as birth, and I must peacefully accept this"*

desire to not repeat old, destructive, patterns of behaviour. It was suggested that I wait until Step 9 to do this, and again, I am so grateful for this teaching, for when I eventually came to this point some years later, I had an absolutely thorough understanding of what I was expressing and the personal responsibility that I held, to ensure there was substance to my words.

This self-awareness has extended to the present moment, and whilst I work with people unconsciously acting out on their grief, by becoming overly controlling, retreating into silence, or voicing stoic pragmatism for example, I consider myself so very fortunate to be able to observe my own process with some clarity. The years of working a programme, engaging with therapy, and training as a therapist, have armed me with the ability to recognise that my rage-full intolerance is just a displacement of my over-whelming loss, not the reality of my interactions, and this helps me to remain compassionate with those around me, without suppressing the intensity of my grief or converting it into something else.

During the last week of his life, my Father starting making comments like; 'I think this could be the end of my time', and as he wasn't suffering from anything terminal, or so we thought at the time, we attempted to bolster his spirit with replies such as; 'Don't be silly, you're going to be fine, you'll be home soon, don't worry'. I took this to therapy to explore my process, as I do with most of the significant events in my everyday life, and again discovered that my responses were more to do with how I felt, than truly considering what might be going on for him. My therapist suggested that maybe he needed a space to talk about it, and so on my next visit to see him in hospital, I waited for the appropriate moment to ask him how he felt about dying.

Being the Buddhist scholar that he was, he clearly stated; 'This is Dukkha, death is as much a part of life as birth, and I must peacefully accept this', but being the therapist that I am, I gently challenged him; 'I acknowledge the Buddhist perspective, but having lived a worldly life of attachment, adopting this approach can sometimes result in an emotional bypass of sorts, what are the feelings you have underneath your intellectual understanding?'. To which he replied; 'I am sad, I am sad to leave you all', and we held that feeling together, for what felt like hours but was literally only minutes, a moment of absolute truth between father and son, beautiful and pristine.

Would this level of communication have occurred had I not been in recovery? I doubt very much it would. I know how lucky I am. I know this isn't everyone's story, but working a programme has been the catalyst for so many blessings in my life. The quiet passion of the counsellors I met in treatment inspired my desire to follow their path, the self-discovery in each step informed my knowledge of human process, which in turn has found connection to the theories I have learnt in training, and the fellowship has given me a safe place to express my pain, without fear of judgement, and kept me safe in my bereavement.

I strongly believe that not only are the 12-Step programmes perfectly designed for sustainable recovery from addiction, but they can also be utilised as programmes for life. They have the flexibility to support all persuasions, the availability to reach all social classes, and the structure to hold us through most of the challenges that life may throw at us, and if not, they will often then point us in the right direction to get the support we need.

My personal experience has been that; providing the roots are plentiful and deeply imbedded, then the trunk will grow secure, and as long as we water with care, prune when necessary and allow adequate space for growth, then the leaves will shine and the flowers will bloom, no matter what the storm we must walk through.

Recovery Coaching

From conference to Companies House, join ***Stephen King*** as he takes us on his coach trip…

I first came across recovery coaching when I attended the inaugural conference of the Foundation of Recovery Coaching (FRC), held in London in October 2012. There, people from all over the world gathered, and the presented evidence and debate was enlightening. Here was a model of coaching being applied to addiction recovery.
I learned that recovery coaching is strength-based. It is a wellness model rather than the illness model I had been so used to working with. I left the conference thinking "This is what people need in their recovery, a coach who can work with them, long-term, if necessary", and fuelled with energy, I started researching coaching as a concept. For me, recovery coaching offered a model that spanned various different domains of healthcare challenges, such as mental health, eating and weight challenges, gambling, cancer & chronic pain management, and veterans suffering with PTSD.

Anthony Eldridge-Rogers, Founder and Director of the Foundation of Recovery Coaching International (as it is now), had spoken about a 'momentum' building here in the U.K. I contacted him and informed him that I was 'into' momentum and what did he need to get this on the move. I arranged, through my contacts, a free training venue with Southwark Drug and Alcohol Action Team and held the first training of the FRC coaches. Now there are FRC coaches spread across the U.K.
It was at this time that I met Leah (now my wife). She was a volunteer at a large drug and alcohol treatment provider in Bedford at that time. I spoke with Leah about recovery coaching and she liked the concept as much as I did. We both undertook the coaching training and in June 2013, we became certified recovery coaches specialising in substance misuse/ behaviour addiction.

In March 2014, we had managed to obtain a venue (a Morrison's Supermarket training room!). We invited a number of people from substance misuse and police & crime commissioning, Public Health England (Eastern Region), representatives from the local treatment provider and community business leaders. Also in attendance was our dear friend Anthony Eldridge-Rogers, who gave a presentation on recovery, recovery orientation, recovery coaching and recovery communities. It was agreed by all in attendance that there was no 'visible' long-term recovery community within Bedfordshire.

We carried out some surveys in Luton, Dunstable and Bedford during the summer months of 2014 and found that when the concept of recovery coaching was explained, people really welcomed the idea of having a coach, particularly those who had never entered addiction treatment services, one reason being, the stigma and the associated language attached to it.
We knew in our hearts and mind that coaching as a concept was a powerful tool but we were also aware that we were never going to do it on our own, we needed more coaches!
In August 2014, we registered Bedfordshire Recovery & Wellness Coaching as a Community Interest Company with Companies House, giving us legal status.
We then approached our local M.P. Andrew Selous, who agreed to become the Patron of our C.I.C
Recovery for Leah and I did not just happen from Monday to Friday 9am-5pm when services were open. It took place of an evening, it happened during the night and it especially happened at weekends…….but nothing was open at weekends, that time when people are, in our opinion, at their most vulnerable. We needed to put something in place that was attractive, purposeful and gave people something to do.
We contacted Dunstable Leisure Centre (1 Life) and made an appointment with the Health & Fitness Manager.
The first thing we informed her of was the fact that we did not have had any funding. We explained who we were, what we wanted to do, why we wanted to do it and that the leisure centre was part of our community and what did we need to do together to create something good for people in recovery. They liked our idea so much that we now have a free weekend Gym & Swim Club. People in recovery entering our coaching programme pay a £5 administration fee and can then have free access to both the gymnasium and swimming pool for a period of 6 months. After this period, individuals are offered a non-contract discounted membership to encourage them to maintain their health & fitness.

In October 2014, we signed a 5 year agreement with the FRC, whereby the FRC would provide training for our coaches, together with the on-going support they would need for their continual development. The FRC also provided us with a free website URL within their website (http://recoverycoachingfoundation.co.uk/ bedfordshire). We also became Associate members of the FRC and agreed to promote the organisation in all of our work…..and we are very proud to do so.
We put together a six person Executive Committee (EC) which oversees the running of our company. This is made up of two directors, a representative of the FRC and three members from the recovery community. This ensures that the voices of our members are heard and acted upon at the highest level and that we are always peer-led and driven.

