intervene

THE RECOVERY MAGAZINE

ISSUE 157

ELEPHANT INTERACTIVE THERAPY ◆ SEX IN THE DIGITAL AGE ◆ CO-DEPENDENCY
EQUINE THERAPY ◆ MUSIC SUPPORT ◆ HEALTH AND NUTRITION

NEWS COMPREHENSIVE TREATMENT DIRECTORY
TRENDS COMMENT DIARY BOOK REVIEWS SELF HELP

WELCOME TO INTERVENE 157

Three years ago the publication you are reading changed. We upped our production values, re-designed and changed our name from Addiction Today to Intervene. We also launched a digital version which over 4,000 of you subscribe to and as a consequence many of you are reading these words on a tablet or smart phone.

One thing that has remained constant is our mission to bring you the very latest in cutting edge approaches to the treatment of addiction - in all its forms. In the last 28 years we've seen the development of the magazine in the UK and Europe which has resulted in Intervene becoming the 'go to' title in the sector whether you're an academic, recovery practitioner or simply interested in learning about dealing with addiction. We lead the field in delivering quality information sourced from the best of international thinking and have become as much a journal of research as we have a quarterly read.

It's because of this constant drive to improve that we're now moving into the latest stage in our development. The success of the digital version of Intervene and the positive feedback you've given us has inspired us to move exclusively to a digital platform.

We'll no longer be constrained by the processes associated with quarterly publication, we'll be able to bring you up to the minute information on a daily basis whilst giving you immediate access to our enormous archive on addiction – we'll also be kinder to the environment!

In many ways we'll miss the magazine but there's so much more we want to bring to you and the opportunities offered by a move to a fully digital format are really exciting. Change is inevitable and in the words of the late Buddhist philosopher Alan Watts, "The way to deal with change is to plunge into it, move with it, and join the dance".

For news and updates direct to your inbox, subscribe at www.intervene.org.uk or follow Intervene on Twitter (@intervenemag) or Facebook.

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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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NEW RESIDENTIAL DRUG AND ALCOHOL TREATMENT CENTRE FOR YOUNG PEOPLE

A long-needed, new specialist drug and alcohol recovery unit for young people and families starts its construction this month, with the first turf being officially cut by Colonel Bolitho, Lord-Lieutenant of Cornwall and the Isles of Scilly and construction expected to be completed towards the end of the year. Colonel Bolitho is President of the charity, Bosence Farm Community that has been providing specialist drug and alcohol treatment services for adults on the site for twenty years. Colonel Bolitho commented that "Bosence Farm is an outstanding organisation, providing live-saving support to a great many people in Cornwall. This new facility will enable even more people to be helped and is hugely to be welcomed."

The facility, when open, will be the only unit in the country to offer residential assessment, stabilisation and detoxification to young people and those with families facing drug and/or alcohol dependency.

Colonel Bolitho cut the first turf at a ceremony on the site on 18th May, attended by the Drug and Alcohol Action Team commissioner, Kim Hager, Councillor Andrew Wallis and Viv Hughes, Addaction, Manager of YZUP, Young people's drug and alcohol services. Kim Hager said 'This service will fill a large and vital gap in provision in Cornwall and shows the great role that the Voluntary Sector has to play in meeting thorny and complicated problems with creative solutions'.

Kate Cook, Bosence Farm's CEO explains the impact the centre will have: "There is no residential provision in Cornwall and limited provision in the country for young people under 18 who have problems with drugs and alcohol. We also know that there are significant barriers to parents in need of treatment taking up residential support because of concern for their children's wellbeing particularly when the seriousness of their problems may mean they lose custody altogether. This third centre will mean that we can help families and individuals with complex needs right here in Cornwall, and significantly improve the outcomes; all the current research shows that it is better for those needing treatment to get it closer to their homes and wider support networks. It also has the wider community benefit that this should be much better value for money all round."

The scheme, funded through a successful application to the Public Health England Capital Grant scheme in 2015, supported by Cornwall Council, will be delivered jointly by Bosence Farm Community and the Drug and Alcohol Action Team, and the service will be provided in partnership with a number of local organisations, including Addaction (a charity that provides all the advice, information and support in the community in Cornwall), YZUP, and Children and Families Services.

Viv Hughes, Manager at Addaction's Cornish young people's service YZUP said: "This resource will be hugely beneficial to those young people who are unable to break out of the cycle of substance misuse whilst living in the community. It will offer a safe and supportive space for young people to stop their substance use, begin recovery and prepare for their reintegration back into the community. We're delighted to have it opening and to see the first young people start their road to recovery here."

Bosence's Kate Cook added: "We want to see a society where every person suffering from drug and alcohol problems can receive high quality treatment and support to meet their needs, and help them become fulfilled and productive members of their community. This facility will mean that we can take a step closer to this vision."

ADFAM RESEARCH MEANING OF RECOVERY FOR FAMILIES

Adfam have partnered with Sheffield Hallam University to find out what recovery means for families - a family-focused sequel to their Life in Recovery Project. The Life in Recovery research used online surveys to explore what the everyday realities are for people in recovery, and the same questions will be asked of families whose loved ones are in recovery from drug and alcohol addiction.

They are also running an innovative peer support project for parents affected by child to parent violence where the child is using drugs or alcohol. Adfam invite people who work with children who may be experiencing this issue and would like to know more to contact them.

They produce free monthly policy briefings for professionals: www.adfam.org.uk/professionals/latest_information_and_events/policy_briefings . To find out more about Adfam's work visit: www.adfam.org.uk or call 0207 553 7640 (also Twitter @AdfamUK or find them on Facebook).

'FREE ME' – RECOVERY PROGRAMME USES FASHION.

Free Me is a therapeutic programme which has its own fashion label, Sweet Cavanagh. Women supported by this free outpatient service learn how to design and make jewellery, which is then sold online. Each woman receives commission when one of their pieces is sold.

Free treatment for eating disorders in the UK is limited and private providers are, for many, too expensive. Free Me provides an essential outpatient provision designed to support women in continued recovery. The charity has developed "Work to Recover", in partnership with London based recruitment agency Sidekicks. They run monthly workshops on CV writing and interview coaching. Graduates from the Free Me recovery programme also have the opportunity to do work placements. Awareness of Free Me's approach to continued recovery is growing and the organization receives referrals from GPs, inpatient and outpatient therapy provisions and international treatment centres.

Free Me is funded entirely by grants, donations and jewellery sales. For more information on the programme visit www.sweetcavanagh.com. Alternatively, email Amy Lucas (HCPC, BADth) amy@sweetcavanagh.com or Gemma Wood (BACP) gemma@sweetcavanagh.com

OUR BRIAN IS OFF ON A JOGLE!

Brian Dudley CEO of Broadway Lodge is cycling and jogging from John O'Groats to raise funds for Broadway Lodge.

In 2015/2016 Broadway provided 929 Charity bed nights and a further 1013 discounted bed nights to private fee payers.
The mutually agreed completion rates for providing these placements were 89.8% for detox interventions and 76.0% for residential rehabilitation interventions.