Working with people in recovery does present risks and we needed to have policies and protocols in place to eliminate those risks .We now have a company handbook detailing these at length.
I mentioned earlier we were never going to do it on our own, and we needed more professionally trained and certified coaches. The FRC notified us that there was going to be FRC training beginning in March 2015, and that our company could have some ring-fenced seats to assist in our company development. Members of our Executive signed up, as did some ordinary members. The training took place at Goldsmiths University over two weekends. We were on our way!
The training is inter-active, and is a genuine eye-opener as to people's perception of recovery.
The FRC International are holding their Annual Conference in London this year on September 29th and 30th, and it will also be available via virtual conferencing. There will be a Gala Dinner Fundraiser on the eve of the conference, with the proceeds going towards our company to help and support our development.

Finally, a massive thank you, to Anthony Eldridge-Rogers for his continued support.

For information about the conference see
www.conference.frcint.com
For more information about FRC in the UK see
www.recoverycoachingfoundation.co.uk
For FRC International see
www.frcint.com

You can find us on Facebook at https://www.facebook.com/Bedsrecovery You can follow us on Twitter : @Bedsrecovery

Stephen King, Managing Director of Bedfordshire Recovery & Wellness Coaching CIC, has been a drug and alcohol service user and practitioner, a Carer Involvement Co-ordinator and was a Regional Organiser for the voluntary organisation, the London User Forum.

Trauma, Treatment and Men!

Counsellor and Interventionist, ***David Brown***, explores the area of gender responsive treatment and the specifics of working with male clients.

Over the past twenty years, the mental health and addictions fields have begun to recognise the tremendous importance of trauma on human behaviour. Our increased understanding has developed, in part, as a result of sophisticated brain research on the physical effects of trauma. The Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR) of the American Psychiatric Association (2000) defines trauma as "involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness or horror (or, in children, the response must involve disorganised or agitated behaviour). There are many factors that influence how a male responds to a traumatic event, including age, family background, personal resources and resilience, the health and response of the environment (e.g., family, work, social), previous trauma, etc. Estimates are that anywhere from 42 to 95% of males coming to treatment have been exposed to trauma. In fact this large range may be a reflection of how poorly male trauma has been assessed.

I have found that many men have never been given permission to talk about their trauma as it is bounded in such deep shame. They feel uncomfortable discussing what happened in a safe and understanding environment. In our culture, a principal rule of being a man is to not admit weakness, the quintessence of which is to deny abuse or the incredible pain caused by traumatic events. Many males, as a result of how they are raised and the gender-related messages they are inundated with, may see violent/abusive events as normal and not as trauma.
Therapists and clients need to be educated in three core elements: an understanding of what trauma is, its process, and its impact on both the inner self (thoughts, feelings, beliefs, values) and the outer self (behaviour and relationships). We also need to know about coping skills, grounding exercises, and interactive exercises so that we become comfortable working with men. This being said it is also critically important that therapists do their own work if they have been exposed to their own trauma as they will be unable to help if their own trauma still gets in the way. This brings me to the internationally known mental health and addiction specialist, Dan Griffin. Dan authored, A Man's Way through the Twelve Steps, and co-authored, with Dr Stephanie Covington and Rick Dauer, Helping Men Recover, the first trauma-informed curriculum to specifically deal with men's unique issues and needs.

Dr. Covington defines addiction as
"A chronic neglect of self in favor of something or someone else".

How does an addicted man shift from chronic neglect to a healthy care of self? How does he shift from a downward spiral to the upward spiral? How does he grow and recover? These are the questions that we are beginning to answer in this very different approach to male treatment. The sad thing is that we are still in the early days of what could be breakthrough thinking and it is my hope that in reading this article you will begin to ask yourself new professional questions about how you are treating men? Is it in the manner of the ages or is it in a new and enlightened atmosphere. It is time for us to be doing something different, something which is responsive to the needs of men.

This is important work as it is a well-worn thought that men do not get the same kind of attention in treatment or with regard to their trauma as women do. This leads to men being re-traumatised as the system does not understand the connection. Let me give you an example from my own practice. I had a young man in treatment with me for a substance abuse disorder. As a young man he had been serially molested by female relatives including his mother. He used alcohol as a means of self-medicating. He was on probation and had a very tough female probation officer who just saw the client's behaviour as defiance. It was only when we suggested to her that his reactions to her had been programmed by his trauma history. He was frightened of her and her attitude towards him reactivated his paralysis and trauma. When I saw him I saw a strong looking, masculine man who had not dealt with his history and was stuck. Here was a case where this man had taught himself to minimise his traumatic life experiences and to act "as if" using alcohol as his "fixative". When I had the opportunity to talk to the probation officer about what was happening, she was mortified that she had caused re-traumatisation. Nowhere in her experience had she had any training to prepare her for this and so she was doing what her experience taught her to do which was to get this man's attention and bring him down a notch or two.

I would like to say two things at this juncture. As a man in long term recovery everything I had heard in early recovery made sense. But there were still important pieces missing as I was a victim of my environment, trauma and best thinking. These were the pieces that had never been addressed and such always represented a real danger to me from a relapse potential as they were unresolved. At this point I met Dan and was introduced to his book. Once I picked it up I could not put it down as it was life changing for me. It helped me see why I thought the way I do and why there was always a tendency for me to self-sabotage as my trauma was still bubbling away under the surface and keeping me stuck. My attention was captured early in his book with this very simple thought that, being a man equals the consumption of alcohol. Believing "Real men don't get out control" coupled with "Real men know how to party" (i.e., get drunk). Believing men are powerful. Believing men are in control. Keeping thoughts and feelings to yourself (talk trauma are you kidding?). Always keeping up a good front and being fiercely independent; relationships are not a priority.

With this simple paragraph and these simple thoughts I recognised me. I recognised that is the way I had always thought and that was the source of being a legend in my own mind. The source of so much trouble and confusion, even in recovery. Then I saw

8 AGREEMENTS ON **MALES**, **TRAUMA** AND **ADDICTION TREATMENT**

1. While progress has been made in the understanding of trauma, there remains a myth that trauma is not a major issue for males.