Broadway needs help in order to continue providing this service which is unrivalled by any other provider in the UK.
As the CEO Brian is undertaking a charity bike ride from John O'Groats to Land's End (913 miles and over 54,000ft of climbs) in order to raise funds.

Please help us to help them and these funds WILL directly save lives.

Broadway Lodge
JUST GIVING
www.justgiving.com/broadway-lodge

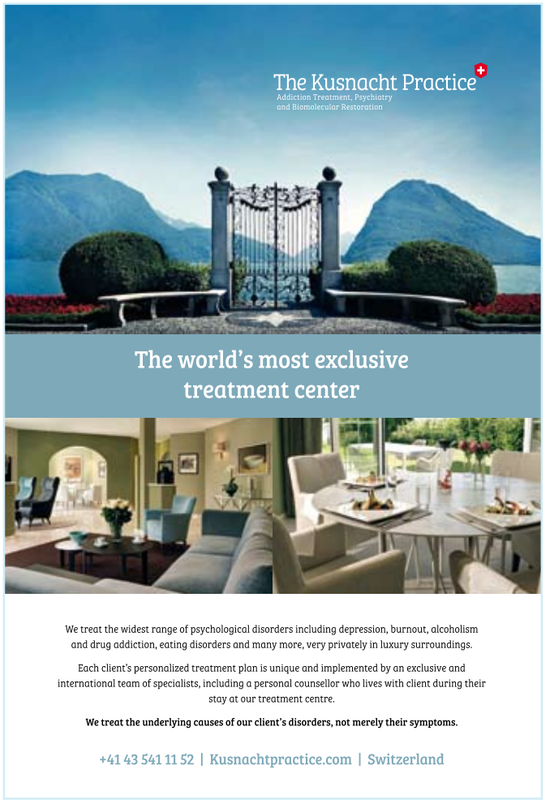
THE ICARUS TRUST AND ITS FAMILY FRIEND MODEL

Addiction is an issue that affects the whole family: whether it's stress, feeling undervalued and unhappy or more serious physical and mental health problems. The stigma around drug and alcohol use also plays a huge part, and can make it harder for families to take the first steps to look for support for themselves.

If someone close to you is using drugs or alcohol and you want some support, the Icarus Trust can help. The charity was created in 2013 with a mission of helping any family negatively affected by addictive behaviour, including drugs or alcohol. To achieve this Icarus has developed a network of 'Family Friends' who are trained to offer support. It can be daunting trying to find help for your situation – where do I turn? Which one is best for me? What if it doesn't work? – but Family Friends will support you over email by listening to you and the problems you are facing, and helping you find the best and most appropriate needs. They have personal experience and can understand your situation, speak your language, offer a sympathetic response and help point you in the right direction.

The Icarus Trust can support you for as long as you need it, free of charge, and will tailor their support to meet your needs.

Get in touch with a Family Friend by emailing help@icarustrust.org. A proportion of family members can also access free support from an accredited psychotherapist – please mention if you are interested. Read more at: www.icarustrust.co.uk.



Action on Addiction

Action on Addiction exists to disarm addiction

Treatment and rehabilitation
Families and children
Professional education
Research
Advocacy
Prevention

A is for action

www.actiononaddiction.org.uk | T 01747 830 733 | E action@actiononaddiction.org.uk
Head Office East Knoyle Salisbury Wiltshire SP3 6BE Charity No 1117988 | Company No 05947481

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

ACTION ON ADDICTION FUNDRAISING EVENING AT THE WEST END PRODUCTION OF PEOPLE, PLACES & THINGS

Action on Addiction held a fundraising event in conjunction with the critically acclaimed production of People, Places & Things on Tuesday 14 June at the Wyndham's Theatre in London. The funds raised will enable more people to recover from addiction by getting them into residential treatment.

People, Places & Things by Duncan Macmillan is a co-production between the National Theatre and Headlong and directed by Jeremy Herrin. Denise Gough plays the central character of Emma, an actress whose life – like many others with whom the charity works – has spun recklessly out of control because of her addiction to drink and drugs.

The performance was followed by an onstage discussion about addiction and recovery, hosted by Sacha Gervasi and featuring TV presenter Davina McCall, writer and critic AA Gill, Denise Gough and Duncan Macmillan.

Robert Fox, theatre and film producer and Trustee of Action on Addiction said:

"Addiction is a complex and stigmatised condition. It is wonderful to see this issue being tackled in a very open and honest way, and made accessible to the wider public through this extraordinary play and production."

ALL PHOTOGRAPHS © DAVE BENNETT

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

▲ AA GILL

▲ DAVINA MCCALL

▲ GILLIAN ANDERSON

▲ NICOLA FORMBY & MARIELLA FROSTRUP

▲ SAMANTHA CAMERON & EMILY SHEFFIELD

▲ CHARLOTTE TILBURY

▲ TANIA BRYER

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

This year's UKESAD was the best attended yet with more exhibitors and sponsors taking part than ever. The conference took place at the Royal Garden Hotel Kensington and was opened by Shovel, a shamanic healer, who brought together participants in a spirit of positive goodwill that flowed through the following three days of the event.

Over 90 experts in their fields, including innovators like Rokelle Lerner and Dr Robert Lefever, presented lectures and ran workshops. Two of the highlights of UKESAD 2016 included a panel lead debate on new thinking on the pharmacological treatment of addiction that featured the, sometimes, controversial Professor David Nutt and a lively debate around legalisation, chaired by Mike Trace of RAPt. saw a passionate exchange of views between Johan Hari and Iain Duncan Smith.

UKESAD 2016 was the most dynamic yet in terms of the variety of organisations represented and offered significant opportunities for the sharing of best practice and networking opportunities.

▲ DAVID NEITA & SHOVEL

▲ FINTY WILLIAMS & SAMANTHA QUINLAN

▲ RYAN MARTIN & REV JACK ABEL

▲ BRIAN DUDLEY

▲ ROBERT HUDSON

▲ MIKE DELANEY

▲ RAYMOND GUDDAH

▲ HILDE STERK & COLLEAGUE

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

▲ JULIE CLARK & COLLEAGUE

▲ ALASTAIR MORDEY

▲ PAULA HALL & NICK TURNER

▲ MICHAEL ROWLANDS & KATHLEEN O'HARA

▲ SANDY SALMONS & JOHN MCCANN

▲ KATHLEEN BIGSBY & JILLIAN MCCARNEY

▲ DAVID CHARKHAM

▲ TIM WILLIAMS & MARK JONES

▲ JOHANN HARI

Contributors...

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

NOEL MCDERMOTT

Noel McDermott Is a psychotherapist with over 20 years clinical experience, spanning kids, adults and families. He's specialised in recovery, trauma, relationship, identity and life transition issues. He offers cognitive behavioural, psycho-dynamic, creative arts based therapies principally. In the family work using systemic approaches. His general approach is proactive, creative and solution oriented.

ELISABETH ESCOBAR

Elisabeth Escobar has been working in the field of Substance Abuse for the past 30 years. Elisabeth has served as The Director of Admissions in both Adolescent and Adult Substance Abuse In-Patient Treatment Programs in Oakland, California. She also worked with teens and adults in an Out-Patient Treatment Program in the Washington DC area. She was the School Counsellor at three International Schools in Rome, and currently offers, "Social Skills Coaching for Kids, Teens & Adults" via Skype as she divides her time between Lisbon, Portugal and NYC, NY. Elisabeth completed her Masters Degree in Counselling Psychology in NYC and recently completed a Clinical Intervention Training with Love First Intervention Services. You may reach her at: jojoinoak@gmail.com.