2. Trauma is a significant issue for males with substance and/or process addictive disorders.

3. Males are biologically and culturally influenced to minimize or deny traumatic life experiences.

4. Addiction treatment has been negatively influenced by cultural myths about males.

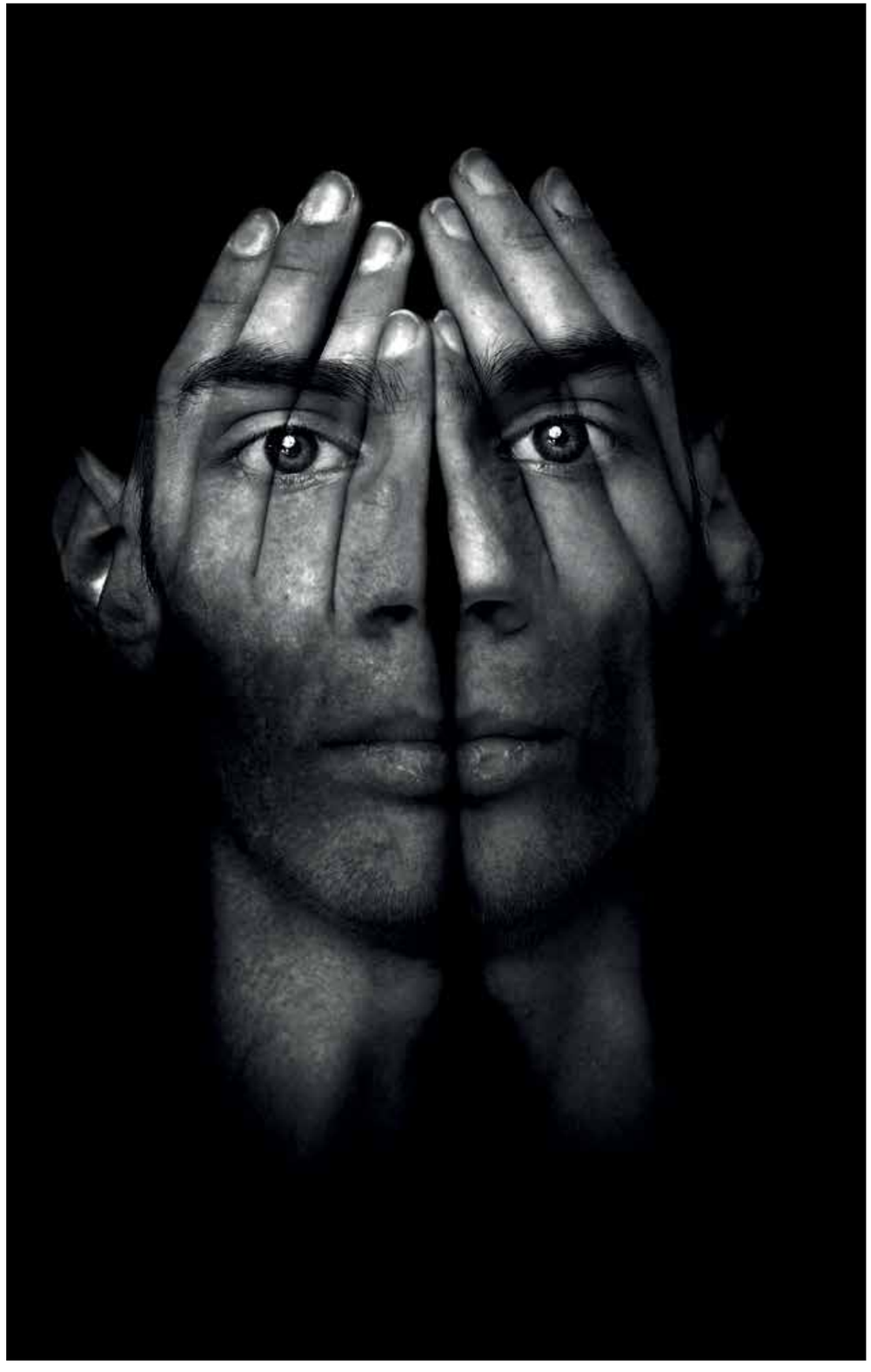
5. Males are often assumed to be the perpetrator, which has negatively biased our concepts of trauma and models for addiction treatment, and often results in the re-traumatization of males.

6. Male trauma must be assessed and treated throughout the continuum of addiction services.

7. Male-responsive services will improve addiction treatment outcomes.

8. Effective treatment of male trauma will help to interrupt cycles of violence, abuse, neglect, and addiction.

The following individuals arrived at consensus on the Eight Points of Agreement as part of the Summit:
Miles Adcox, Onsite. Jacquie Wheeler, Jaywalker Lodge. Mike Barnes, Ph.D., CeDAR. Richard Bebout, Ph.D., Community Connections. Allen Berger, Ph.D. Lou Cox, Ph.D. Judy Crane, The Refuge-A Healing Place. Richard Dauer, River Ridge Treatment Center. Tian Dayton, Ph.D. Teresa Descilo, Trauma Resolution Center. Eduardo Duran, Ph.D. Norma Finkelstein, Ph.D., Institute for Health and Recovery. William Ford, Ph.D., C4 Recovery Solutions. Rawly Glass, The Bridge to Recovery. Dan Griffin, Griffin Recovery Enterprises, Inc. & Males for Trauma Recovery. William Pollack, Ph.D., Harvard Medical School. David Powell, Ph.D., International Center for Health Concerns. Pat Risser, Males for Trauma Recovery. ime Romo, Ed.D., Males for Trauma Recovery. Cheryl Sharp, The National Council for Behavioral Health. Dr. Brian Sims, M.D., Psychiatrist, Correctional Mental Health Services. David Washington, Males for Trauma Recovery Rob Weiss, Elements Behavioral Health



the next thought which became the clarion call for my own liberation and the beginning of me being able to find other men, my wife and therapists to talk to as I realised that was the key for me. Strangely nobody laughed at me. I saw that being a man equals the absence of alcohol. Embracing powerlessness and acceptance. Letting go of control. Admitting or confessing – allowing yourself to be known to another; unmanageability. Being part of the group and in close relationships with others.

What joy! What sweet liberation. What incredible permission to rid myself of that 800 lb. gorilla that had always lived on my shoulders. Welcome to the world David!
How does this relate? For too long gender responsive has meant for women. Somehow men were excluded. Maybe because we were not sure how to treat them. Trauma was certainly not treated as most clinicians did not understand it. Think about it from this perspective too. "70% of people working in the field are women, but 70% of those going through services are men," (Dan Griffin).

Helping Men Recover, the first trauma-informed curriculum to specifically deal with men's unique issues and needs is the curriculum that we use in our practice to treat men. For over two years, we have facilitated 90 minute Men's Groups every Monday and Wednesday in an outpatient setting. The men have responded to the curriculum very well. Men respond to it and are daring to talk about issues that historically they would never have thought of discussing. We see male socialisation being used effectively which in turn is having a positive impact on men's recovery. We have witnessed that if men feel safe, men are willing to look at many important, although difficult, issues which were commonly overlooked in traditional treatment. In many cases, this was because the counsellor was female and she was uncomfortable talking to men about the issues that really needed to be looked at. Clearly this held these men back. The issues we routinely talk about are relationships, sexuality and sexual behaviour, power and control, privilege and entitlement, and grief.

We are helping men reflect on their common experiences which improve their chances of successful long term recovery. It is exciting to see how they bond as they first take those baby steps in communicating stuff that they have never felt was worthwhile talking about or they were too traumatised or ashamed to do so. It is marvelous to be an observer in the room and see leaders emerge who demonstrate what healthy communication looks like because they have been given permission for the first time in their lives to talk about these negative experiences that have shaped them into who they became. It is exciting to witness as these men grow and cast off the trauma that has held them back as they make a conscious decision to live in the solution and not the problem. It is suspected that anger, domestic violence is reduced and general well-being is improved the more of this work that the men participate in.