MIKE DELANEY

Mike Delaney is Director, Senior EFP/L Practitioner and Trainer at LEAP, a dedicated provider of equine therapy, helping clients with drug or alcohol dependence or psychological conditions overcome their problems through working with horses. It also provides an intensive training in the LEAP model of EAP. LEAP is the only organisation with training courses endorsed by the BACP (British Association of Counselling and Psychotherapy) as a CPD activity and has treated well over 1,000 clients to date. He also regularly hosts client clinics in London and travels throughout the UK, Europe and worldwide for client therapy and business consultancy.

CATHERINE CILLIERS

Catherine Cilliers, is a South African clinical psychologist and therapeutic director of Vincere Huguenot South Africa. Catherine developed the elephant interaction therapy program and currently runs it together with her team in Knysna, South Africa. **Elephant Photography by psychologist, Petra Meus.**

DUFFLYN LAMMERS

Dufflyn Lammers is an International Recovery Coach, writer and actor. For coaching inquiries and her blog "Recovery Girl" visit: www.dufflyn.com Lammers tours a one woman show and leads workshops for anyone who wants to explore their own story.

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.

Contributors...

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

DR ROBERT SIMPSON

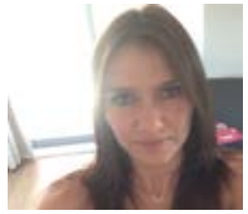
Robert was born in the UK and lived in London until his parents emigrated to the United States. After being expelled from some prestigious schools in both countries he had a colourful early adulthood..

He is certified by the American Board of Addiction Medicine and is a member of the American Society of Addiction Medicine. His interests include acute detoxification, the role of spirituality in recovery and the treatment of addicted health care professionals.

Robert is an active member of his recovery community in Salt Lake City, Utah and is a member of the "Like Minded Docs" and International Doctors in Alcoholics Anonymous (IDAA). He is co-chairman for the upcoming IDAA meeting in Snowbird Utah.

KATHRYN STARON

Kathryn Staron has a Masters degree in Clinical Psychology and is recognized 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 the former Coordinator of the Addiction Studies Program at Madonna University and an Adjunct Assistant Professor in the Psychology Department. She is currently in private practice and can be reached at kathrynstaron@gmail.com



AMANDA LENNON

Amanda Lennon is 37 years old and lives in London. She recently graduated from Goldsmiths University of London with a Batchelor of Arts in History. She is currently studying for her M:A in Interactive Journalism. Amanda is a qualified kundalini yoga instructor and is interested in Addiction Recovery, Theology and Travel.

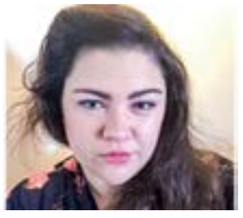
ASHLEY HOWARD

Ashley Howard, is an Addition Therapist, CSAT - is a member of the clinical team at The Hudson Centre working with sexually addicted clients both in group and on a one to one setting. He also works closely with Robert Hudson providing addiction treatment for men and women struggling with addictions.

NICK MERCER

Nick Mercer is an experienced psycho-therapist and an authority on treatment of addictions who has written, managed and established total abstinence programmes in a wide variety of locations. Alongside his consultancy work and a thriving private practice, he has adapted and successfully delivered a 12 step programme for young offenders in Reading HMYOI and Aylesbury HMYOI and was instrumental in delivering the first 12 step easy access day programme in Liverpool (SHARP) His mission is to extend to clients the same opportunities for spiritual and personal growth that were extended to him.

OLIVIA PENNELLE



Olivia Pennelle author and nutrition and recovery advocate, entered recovery in March 2012. Whilst 12 Step fellowship forms the foundation of her recovery, Liv passionately believes in a fluid and holistic approach.

For Liv, the kitchen represents the heart of the home and her blog features her expanding recipe collection. Liv currently lives in Manchester, England. She is undertaking a nutrition coaching course and is active in her local recovery fellowship

DR PREM KUMAR SHANMUGAM

Dr Prem Kumar Shanmugam is CEO and Clinical Director of Solace Sabah. Solace is the first private, addiction treatment retreat located in Malaysia. He is one of the founding members and the Regional Director of the Asia Pacific Certification Board (APCB). APCB is actively involved in certifying addiction counsellors/therapists around the Asia Pacific Region. Prem also acts as the President of the Psychotherapy and Counselling Association of Singapore, while being one of the founding members as well.

What can we do to stop children dying after ingesting medications used to treat drug addiction?

Rachael Evans of Adfam

Over the past thirteen years, hundreds of children in the UK have died or been seriously harmed after ingesting medications prescribed to their parents to treat opioid dependence. The mainstream media has picked up on some of these cases, like the tragic death of Fenton Hogan in 2013, whose mum gave him methadone 'to help him sleep.' But these reports do not get to the root of the problem, preferring to instead demonise 'drug addicted' parents, rather than look at what went wrong and what could have been done to prevent this tragedy – and others like it.

When Adfam started looking into this problem, the huge gap in knowledge around the risks to children posed by opioid substitute therapy (OST) medications (usually methadone or buprenorphine) became immediately obvious. We didn't know how many people with parental responsibility or contact with children were allowed to take home these medications, let alone how many children had come to harm after ingesting these drugs - nor did we know anything about the circumstances in which children were coming to ingest them. After two research reports, we now have a better idea of the prevalence and scope of child ingestions of OST, but so much more still needs to be done. One child dying is one too many – these deaths are preventable.

"All incidents involving a child's ingestion of these medications must be fully investigated and recorded"

Between 2003 and 2013, at least 110 children and teenagers died from the toxic effects of OST medications in the UK, with methadone being responsible for 107 of these. Of the 73 deaths in England and Wales, only seven resulted in serious case reviews – an investigation by the local authority into the harm or death of a child where abuse or neglect is suspected. In the same time, at least 328 children in England were hospitalised with methadone poisoning. That methadone can be dangerous is, of course, not news: it is responsible for a growing number of adult deaths, reaching 394 in 2014. Safety measures have already been put in place by manufacturers in the form of childproof bottles, lockable storage boxes, safety information and supervised consumption regimes – so, how is this still happening?