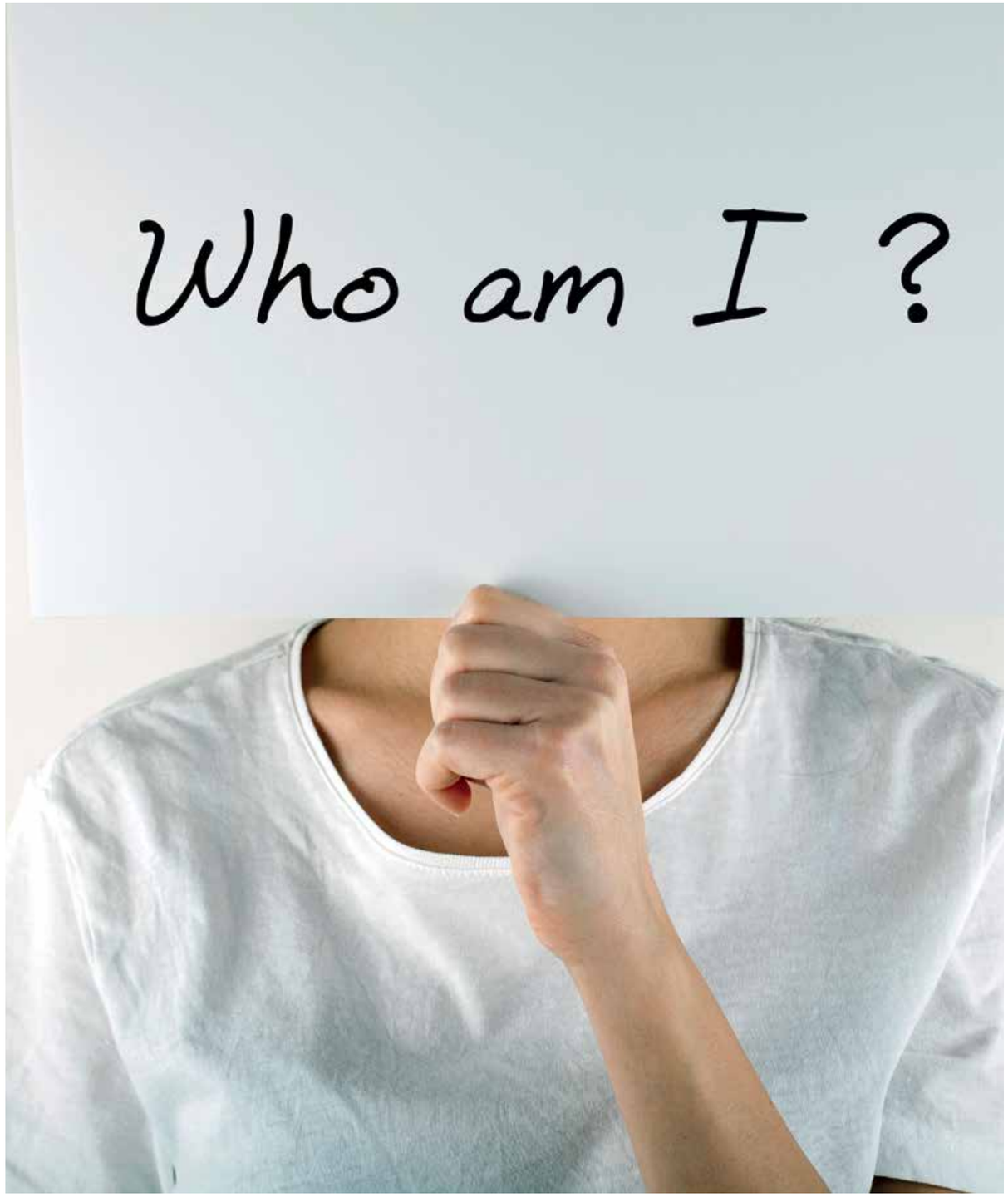
We are finding that confronting men is not an effective strategy for getting them to engage in treatment. After all, remember **society says real men don't cry, tell them not to show your emotions unless it's anger, be strong, don't ask for help, don't be vulnerable**, be sexually aggressive, put work before relationships, put success before relationships. Society tells men that power and having power is central to being a man. Then **we put them in an environment where we say we want you to be vulnerable, we want you to ask for help, we want you to talk about your feelings, and anger is not OK.** This tension is the elephant in the room. I have found that when we work with men in ways that help them verbalise and understand this tension, when we point out to them that it makes sense for the situation to feel difficult and challenging, there is an entirely new context for them in terms of treatment, their addiction, powerlessness, and any of the other challenges they have in recovery. I feel blessed to be able to do this work with men as it is sacred. It must become the norm!

** From the FINAL REPORT, MALES, TRAUMA, AND ADDICTIVE DISORDERS 2013 SUMMIT

This article could not have been written without the assistance and input of Dan Griffin. Dan Griffin, M.A. has worked in the mental health and addictions field for over two decades. His newest book, A Man's Way through Relationships is the first trauma-informed book focused solely on helping men navigate the challenges of creating healthy and intimate relationships. He is author of A Man's Way through the Twelve Steps (Hazelden), the first trauma-informed book taking a holistic look at men's experience of recovery from addictions. He is co-author of groundbreaking curriculum Helping Men Recover, the first trauma-informed curriculum to deal with men's unique issues and needs.

David Brown is a professional interventionist, mentor, coach, public speaker and educator.

Assessing Teenagers: how do you get to know them when they don't know themselves? Part one…



"Parents Just Don't Understand" famously written by the actor and former rapper Will Smith captures the mentality of our youth today. When assessing teenagers we want them to feel heard and understood.

Working with Adolescents is both rewarding and challenging. Teenagers often test the helping professional by refusing to engage, changing the subject or by being provocative. Establishing rapport with a teen can be difficult, but this article will help the reader develop some necessary skills when working with this age group. Due to the fact that maturity levels vary, not only in their chronological age, but also from teen to teen, it is important to have many tools in your toolbox.

GENUINENESS

The one thing that is universally needed when working with teenagers is genuineness. Teenagers often do not "trust" adults because they see us as trying to change them. They often feel criticized, judged and shamed, even when the therapist is silent. While boundaries are important, as in every therapeutic encounter, it is imperative that the client sees the therapist as "having their back" and we share this sentiment with the kids early on.

ENCOURAGE THEM TO LISTEN TO THEIR PARENTS' PERSPECTIVE.

"Paul, I am going to start with your parents and I will ask them lots of questions today. I would like you to sit here and just listen for now. If they say anything you don't like, or you don't agree with, just hold on to your thoughts because the good news is that you get to hear everything they are saying, but after I am finished asking them questions, I will ask them to wait in the lobby and they won't get to hear anything you are saying! Is that a deal?"

The teenagers we have worked with have, almost always, agreed to this. This cuts down on disruptions and allows the therapist to be aware of body language when the caregivers make statements that the teen obviously takes issue with. When the adults leave the room, the best opening lines are, " So? What did you agree or disagree with?" and then the kids are off. They love to say either, how their parents have it all wrong, or, often times, they agree with the parents, but then add their version of why a particular incident occurred. In short, it is a great way to establish a rapport because the client knows you want to give him/her "equal air time".

Note, parents may not be fond of this approach. They often feel entitled to all of the information. Educating the parents on the importance of confidentiality (and its limitations) in its ethical practice, as well as its importance in establishing rapport, often helps alleviate the anxiety the parents may experience.

GATHERING VALID INFORMATION

Despite numerous attempts at prevention and early intervention, unfortunately experimental drug use in adolescence is not the exception to the rule. When assessing a teen for drug use, framing the questions is imperative. Rather than allowing the teen to answer with a "yes" or "no" response (which provides limited information) you should consider asking the teen, "When was the first time that you used Marijuana?" "When was the first time you used prescription pain medication?"

By wording the questions in this fashion, the clinician removes the likelihood that the teen will lie about their experimentation in their response. "How awful!" you may say, "to assume that teenagers have used multiple drugs or that teenagers will lie." Rest assured that teenagers will quickly correct the clinician if they are making false assumptions. "I have never used opiates!" they will say with great enthusiasm. Note that teenagers, like others, may lie about the quantity and frequency of their use. Experience has

shown that when teenagers have been admitted to treatment centres, they often say to the assessing clinician, "I'm sorry I lied to you in the interview….I really drank every weekend and not every other." We would always reassure them that getting honest with themselves and others is a process and we are just happy they are in the program.

NOTE TAKING

It is best to not take notes when working with teenagers as they see it as a huge barrier and as a trust issue. This is often difficult for therapists because we need to keep track of details. The best approach is to let the client know that we will need to take a few notes (the what, when, how often and why) in order to keep the important details at the forefront of our mind. Allowing the client to read our notes before the end of session often eases their mind.

UNDERSTAND THEIR POINT OF VIEW

A third, and very important point for both teenagers and adults alike, is the defence of denial. When working with substance users it is important to help them understand the negative aspects of their use. It is the clinician's natural tendencies to convince the client that they do, in fact, have a problem. This practice is not as effective as "rolling with the resistance" that is clearly defined in Motivational Interviewing. Remember, one goal in the assessment is to gather valid information, but also to allow the teen the room to verbalize their understanding of the situation. If they know that the clinician has their best interest in mind, the end goal, level of care recommendation, will be met with a more genuine and thoughtful response.

> *"Despite numerous attempts at prevention and early intervention, unfortunately experimental drug use in adolescence is not the exception to the rule"*

Allowing the client to identify the "positives" of their use, aka "why they use", is an important starting place. Then we encourage the client to take a genuine look at any negatives of their use. "None" they may say. "I'm only here because my parents think I have a problem!" This common response can easily be disputed in a loving way by asking, "How do you feel about having to come and sit with me? Is it bothersome to answer all of these questions?" The most likely response is "Yes, this is pointless, I don't need to be here." With a welcoming smile we may respond with, "So because of your drug use you have to come sit here with me. That sounds like this may be a negative! Well, now we are on to something."

Read part two in the next issue of Intervene.

By Elizabeth Escobar, Kathryn Staron

Michael Hebb charts the development of his 'dinner' initiative and outlines the thinking behind the idea and the simplicity of its goals....

On August 24th, 2013 a little project called Let's Have Dinner and Talk About Death launched a website: www.deathoverdinner.org. There were no press releases, no staff, and a projected annual budget of $0. Over 400 dinners occurred around the globe on the first night; Ram Dass and Frank Ostaseski broke bread in Maui, Japan's Minister of Health gathered a group of 22 leaders in Tokyo, and a nursing home in Bellingham, Washington filled a long table with residents and their children. The media quickly took an avid interest in this leaderless movement and soon features began appearing on the front page of Bloomberg, The Atlantic and Huffington Post. Within months, the coverage grew to include NPR, The New York Times, Wall Street Journal, The Washington Post, USA Today, and dozens of regional newspapers across America.

The goal of this strangely named project remains simple: change the national conversation about death and dying. If the conversation can change, so can the ghastly reality of how we die in America. 70% of Americans want to die at home, yet only 30% of them have this wish fulfilled. The costs to the system and the emotional weight of this disconnect are tragic. For a country that prides itself on choice, America is failing. Since that lovely summer evening, over 100,000 folks have participated in death dinners by utilizing the online tool kit that deathoverdinner.or offers, the little website that could is just beginning to catch stride.

Not long after deathoverdinner.org sprung to life, the core team that designed and built the project began hunting for a second topic/crisis to tackle. The search was short and led to Jamison Monroe, the founder of Newport Academy, a holistic teen rehabilitation center with locations in California and Connecticut. Jamison shared a staggering statistic with our team: of the 23 million Americans who suffer from addiction, only 10% receive treatment. We were all astounded. How could a public health crisis like addiction be so poorly managed? After our first test "drug dinner" with esteemed folks like Dr. Gabor Mate, Dr. Carl Hart and Ethan Nadelmann, we began to understand. The issue is one of public perception - specifically, how we perceive addicts. If we continue to dismiss addicts as failed humans or people with weak wills, instead of individuals with a treatable medical condition, the tragic gap between suffering and treatment will remain.

While the paint was still fresh on our first platform, we began building Drusoverdinner.org, and it launches on April 21, 2015. Our hope is to once again change a national conversation by creating a deeply local conversation. If post-drug-war America is going to pick itself up from the battlefield, we need citizen led efforts and a medic kit full of beautiful new tools. People need to be inspired, emotionally compelled, and heard. Our grand hope is that Drugsoverdinner.org will create a million compassionate conversations between family and friends. Can dinner conversation help change the public health crisis known as addiction? If one family is transformed by our platform, our reward will have been achieved.

Michael Hebb is the founder of Deathoverdinner.org, Drugsoverdinner.org, and Seder2015.org.

ROCK BOTTOM

WHO:

SIMON MASON

WHAT:

CRACK & HERION

WHEN:

2ND JUNE 2006

WHERE:

A MOTORHOME IN SPAIN

HOW:

12-STEP FELLOWSHIP

"The culmination of a descent to a place where a person has nothing left to lose in terms of possessions, status, wealth and perhaps even shelter, food and warmth as a result of self-destructive behaviour."

My own experience therefore, if based on that particular description, went on for many years.
I started using drugs and alcohol in my early teens and aside from what I would consider the 'occupational hazard' of horrific speed comedowns (Is there any other kind?) and the occasional 'bad' acid trip, it wasn't until I was in my mid-twenties that I started to experience some of the situations described above.

Maybe it says much about my own lack of self-worth/care, or perhaps it was the naivety of a drug saturated youth, but having a gun pulled on me, while out of my tiny mind on acid and crack in Los Angeles during the late 80's, didn't really seem to be anything other than a minor annoyance. I'd be lying if I said I wasn't terrified by that and quite a few other similar situations at the time, but 'rock-bottom'? No, nowhere near it I'm afraid! It's just what 'happens' right?

My decent into crack-induced psychosis, a journey that started in California in 1988, was somewhat interrupted by a return to the UK and my unbridled enthusiasm for taking huge quantities of Ecstasy and acid. As I could see, it would have been rude to not join in with the rest of the country plus the fact those two drugs and a few tonnes of weed of course had as I have already mentioned, stopped my inclination to smoke crack and get guns pointed at me, 'rock-bottom' was still, many years and a lot of late night/ early mornings of "I really love you mate, got any pills?" away.

Oh yeah and then there was the heroin addiction that was NEVER going to happen to someone like me of course. *sighs*.
You're 21, you've been awake for three days raving, you've done A LOT of pills/coke/speed/acid and been terrorised by French techno, then your best mate pulls out some tinfoil with a fat beetle of skag clinging to it,
"Fancy a go on this mate?"
When in Rome and all that eh?
You are suddenly feeling better than every other drug you've ever taken could possible make you feel, you are Keith Richards jamming with Hendrix, Moon and Morrison AND you can go at it with the girl lying next to you for HOURS.
It's not as if you're ever going to get a habit or start injecting is it?
Of course not, that would be stupid right?
17 years later you are living in a stolen motorhome, marooned on the side of a mountain in the middle of the Spanish countryside. You have not had a bath for 3 months, your teeth are falling out, breakfast consists of a litre of something almost resembling cheap wine. You are a shade of yellow that would make a budgie look anaemic, you occasionally phone home to emotionally terrorise your aging mother for money which, if not sent IMMEDIATELY, will mean an imminent death at the hands of the local Gitano's (that's Spanish gypsy in case you didn't know).