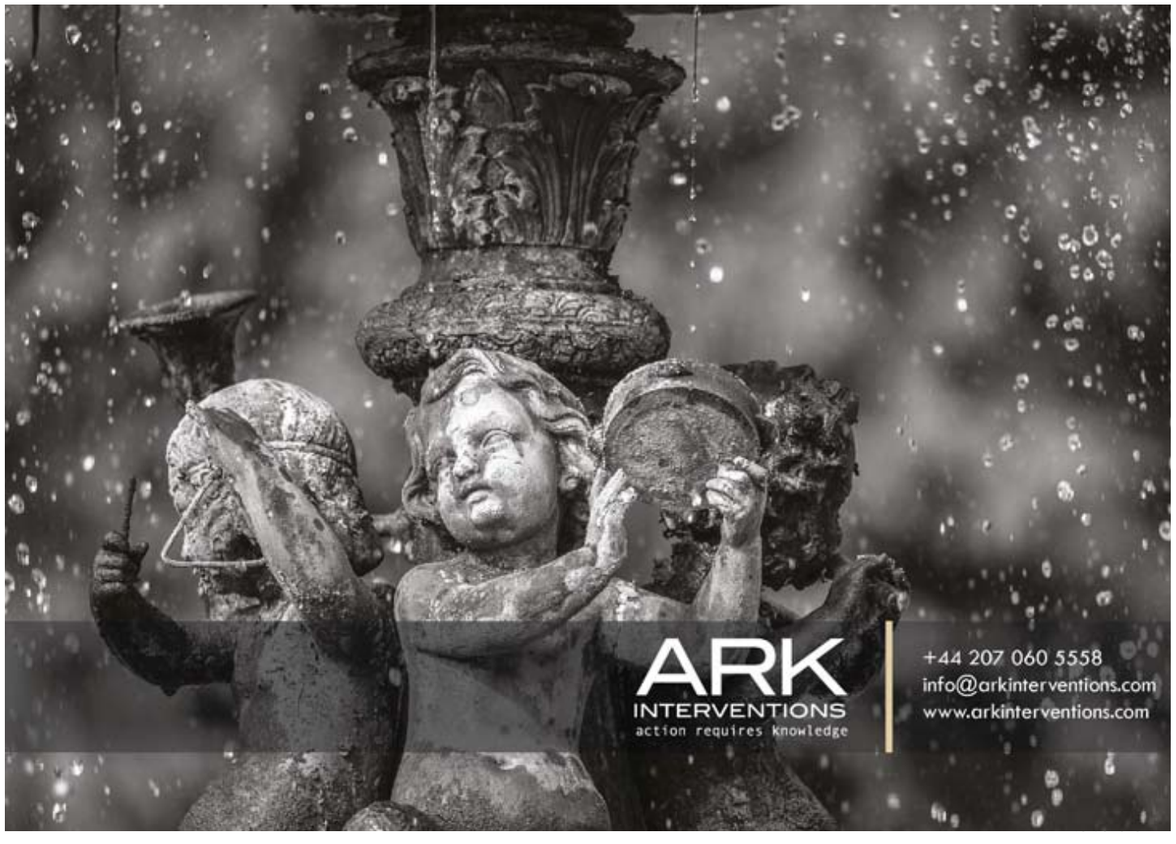
Many of the reviews explain similar sequences of events – methadone left lying around the house or stored in baby beakers, or parents trying to placate their children with it – and make similar recommendations for practice, like restrictions on take-home medication. History has repeated itself from Bradford to Bridgend, without any platform of proactive, national learning. The risks to children posed by OST medications are not sufficiently managed in practice, and we can't wait for every local authority to experience one of these incidents before something changes; indeed, some areas have had multiple cases, showing that improved practice has not always followed an ingestion incident. Perhaps one of the most surprising findings is that whilst many of the children swallowed the drug accidentally, some were given them by their parents in a misguided attempt to soothe or help them sleep. These parents are not trying to harm their children, they simply don't know or understand how dangerous and toxic these drugs are to children, even in tiny amounts. Better education of parents and professionals of the dangers of OST to children is an obvious necessity, as is the provision of safe storage boxes to parents, but, in addition, professionals must address the possibility of intentional administration with parents in no uncertain terms.

Some professionals are shocked at the suggestion their clients might be giving their children these drugs, and assume they know what the dangers are, so don't need to discuss it. This is a mistake. The number of deaths and incidents unequivocally show that this is an issue that must be tackled directly. OST is proven to reduce dependence on street heroin, and by doing so it saves lives, improves health and wellbeing and cuts crime. The rightful place of these medications in addiction treatment is not at issue, but it's imperative that the risks they pose to children are better addressed and future incidents prevented.

So what needs to change? Although there is no magic bullet – no one measure can eliminate risk – there are some relatively simple steps which could make a real difference. Firstly, all incidents involving a child's ingestion of these medications must be fully investigated and recorded; and analysed centrally by government, with learning shared with local services. The wide range of professionals who come into contact with parents and carers prescribed OST medications must all be trained about their potential harm to children, and services must work together and share information more effectively to minimise risk.

The lessons from previous tragic cases have not been heeded, and children are still dying. The vast majority of parents prescribed these medications will use them safely and appropriately – but the number of children now identified as having been harmed lends the issue even greater urgency. Some areas have taken positive steps: for example, by employing specialist family workers in drug treatment agencies which work with pregnant women and families to help the service to maintain a family-focus, and ensure that safeguarding is a prime consideration when treating parents for opioid dependence. Inter-agency joint protocols between drug services and health visiting teams will also ensure that vital information is shared, and allows for joint home visits to be conducted. The better agencies involved with the family work together, the lesser the risk – this is a consistent finding of serious case review panels looking into these cases.

Adfam has delivered training to multi-disciplinary teams across the country to help them develop a blueprint for best practice on the issue – as well as providing an opportunity to get everyone in the room, to link up and encourage improved future communication amongst local agencies – and will be offering this training to more local authorities in the coming months. If you want to know more about this email: admin@adfam.org.uk.



The Addict as a Vessel for Systemic Disturbance

Chula Goonewardene examines the causal effect of unresolved family trauma and its consequent impact on addictive behaviour

It saddens me that I continue to observe society view the addict as the root of all evil; the morally deficient individual causing all the chaos, unhappiness and destruction that surrounds them, often without any thought given to what may have originally contributed to this person's spiral into the progressive illness of addiction.

We have learnt and advanced so much in the private treatment field, that it is easy to forget that the general population are several steps behind us, and the statutory support offered to the majority has only acknowledged and adopted a systemic approach in recent years. The medical model of opiate substitute prescribing, for example, still prevails to pertain that a 'therapeutic dose' of methadone (often 80mg plus) is the answer in supporting someone to cease illicit drug use and create a foundation for successful recovery, without any acknowledgement or true understanding that treating the symptom in this way actually obstructs the chance of anyone being able to treat the underlying disease.

Luckily, we do have the knowledge that a systemic approach to the treatment of addictive disorders is the most effective way forward and at the very least; educating the family to some degree, will provide a significant supportive factor for long-term, sustainable recovery of the individual, but sometimes we need to look much deeper into the addict's family system, especially in their early years, to really see where it all began for them.

How many times have we seen the addict find recovery in treatment, only to return to the supposedly supportive home environment and relapse, back to where they had been, or worse. And how many times have we heard people say upon their return to treatment that they had stopped working a programme of recovery prior to their relapse, at the encouragement of good-intentioned family members, who mistakenly assumed the addict had been cured and 'didn't need to go to those meetings any more' or was 'safe to drink socially again'.

Sometimes this happens out of pure ignorance; both the addict and their family believe that having had a long stretch of productive and positive abstinence, the issue has been completely resolved. But on many occasions, it is the underlying codependent machinations of a dysfunctional family dynamic, driven by the unresolved issues of those around the addict, that contribute significantly to the individual's ultimate decision to pick-up again.