Although surrounded by a community made up of pan-European soap-dodgers, drug dustbins and criminals on the run from Interpol, you are, by far, the smelliest, most toxic and unpopular excuse for a human being for miles around.

At least the weather here is decent though eh?
By now, there is only one 'Gitano' drug dealer that will still have anything to do with me, possibly because he actually does smell worse than me and therefore standing next to me for a few minutes each day while I try and sell him some useless bit of crap I've probably stolen from a hippy while they were busy hugging a tree, makes him look good.

He doesn't sell heroin or crack as separate commodities, his 'bags' contain a heart attack/respiratory failure combination of the two. The fun bit is, not knowing what percentages he's gone for while making up his 20 euro baggies of joy. It's soon apparent, today is a heart attack kind of day, a scenario that plays itself out while I'm staggering about in a disused chicken shed a few minutes' walk from his place.
I'm going to die surrounded by fossilised chicken shit, discarded crack pipes and human
effluence in Spain, at least the weather here is decent though eh?
I didn't die. (In case you hadn't figured that out yet)
Four weeks later, 2nd June 2006, I staggered into a 12-step meeting, still using, after which, I went to stay with a friend where with the help of her and a 12-step fellowship here in London, I have managed to stay clean, a day at a time, ever since.
How? I did what was suggested, simple as that.
I am now a father to a 7 year old daughter who I adore more than words could possibly say.

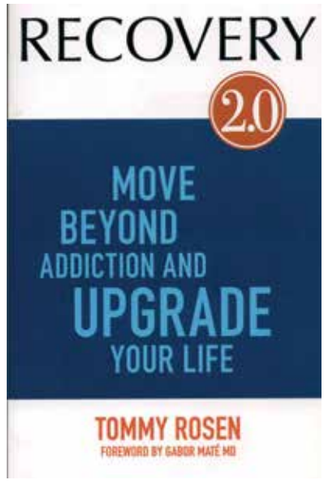
I spent 6 years working within the treatment 'field' but left in June 2013 to pursue a more creative career.
I have just completed a four week, West-End run of my own one man show, based on a novel I wrote which was published in 2014, entitled,
Too High, Too Far, Too Soon.
I still attend meetings on a regular basis and my beloved Liverpool football club have still not won the league title, but we live in hope eh?
Life's good.
Simon Mason
@simonmasonsays

"The culmination of a descent to a place where a person has nothing left to lose in terms of possessions, status, wealth and perhaps even shelter, food and warmth as a result of self-destructive behaviour."

Where to find... *guides*

In this issue we feature publications examining the 12 Steps as a foundation from which to move into the 'frequency of recovery', a powerful story of gambling addiction and the therapist/patient dynamic on the road to growth.

RECOVERY 2.0
MOVE BEYOND ADDICTION AND UPGRADE YOUR LIFE
By Tommy Rosen
Published at £11.95
Published by Hay house
www.hayhouse.co.uk
ISBN 978-1-78180-460-5
£12.99



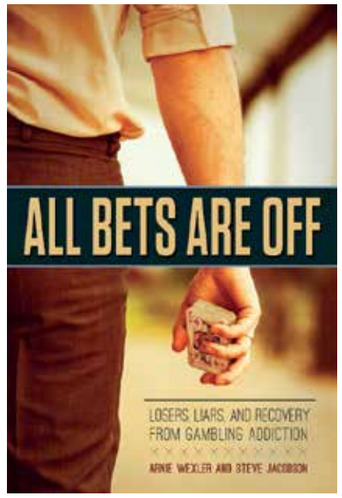
Sharing his "experience, strength and hope" in telling his own story of recovery from addiction with the help of the 12 Steps (Recovery 1.0), Tommy Rosen has written a truly inspiring book. However, as he says, "Don't let the 12 Steps become your life. Get a life because of the 12 Steps."
Recovery 2.0 offers guidance on how to move from the Frequency of Addiction into the Frequency of Recovery. In particular, it addresses the issue of meditation which is mentioned many times in 12 Step literature but without any specific suggestions on how to do it. Using the resources to be found in the practice of yoga, breath work and mindfulness, the reader is guided towards the goal of finding much, much more from their recovery than just abstinence from their substance of choice.
The issue of diet and the recovering person's relationship to food is also explored in a very sensitive way. The impact of caffeine and sugar on emotional balance is detailed and suggestions given on how to improve one's general diet without giving up either the enjoyment of food or the company of others whilst doing so.
Writing from his own experience, Tommy Rosen shows how to find a sustainable recovery by transforming the way we interact in all our affairs, and how to thrive in recovery.

ANTHONY SCRATCHLEY
is a Hazelden-trained counsellor, with some years in practice, specialising in family work and relationships around addiction

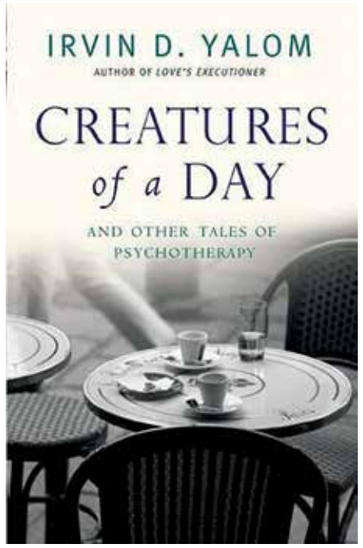
ALL BETS ARE OFF
by Arnie and Sheila Wexler
Published by Central Recovery Press (centralrecoverypress.com)
ISBN 978-1937612757
£11.99

In Arnie and Sheila Wexler's excellent book, gambling, that rawest of addictions, is laid bare in all its devious and domestic horror without hyperbole or an excess of the confessional. This is a very sober book and I finished it feeling a tad more able to serve those cursed by this terrible affliction who seek my help. Arnie's unsentimentalised account of his descent into the abyss of his addiction – and his recovery – is interwoven with Sheila's story, and this allows us to fully see the extent of the insidious relational aspect of this condition. Sheila is frank in her acknowledgement of the elements in her own history that rendered her vulnerable to the potentially deadly embrace of this folie a deux, and Arnie, similarly, has both the humility and the courage to own that his desire to make reparation for his past still drives him – which, of course, benefits us all. This deceptively modest book is a power-house of information garnered from many years of front-line experience and I envisage it as providing a gateway to recovery – a first step if you will – for those so trapped in this solitary illness that it's a struggle simply to leave the house, let alone attend a meeting unaided. The reading of this book may well provide the inspiration and encouragement to get them there.

NICK MERCER
is a psychotherapist with The Philadelphia Association and a consultant for RAPt.



CREATURES OF A DAY
by Irvin D. Yalom
published by Piatkus
www.piatkus.co.uk
ISBN 978-0-349-407-42-5 £14.99



This captivating book of professor Yalom takes the reader on a journey through the depths of human struggling with life's limitations of ageing and mortality. The author masterfully depicts ten therapeutic interventions revealing fascinating individuals' stories and their existential tensions. Both patient and psychotherapist are engaged in the profound dilemma to expose, clarify and resolve these tensions.
One after another the stories present to the reader the nature of the crises and the processes involved in their resolutions. Fixation on a past passionate experience is untangled to encourage an embrace of the vibrant present. Transformation is achieved through the patient's creativity in reinterpreting the past. Self-realisation is illuminated by the ancient wisdom of virtue and personal character. The negative emotional past is overcome by the patient's altruism. The human anxiety with the inevitability of ageing and death is managed and the spark of life curiousness is lit once again.
The interventions reveal the inner tensions of the therapist when self-worth is only shaped through association with a famous person, terminal illness shatters life and diagnostic limitations impact the richness of individual's personality. Dr. Yalom resolves all of these through an emphatic person-centred approach based on well-developed rapport, providing resourceful therapeutic framework and empowering restoration in all spheres of life.
The book offers an exciting opportunity to engage with patient and therapist through their struggles and victories on the road to individual growth.

DR. YORDAN ZHEKOV
is an accredited counsellor working in the fields of homelessness and addiction. He is the author of Conscience in recovery from alcohol addiction (2013) – www.consciencetherapy.co.uk.

Where to go... *events, training, learning*

MAY

Stories of Recovery – Saturday, 2nd May – 7 – 11pm
The Dry Umbrella 2 Dale Street Manchester, M1 1JW
Tel: 07412 322 644 -
FREE
www.facebook.com/thedryumbrella

Awards Nominations (USA)

The **Joel Hernandez Award** recognizes one local, state or regional recovery community organisation for its success in assessing the specific needs of their community. The Vernon Johnson Award recognizes individuals who are in long-term recovery from addiction to alcohol or other drugs who have given back to their communities. **The nomination period ends May 8, 2015**. (See July listing for award ceremony details) http://www.facesandvoicesofrecovery.org/nominate-recovery-community-organization-joel-hernandez-award

Smoking Cessation in Mental Health –
Monday, 11th May
Improving the Physical Health of People with Mental Health Conditions London
http://mxm.mxmfb.com/rsps/wlnk/c/812/r/94567/e/14764

JUNE

Rights for Life: Supporting Recovery and Ending Discrimination - 2nd & 3rd June
A solutions-focused, mass participation event for people to come together around mental health rights and recovery.
Glasgow
FREE
www.scottishrecovery.net/Latest-News/rights-for-life-a-landmark-event-for-mental-health.html

JULY

Summer Addiction School – Sunday, 5th – 17th July
This two week Institute seeks to provide a multi-disciplinary approach to the study of addiction..
Amsterdam (Course is delivered in English)
http://gsss.uva.nl/summer-winter/summer/summer-programmes/summer-programmes/content/folder/alcohol-drugs-and-addiction/programme-description/programme-desciption.html

Delivering Excellence : Working Therapeutically in the Criminal Justice System -Wednesday, 8 July 2015 to Thursday, 9 July 2015
A two-day programme of international speakers with workshops looking at contemporary issues for therapists.
Durham University
https://www.dur.ac.uk/conference.booking/details/?id=422

America Honors Recovery - 23 July -
6:30 PM to 8:30 PM
Awards Dinner and Gala
Washington
http://www.facesandvoicesofrecovery.org/nominate-recovery-community-organization-joel-hernandez-award

ADVANCE NOTICE!

SEPTEMBER

An Evening with Erkhart Tolle (Author of the best seller, The Power of Now) – Monday, 7th September
Royal Festival Hall - London
http://www.southbankcentre.co.uk/whatson/an-evening-with-eckhart-tolle-89818

7th UK Recovery Walk – Saturday, 12th September
Starting point at The Sands, Durham – 12pm

Bringing Coaching into Healthcare –
29–30th September – RSA, London.
http://conference.frcint.com/

OCTOBER

Blackpool's Annual Recovery Walk – **The Lights** – 3rd October – 6pm
Contact Shughie on 07944532001 for details

17th International Society of Addiction Medicine (ISAM) World Congress – Monday, 5th to Thursday, 8th October
Addiction: from Biology to Recovery: Translating research evidence to improve clinical practice and community resilience.
Dundee
http://isamdundee2015.com/

Multiple Pathways of Recovery Conference – Monday, 19th – Wednesday, 21st October
An exploration of pathways used to foster long-term recovery from addictions. Speakers include William White and Phil Valentine. - Connecticut
http://myemail.constantcontact.com/CCAR-invites-you-to-the-Multiple-Pathways-of-Recovery-Conference--.html?soid=1101691850752&aid=TygTHVMLb0A

FREE ONLINE LEARNING

The Addicted Brain

This is a course about addiction to drugs and other behaviours. It will describe what happens in the brain and how this information helps us deal with and overcome addiction.
www.coursera.org/learn/addiction-and-the-brain

Future Learn, in partnership with the Open University offer a variety of courses throughout the year of interest to the addiction field.
https://www.futurelearn.com/

Where to find... *self help*

Where to find mutual-aid groups, formally recommended by NICE and WHO.

ADDICTIONS ANONYMOUS
020-7584 7383

ADULT CHILDREN OF ALCOHOLICS
PO Box 1576, London SW3 1AZ
www.adultchildren.org

AL-ANON...
for families and friends of problem drinkers – including after they quit
...AND ALATEEN
for people aged 12-17 affected by someone else's drinking.
Information & helpline for both:
020-7403 0888, 10am-10pm.
www.al-anonuk.org.uk

ALCOHOLICS ANONYMOUS
UK helpline: 0845-7697 555
Enquiries: 01904-644026
www.alcoholics-anonymous.org.uk

BULLYING*
& NATIONAL BULLYING HELPLINE:
0845-2255787
www.bullyonline.org

CITA*
(Council for Information on Tranquillisers & Antidepressants)
Helpline, Mon-Fri, 10am-1pm:
0151-932 0102 0151-474 9626
www.citawithdrawal.org.uk

CHRISTIANS IN RECOVERY
www.christians-in-recovery.org

COCAINE ANONYMOUS
for cocaine/crack and other substances
helpline: 0800-612 0225
www.cauk.org.uk

CODA
(Co-Dependents Anonymous)
www.codependents.org

COSA
for recovery from sexual codependency – meets Fridays
07986-697987
www.cosa-recovery.org

CRUSE BEREAVEMENT CARE*
0870-167 1677
www.cruse.org.uk

DEBTORS ANONYMOUS
for problem debting, compulsive spending, under-earning & other money/work issues
www.debtorsanonymous.org

DEPRESSION ALLIANCE*
Self-help groups, workshops & conferences.
020 -7633 0557
www.depressionalliance.org

DEPRESSIVES ANONYMOUS *
0870-7744 320

DRINKLINE*
0800-917 8282

EATING DISORDERS ASSOCIATION*
Youth helpline: 0845-634 7650
Adult helpline: 0845-634 1414
www.edauk.com

EMOTIONS ANONYMOUS
www.emotionsanonymous.org

FAMILIES ANONYMOUS
for relatives & friends of people with drug problems
0845-1200 660
020-7498 4680
www.famanon.org.uk