To understand this fully we must approach the search for recovery from a systemic perspective and take a close examination of how the addict's disordered behaviour came to light. I will use myself as an example, bearing in mind that this is not about attributing blame; addiction is an illness and one is either afflicted or one is not, but as a way to illustrate how external factors influence development of the mountain of issues that one has to face once the dummy that once soothed so well, but now fails to pacify, has been prized from the addict's grip.

When I was about 4 yrs old, my mother started to lose her sight, and by the time she became completely blind I had two baby brothers and an ever-growing mischievous streak. If I look back it is clear to see that I developed addictive behaviour in my patterns of relating to people and the world, for example; becoming completely obsessed with a toy and relentlessly nagging my parents until it (or something similar) was bought for me, only to become very quickly bored and uninterested once it was in my possession, which often resulted in a ritual breaking or burning of said item.

I also remember standing on the ledge of an upstairs open window, shouting to my mother that I would soon be jumping to my doom, so that she would come and physically stop me and I would feel as if I'd truly been heard…and seen. It seemed to quickly register that I had to do just that little bit more to gain her attention and that the instant comfort that I had previously been lavished would perhaps have to be sought elsewhere, through external means of my own

devising…an avoidant attachment style was seeded.

I have learned through my time in meetings and in therapy, that the loss of my mother's sight was very much a loss for me, and the eradication of the eye-contact that had communicated so much during my early years, would have been extremely distressing for a young child. Hence the need to demand attention through extreme behaviour, to develop a compulsive desire to self soothe with external objects, and to spend hours in imaginative creative fantasy; all typical addict traits.

I have been fortunate enough to explore my patterns of relating that were born from this most unfortunate experience and give sense to my difficulties in trusting people, especially female partners, accompanied by a chronic fear of rejection that has led to many a manipulative codependent deed, and the constant sacrificing of my own needs to prioritise meeting the needs of others.

This personal example however, isn't so much about these behavioural characteristics that were initiated by my mother going blind, but the impact upon me of the necessity for those around me to suppress the emotional horror of the situation.

The brutal tyranny of disability affects many, and we all deal with this in different ways, but my parents are incredibly strong people, and they weren't going to let it beat them, no way. My father went to work, did the shopping, ferried us around, took my mother to Moorfield's and back, and as soon as she was out, regardless of her not being able to see, my mum was washing, cleaning, cooking and feeding us, just like any normal mother would, in fact she has accomplished more in her life than most sighted-people do and inspires many, especially me, in every step that she makes.

I have nothing but the utmost love, admiration and respect for my parents, it took immense strength and courage on their behalf to face this awful tragedy, but unfortunately there was a consequence, because I believe that in order to accomplish this mammoth task, they had to suppress their fear, their anger, their sadness and their outrage that such devastation could be bestowed upon their family, there was really nothing else they could have done to survive it, and it wasn't such an age where therapy was an automatic and accepted referral.

I liken this process to that of addiction, in that ultimately it is an emotional bypass that prevents us from caving in. The drugs/obsessive behaviour/suppressive avoidance/denial of a harsh reality do work, temporarily, to get us through, and perhaps worse would happen without this utilisation, but the result for me in this situation was that I became a vessel for the disturbance in my family and acted out the hidden feelings, the ones that were too painful for them to let out or let take them over, disguised by a stiff-upper-lip and a just-get-on-with-it approach, that they had to adopt, to hold us through the storm, so that we could all be survivors instead of victims.

"I became a vessel for the disturbance in my family and acted out the hidden feelings, the ones that were too painful for them to let out or let take them over, disguised by a stiff-upper-lip and a just-get-on-with-it approach, that they had to adopt, to hold us through the storm, so that we could all be survivors instead of victims."

My behaviour at this time was very easy to label; naughty, difficult, rebellious, disobedient; and became characteristics of my personality by the age of 9 years old, when my unconsciously inherited rage took me unprepared into the darkness of being subjected to sexual abuse, and subsequently introduced me to the medicinal value of cigarettes and alcohol, to kickstart twenty years of active addiction.

We can draw parallels with this perspective from Foulkes' group analytical theory;

'Disturbance located in the group may show up in an individual's behaviour. Thus we might see a person dominating a group. Our tendency is to identify the person as difficult - a monopoliser. But what does this behaviour tell us about the group? Foulkes would see this as an unconscious collusion between the monopoliser and the group. The monopoliser's behaviour is in some way serving a function for the group - after all, nobody else has to talk and may thus be avoiding a difficult issue.'

Again I'd like to emphasise; I'm not blaming anyone or this situation for my illness, I'm merely acknowledging that some of what I had to self-medicate wasn't mine, it was a disproportionate absorption of a shared trauma, that had to be spat out or pushed down, and when the former brought me rejection, I unconsciously decided that the latter would protect me better and pursued it with vigour.

The reason I've shared this with you, is because my experiences working with addictive disorders have shown me that we can translate this perspective to any family of an addict where there is generational trauma and abuse, such as; premature bereavement, the scarring of war, childhood sexual abuse, poverty and social exclusion...the list goes on.

When we support an individual we must always start by looking at what is theirs, but it is also important that we look at what they carry emotionally that is not theirs, what environment and history have contributed to their make-up, and what may be lying dormant and unresolved in those around them. It is very easy to assume that if they remain abstinent, work a programme and adopt a productive lifestyle, that a successful, long-term recovery will be sustained, but if the systemic disturbance is not addressed to some degree, then relapse will likely be imminent.

I feel that a psychodynamic approach in therapy, once someone has become sober, is helpful to ascertain where this lies, in order for the addict to work it through and build healthy boundaries that will prevent old behaviour reoccurring, or the slipping back into unhealthy patterns of relating in new relationships, but a further step needs to be taken.

If it is discovered that there is unresolved trauma in the family of the addict, and the addict is returning to that family, be it mother, father, sibling, or spouse, and even more so if they are cohabiting with them, then the ideal solution would be the treatment of the relative in their own 1:1 therapy and the psycho-education of the family, together with the addict.

This will raise awareness of what each of them brought to the table in the original dynamic, before and during the individual's active addiction, which will in turn inform what each of them brings to the table now the addict is in recovery, with the hope that all concerned can learn together, work on issues unresolved, and be empowered to choose to set the table differently...in order to have a significantly more positive and healthy 'dining' experience in the future.

Ask the Expert

An Interview with **Dr. Robert Simpson** reveals some practical advice for working with fellow professionals experiencing difficulties

By Elisabeth Escobar MA M.Ed

Dr. Robert Simpson was born in England, though he completed his medical training at The University of Texas Southwestern Medical School. He graduated from there, with honours, in 1997 and went on to complete his internship and residency in Internal Medicine at Baylor University Medical Center. In 2000 he moved to Utah to train in Pulmonary and Critical Care Medicine at the University of Utah. He remained there as faculty before retraining in Addiction Medicine. He is board certified by the American Board of Addiction Medicine and joined Cirque Lodge in 2014. Dr. Simpson has a passion for recovery and for helping others find freedom from the suffering of addiction. Particular interests include acute detoxification, residential treatment and the treatment of impaired professionals.