FARSI ADDICTION RECOVERY SUPPORT (FARS)
promotes treatment and recovery to Farsi-speaking communities in UK
020-7351 3831
www.farsservices.co.uk

FOOD ADDICTS IN RECOVERY ANONYMOUS
help with food obsession, bulimia, overeating or undereating.
01903-520369
www.foodaddicts.org

FRANK*
government-funded information
0800-776 600
www.talktofrank.com

GAMBLERS ANONYMOUS
for gambling problems
GAM-ANON
for relatives of those with gambling problems
For information on both:
020-7384 3040
www.gamblersanonymous.co.uk

HEROIN ANONYMOUS
www.heroin-anonymous.org

HEROIN HELPLINE*
020-7749 4053 (office hours)

HIV ANONYMOUS
www.hivanonymous.org

MARIJUANA ANONYMOUS
for those who wish to stop using marijuana
07940-503438
www.marijuana-anonymous.org

MUSLIM YOUTH HELPLINE*
confidential counselling service for young muslims in need
Numerous languages spoken
080-8808 2008
www.myh.org.uk

NACOA*
(National Association for Children of Alcoholics)
0800-358 3456
www.nacoa.org.uk

NARCOTICS ANONYMOUS
for drug problems
0300 999 1212
www.ukna.org

NET*
internet addiction in all forms
001-814-451 2405
www.netaddiction.com

NHS DIRECT*
0845-4647; 24 hours/7 days a week
www.nhsdirect.com

NICOTINE ANONYMOUS
Freephone 020-7976 0076.
www.nicotine-anonymous.org

OBSESSIVE EATERS ANONYMOUS
www.obsessiveeatersanonymous.org

OCD ACTION*
information & support for people with obsessive compulsive disorder
020-7253 5272
www.ocd-uk.org

OVEREATERS ANONYMOUS
for problems with food, including anorexia
UK 24-hour helpline/ answerphone:
07000-784985
www.oagb.org.uk

PAN FELLOWSHIP
any dependency/codependency with emphasis on steps 4&10
7pm Fridays at Methodist Hall, Fulham Broadway, London

SAMARITANS*
for anyone feeling low, depressed or suicidal
Helpline 24/7: 08457-909090
www.samaritans.org

S-ANON
for people affected by someone else's sexual behaviour
07000-725463
www.sanon.org
cardifthopefortoday@yahoo.com

SEX ADDICTS ANONYMOUS
London callback answer phone:
07000-725463
www.sauk.org

SEXAHOLICS ANONYMOUS
for those who want to stop their self-destructive sexual thinking and behaviour
020-8946 2436

SEX & LOVE ADDICTS ANONYMOUS
(The Augustine Fellowship)
07951-815087
www.slaa.uk.org

SHOPPING OVERSHOPPING*
www.overshopping.com

SPEAR*
Supporting people who self-harm
www.projectspear.com

SURVIVORS OF INCEST ANONYMOUS
www.siawso.org

TALKING ABOUT CANNABIS*
Supports families of cannabis users
www.talkingaboutcannabis.org

UK SELF-HELP*
website containing hundreds of listings
www.ukselfhelp.info

VIOLENCE INITIATIVE*
offering violent people a chance to change – meetings, one-to-one sessions, conflict resolution training
020-8365 8220
www.tviccv.org

WORKAHOLICS ANONYMOUS
Celia 01993-878220
or George 020-7498 5927
www.workaholics-anonymous.org

* Resources other than 12-step
Many of these resources are free or by donation – readers should check.

Prinsted celebrates its Ten Year Anniversary this year. *Jim Smith* talks with *Brian Ballantyne* and *Caitilin Prinsep*, a couple who have worked together for twenty years, and have become synonymous with secondary care.

JS. IT'S GOOD TO HAVE AN OPPORTUNITY TO TALK WITH YOU BOTH, MAYBE THE PLACE TO START IS TO ASK YOU HOW YOU MET?

B. We met at Farm Place before it was sold by Jim and Joyce Ditzler, we've sometimes been compared with them. So, things evolved, Caitilin and I got on really well and started working together at the 'Coach House' in 1997.

C. After some time we realised we could do this for ourselves. We left the 'Coach House' in 2004.

C. It took us 2-3 years to find the right building, then six months of construction.

B. Prinsted opened in February 2005 and we had the party in April. It's been a great adventure and still is.

J. CAITILIN, HOW DID YOU COME INTO THIS WORK?

C. I come from the place of a family member, I was with someone who was trying to get sober. I went to Al-Anon. I started to train as a therapist in 1989. I worked for the Surrey Alcohol and drug advisory service (SADAS), then I met Christine Kerr and found out there was a vacancy at Farm Place.

J. WHAT WAS THE EXPERIENCE LIKE AND WHAT CHANGES HAVE YOU SEEN SINCE THEN?

C. It was an amazing place to work. I made many friends there;
as far as changes go I think the patients have more complex needs.

B. It's psychiatrically led today, diagnosis is over controlled by psychiatry, there is too much prescribing in some cases.

C. People were in treatment longer, three months in primary and most of them had a thorough Step 1 before coming to secondary.

J. TELL ME ABOUT YOUR JOURNEY BRIAN.

B. I went into treatment at Broadway Lodge in 1979,then trained there in 1982..I qualified and worked there until 1988, took a sabbatical, then worked at Nelson House and on to Farm Place.
Travis Cousins started Broadway, It was called 'Totterdown House'.

J. WHAT GIVES YOU PLEASURE IN THE WORK YOU DO?

B. It's tremendous, there's nothing like it.

C. working with people who come from that broken place, full of fear and pain, the transformation over the years, to see them in healthy relationships with families; that is a great fulfillment, nothing can compete with work like this.

J. YOUR FORMER CLIENTS KEEP IN TOUCH?

C. We have reunions and spiritual weekends.
Our work is long term, six months here, then aftercare, reunions and spiritual weekends.

J. WOULD YOU SAY THE MAJORITY OF CLIENTS WHO ARE STILL IN RECOVERY ATTEND FELLOWSHIP MEETINGS?

B. Without a doubt, we are tremendous advocates of the 12 Steps, they have to go to four meetings a week here.

J. YOU SPECIALISE IN PROCESS ADDICTIONS?

B. Yes, co-dependancy, sex and love addiction and eating disorders.

C. There's a real community here, with lots of boundaries, constants and reliability. We teach communication and interpersonal skills.

B. It's staggering the lack of boundaries clients arrive with.

C. They come to accept and enjoy the safety that boundaries provide. They feel safe.

J. SO YOU'RE IN YOUR 10TH YEAR, HOW DO YOU SEE THE WAY FORWARD?

B. Well, it's a celebration, and an achievement.

C. We're having a party at the end of May, and there will be an event in London.

J. HOW ABOUT BOTH OF YOU?

B. (Smiling)We're beginning to take a bit of a back seat (Caitilin smiles).

C. We're forming a charity called 'Freedom from Addiction', it will benefit people in early recovery, with education,
training, and also support personal development.

B. If anyone reading wants to help with the charity, please get in touch!

Prinsted
Oldfield Road, Horley
Surrey, RH6 7EP

T:01293 825400

info@prinsted.org
www.prinsted.org