1. What issues arise for Professionals with Addiction or other mental health Issues that may differ from the general population?

The biggest difference is that many professionals over-identify with their profession. Getting into recovery helps clients develop a healthier relationship with their professional identity, we also work on helping clients understand that the disease is the same...addiction doesn't care where you came from. Professionals who are in the fields of medicine, law, education, clergy, law enforcement, CEO's - they will all be affected by this disease like the rest of the population...about 12-15 %. We help people embrace recovery. The job comes back, but now, people can hold the whole thing [professional life] in a healthier way.

2. Do you see many Addiction Professionals in treatment?

Yes, we do. It is a bit of a "classic set up" and by that, I mean that these professionals often have their own life-changing event when they get into treatment. They want to become an addiction counselor so they go into the field. They get busy and listen to client's problems and they may not understand that working in treatment does not equal their own recovery work... they become, 'compulsive helpers' which is another way of saying extremely co-dependent. This can cause burn out.

3. What are some of the major themes that people who are in Recovery themselves and who work in the field, come into treatment with?

Often, the primary focus is others and not their own recovery...it is so easy to move into unhealthy helping behaviours! They forget to take care of themselves and get busy taking care of others.....we use the airplane analogy here, 'be sure to put the oxygen on yourself first before helping others'.....this is so important to work in field of addiction for anyone.

4. How do you help people realize that they have become Compulsive Helpers?

This is a disease that is waiting in the wings for us. We become 'in demand' ....when what we need is to be 'egoless' and serve as a conduit to help others get into Recovery....or else we become puffed up....We become too busy to look after ourselves, and it is a mistake and can be a short fall from grace.....Then we become reluctant to ask for help. People who work in the field sometimes forget they are as vulnerable as anyone else and maybe more so.

5. I had a colleague and friend whom I worked with in a treatment program and after 20 years of sobriety, he relapsed. He was asked to leave but I was surprised at the reaction of some of my colleagues. They were angry with him; they refused to talk with him. This is coming from people who are also in Recovery and working in the field. Is this common?

Blame and Shame become rampant when Love and Tolerance needs to be our code. We need to monitor each other without being Co-Dependent. We have Team Meetings three times a week to discuss our patients and, and this is very important, our transference issues.....that must be discussed. Clients can trigger us. Shame is predictable-as night follows day. If we have blurred boundaries, we are more likely to get into trouble. Being in Recovery means attending meetings, meeting with your sponsor and reading the literature.....whether you work in the field or not. If you don't do these three things, it spells trouble for any one of us.

6. Is there a particular issue that is slippery?

Yes, as already mentioned, the compulsive helping and also, sexual issues. Sexual relationships can be a bigger problem than a relapse from chemicals. I would like to see, say, more retreats for professionals who work in the sector...I think this is a good idea... perhaps a two week refresher course every few years."

There is a great paradox here....folks get a great life through Recovery then life becomes demanding and we lose the Recovery.....a good treatment programme will address the stress in their employee's life so that this doesn't have to happen.

7. Any parting thoughts?

We are baffled by our own behaviours and most people don't understand that these behaviours are symptoms of their disease. I feel it is not a horrible secret I have to keep. I see it as my responsibility [as a person in recovery].... to have the freedom to put it out there - it is one facet of who I am and not the whole package. I am more than willing to share, especially if it helps others understand the disease of addiction.

The Family – Responding to a disease of emotions

Prem Kumar Shanmugam examines the concept of addiction as a family disease. Part 1 of this two part series discusses how family members respond to the disease and introduces the concept of codependency.

We realise today that shame and guilt can become the driving forces for people (both the individual and the family) suffering from the disease of addictions. These groups of people struggle to respond to emotions in a healthy manner and very often turn to addictions or codependent behavior in order to manage the perceived pain. Not only do drugs and compulsive behavior numb the emotions almost immediately but the "affect " also provides immediate gratification. That helps us understand the disease of addiction from psychological perspective of the disease model but what about the family member? What about the loved one who is displaying signs of compulsivity with the emotion as a result of the addiction? Are they addicts as well now as a result of the addiction?

Here we shall start to introduce the concept of codependency and later on I will employ two other theories: ***Learned Helplessness*** and ***Trauma bonding*** to help define this approach. I feel strongly that both these theories have something very much in common and a strong hold in families of people suffering from addictions and we will discuss this in detail.

Family members "saving the addict"

In my practice I find I am able to almost immediately pick out signs and symptoms of the disease inflicting the family. Very often we get into discussions about assertiveness and using "tough love" to get someone into treatment. Of course this concept is something new and the families struggle with it.

"How can I not give him money when he asks for it? He will then go out and steal or borrow from other people? What if he starves on the streets?" The family member's cognitions become so distorted they do not see that they are actually conditioning the addictions further by providing the money. They are allowing the disease to manipulate itself further into the family system. The family is permitting the addiction to manifest further not realising that even if they don't provide the money, their loved one will still continue with the addiction. My favorite response to situations like this would be "Sounds like your loved one is parenting you well…." I normally get some silence followed by a surprised look before a response is heard. Very often we hear how family members repeatedly keep bailing their loved ones out of trouble as a result of their addiction and family members feel guilty or responsible for their loved ones actions. "I should have spent more time with him when he was young…" "I was too busy focusing on working and neglected him.." etc. What they fail to understand is that addiction is a disease and they are simply feeding it. Some people are just predisposed to this disease as a result of deficiencies in their brain, specifically the reward system.

As a result of the continuous codependent behavior, unhealthy response systems are conditioned, allowing the addict to continue with the addiction. Cognitions become distorted and relationships fade away ultimately affecting the individual's spirituality . The addict continues to numb his/her emotions, which are soon perceived as being overwhelming, and people just do not want to feel anymore.

What I find equally interesting is that not only are people parented when they are growing up by their families but as adults, parents are "parented" by their loved ones as well. The concept of codependency is not only a result of childhood upbringing but also "adulthood upbringing" as well. I believe that this is due to the "power of the addictions" and the hold it has on the family. Families function as a unit and the main purpose is to keep the unit intact. The dynamics of the family evolve to ensure the functioning of the family continues immaterial of the resulting dysfunction.

John Bradshaw in his book The Family; A new Way of Creating Solid Self Esteem, describes families as a system. He says that wholeness is the first principle of the system. "…the whole is greater than the sum of its parts. This means that the elements added together do

not produce the system. The system results from the interaction of the elements. Without the interaction, there is no system. " (p. 28)

Bradshaw (1996) describes the second characteristic of the system as the relationship. Families have connecting relationships with each other, when trying to understand the family as a system it is important to appreciate the connections between the individuals. "Each is partly a whole and wholly a part. Each person within the system has his own unique systemic individuality and at the same time he carries an imprint of the whole family system. I am my family as well as a person composed of whatever unique characteristics I have actualised as a person." (p. 28)

There is a strong bond that keeps the system functioning. The objective of the family system is to continue functioning. Especially when the "addiction virus" intrudes into the system, members take on roles to protect and keep the unit intact. Though the objective is the same, it manifests into something unhealthy as now the addictions is allowed and even further reinforced by the new unhealthy roles.

Codependency

Codependency is a concept that describes the dysfunctional relationship or behavior of supporting or enabling another individual's addiction, unhealthy behavior, poor mental health or immaturity. Very often also known as 'relationship addiction', people who are codependent end up in relationships that are not only destructive to themselves but also to the other parties as well.

Codependents tend to react to certain emotions with much exaggeration. Their responses to normal emotions such as guilt or shame can be so overwhelming to themselves that they are constantly anxious and sometimes appear irrational. Emotions like joy can appear to be feelings of elation and they tend to act out more than actually appropriate. Simple daily struggles appear like the end of the world is near. An argument or debate may seem like a threat or challenge.

As we have seen above, codependency causes roles to shift while the family continues to evolve. The bond is so strong that it enables each other into achieving their own selfish needs and generally people tend to appear 'addicted to each other". The addict continues to numb his emotions with the substance or compulsive behavior while the codependent numbs his emotions with the relationships with the addict.

The concept of codependency was first observed in families of alcoholics. The family members were constantly faced with shame, fear and anger. They could not do anything about the alcoholic and were constantly fixing all his problems. The main focus of the family would shift to his addiction while the rest of the family members were unable to manage their own emotions. When there was too much of pain and shame, the focus was on keeping the addict happy thinking that would help, which of course conditioned the addiction further. This became a vicious cycle, making the addict happy, neglecting self in the process, continuing to please the addict; allowing the addiction to "blossom" and fulfilling, the now, codependent's own needs (numbing emotions).

The conditioning continues while the relationship becomes dysfunctional. The codependent needs the addict to function and will even sabotage any recovery in order to "function". Just like addiction, Pia Mellody, refers to codependency as a disease. Mellody claims that codependent people tend to put on an act and try hard to present themselves in any way that will allow them to receive constant approval. They need to feel wanted and important but are actually suffering in pain from intensified feelings of shame, pain, fear and anger (Mellody, 2003).

The question that should be coming to mind now is that, "So when and how do people actually become codependent?" It sounds like the addictions causes dynamics to shift within a family and therefore roles change as a result, and as we now understand, the shift takes place in order to maintain the family and continue functioning. Or do codependents already exist even prior to any form of addiction triggering it and the codependency blossoms when there is an addiction involved? This would mean that some people are predisposed to becoming codependents for some reason. If so, we need to look at what leads people to become codependent when there is no addiction involved in the process and how they are able to manage this form of "addiction".

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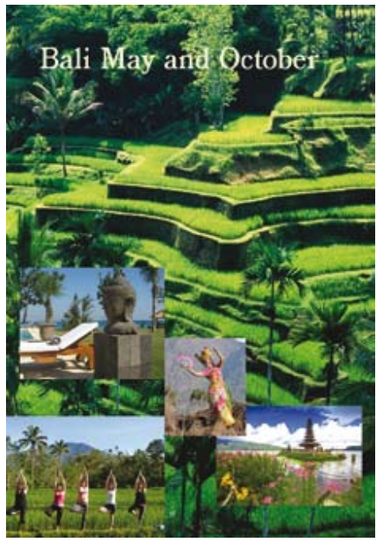

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ELEPHANT INTERACTION THERAPY:

Finding healing in each other.

Clinical psychologist at Vincere South Africa and creator of the elephant interaction program, Catherine Cilliers, describes the unique healing experience offered via interaction with the majestic and resilient elephants of the Knysna Elephant Park, South Africa.

Photography by Petra Meus

The elephants:

The Knysna Elephant Park (established in 1994) has provided a domesticated facility for wild, orphaned elephants in need of a home for the past twenty years and is both nationally and internationally recognised as one of the best rescued,n captive elephant facilities in the world.

The African Elephant Research Unit (AERU) was established at the Knysna Elephant Park in October 2009. AERU is the first elephant research unit dedicated to optimising the welfare of rescued captive elephants in South Africa.

These elephants were orphaned, rejected or abandoned, each one in a desperate search for their last chance at life. The present Knysna Elephant Park herd consists of nine elephants, led by their gracious matriarch, Sally. Each elephant has a history, a story to tell and wisdom to impart.

These elephants that now call the Knysna Elephant Park 'home', have had to adapt to a new environment, accept and be accepted into a new family herd, and develop trust after experiencing rejection and abandonment, some of whom went through unspeakable trauma. The resilience of these animals has always overwhelmed me. These incredible survivors are proof of hope for new beginnings and the resilience of the soul.

We are so privileged to be working together with this particular establishment who have demonstrated consistent care, respect and consideration for the wellbeing of each elephant above all else. Being an avid animal lover, being a part of the Knysna Elephant Park has restored my faith in rescued-captive wild animal parks. The park insists on responsible and educational interactions which allows the elephants to roam free at all times whilst our patients bask in the presence of these awe-inspiring creatures. The elephants are able to chose what and when they want to eat and always initiate contact on their own terms. Observing the interaction between elephant and handler, it becomes clear that this is truly a family that has each other's best interests at heart.

Each elephant has endured its own struggle and triumph. Being able to relate to these individual traumas or challenges has been particularly touching for myself as well as every patient. However, what humbles me most is to be a part of their triumph over adversity. This feeling is also exactly what motivates me to work in the field of addiction.

Photography by Petra Meus

Photography by Petra Meus

The recovering addicts:

Vincere GGZ established Vincere Huguenot in 2014, an inpatient addiction rehabilitation facility located in the idyllic Knysna forest, South Africa. A large majority of our patients come to our facility feeling like this is their last chance. Some who have been through treatment before and continue to relapse lack hope in the process. "What would make this time different?", they often ask as they enter treatment.

Our therapy program, much like the elephant interaction therapy, is designed to redevelop secure attachment styles. A process of reconnection with the self and the other. The nature of recovery depends on this essential element in order to be effective. Healing the insecure attachment styles in addition to the coping strategy, addiction, is what makes this time different.

Head of treatment at Vincere GGZ and psychiatrist, Dr. R. Coppens adds that "issues such as family support and parental protection which is an integral part of an elephant's social behaviour assists the particular needs of the recovering addict in order to cope with the reality of his/her daily life."

The link between us – the lost and found

Whilst other animal assisted therapies have gained recognition, it is my opinion that the relatability factor between humans and elephants is hard to replicate. Elephants rely on their family herds for survival. Each one plays a vital role within the family structure. What amazes me is the ability for these elephants to choose to trust the very species that has directly been the cause of so much grief and loss in the past. This is a true testament of the care they receive from the Knysna Elephant Park.

Additionally, they recreate a new family herd, one that offers safety, mutual trust and unconditional love. This is simply unheard of in the wild. Without the opportunity for relocation and reintegration into a herd these animals would die.

Active addiction mirrors the struggle these elephants go through before joining the Knysna Elephant Park - lack of connection, grief and loss, trauma, behavioural difficulties, rejection and abandonment. Similarly, the recovering addict needs to connect with a secure and recovery-based support structure, reconnect with family and learn to trust again.

I have had the privilege of witnessing patients connect to particular elephants that have experienced similar trauma in the past. This connection based on empathy and respect is what touches the patient in a way that conventional therapy struggles to achieve. Patients who are considerably resistant, dissociated or defiant have experienced an awakening of vulnerability and humility in relating to the elephant and triggering their own emotions that have been suppressed during active addiction, and for some, a large majority of their lives.

Developing the relationship

With the assistance and supervision of Dr Debbie Young (head or AERU), Mr. Sias van Rooyen (elephant manager) and Mr. Geoffrey Phiri (head elephant handler) at the Knysna Elephant Park, the elephants and patients meet once a week to explore, touch, feel, relate and most of all, learn to trust each other. Dr. Debbie Young explains, "Interaction doesn't always have to mean physical contact. Being amongst the herd from a distance also touches the spirit."

Patients are familiarised with each elephant's history and educated on factual information about the park and its inhabitants. Weekly topics such as coping and grief and loss that form part of the elephant interaction therapy are presented by Sias and Geoffrey from the elephant's perspective. Psychologists then reflect on the human and individual perspective of these specific topics with the patients post interaction.

Sias van Rooyen explains, "To be part of so many

COVER STORY

Photography by Petra Meus

Photography by Petra Meus

aspects of this company, rehabilitation, research, our domesticated herd we still learn every day and it is quite an honour to be a part of these elephants and their journeys, some good and some sad."

According to Dr. Young, "The elephants initiate contact, not the patients. This makes the interaction more powerful and displays trust from the elephants towards the patients." During a discussion with Dr. Debbie Young, she recalled her most powerful memory of our elephant interactions together, "The moment the young girl looked into Keisha's (the elephant's) eyes and found an instant connection. As if they were relating to each other's life stories. This level of connection was amazing to see. I have never been so moved before."

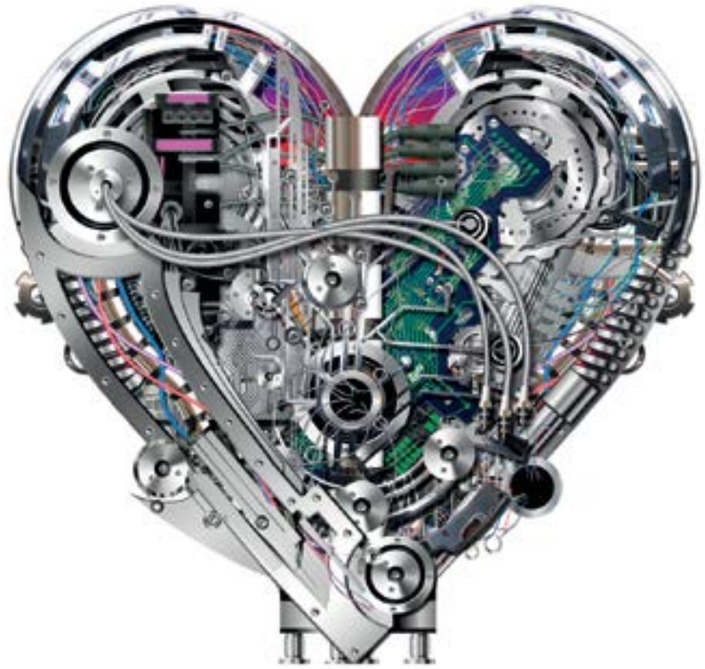
My experience of this soul awakening interaction offers the recovering addict an opportunity to be reached on a level void of his/her defenses. I have not found other modalities of therapy to be this effective at accessing and healing the core self simply through relating and connecting with these resilient and graceful beings.

The power of us:

As we surrender to the power of healing through each other, I continue to grow in awe of these courageous people and elephants who have been so lost and hopeless yet found their redemption and hope in each other, as well as the support and care offered by both the park and Vincere Huguenot.

While I walk back with the patients and elephants to end off our session, I am comforted by knowing that this time will be different. For both the patients and the elephants. Together.

Article written by Catherine Cilliers, South African clinical psychologist and therapeutic director of Vincere Huguenot South Africa.Catherine Cilliers developed the elephant interaction therapy program and currently runs it together with her team in Knysna, South Africa. Photography by psychologist, Petra Meus.



A Culture of being Always turned on

The Hudson Centre's ***Ashley Howard*** considers the current state of sex addiction treatment and examines ways in which developing technologies have influenced sexual behaviours….

The prevailing opinion that marks out the current generation is the notion of always being 'turned on'. This interpretation not only extends to technology but also to the growing body of arousing and absorbing sexually enhanced imagery and related technology. In the culture of always being turned on; 'did someone leave the lights on?' to coin a classic colloquialism, - did the previous generation give us something that has now created a legacy playing out in the world of compulsivity? 'Always turned on: sex addiction in the digital age' by Robert Weiss and Jennifer Schneider examines this subject in detail.

Through the exploration of sexuality and sexual addiction it evaluates the impact of technology that could be argued to contribute to expanding and increasing technologically enhanced sexual practices. Their work also balances the arguments for technology having an impact on the prevalence of sexual addiction across generations. However, to assess technology in relation to sexual behaviours, it is important to know the defining characteristic to all addiction, namely a behaviour that has impacted a person's life to the point of dangerous consequences. The classification of sexual addiction is denoted by ten core elements, which define any behaviour that causes harm to any individual. These are: loss of control, compulsive behaviour, efforts to stop, loss of time, pre-occupation, inability to fulfil obligations, continuation despite consequences, escalation, losses and withdrawal (Carnes, Don't Call it Love: Recovery from Sexual Addiction, 1991). In relation to 'Always turned on.' it posits that no mutually exclusive relationship exists between technology and sexual addiction. Although it argues that technology will enhance an underlying compulsive problem and develop into an addiction. Therefore, the recommendation is that individuals become aware of the impact that technology is having upon their behaviour.

Internet development:
It is important that we open the discussion about how technology has contributed and potentially influenced sexual behaviour throughout the decades. The nature of sex and sexuality has been rethought in the current generation as it pertains to sex. The relatively straightforward and established ways of two persons chance meeting has now morphed into a transactional interaction whereby the exchange is simply the act of orgasm as opposed to intimacy and relationship. Is the latest generation moving the development of intimacy into a new digital age? Or is the current consciousness

on this subject a regression to traditional values? I will discuss below the rudiments of technology and the influences it has on development and interaction throughout the world, especially the world of sex and relating. I will also explore the current state of sex addiction treatment and discuss porn addiction as a separate branch of compulsive sexual behaviour.

Technology through the ages:

With the proliferation of approaches to sexuality in the modern age, it is important to remember the origins of changing sexual behaviour and expanding the way sex and relationships were conducted in a digitally rudimentary era. The early expressions of sexuality and pornography were developed in material form with magazines and images. It was VHS technology that brought pornography into the mainstream and enhanced the availability and imagery that was available. With the advent of the Internet bringing in a new era in the exposure and expression of sexuality the lens through which we view sex was changed.

This single technological advancement paved the way for the latest trends of online hard-core extreme pornography that exists today. The forefathers of pornography developed a medium that would traverse the ages and in turn provide the potential backdrop for the alternative nature of relating. Pornography for any healthy individual is not necessarily a problem, merely a behaviour they can engage with or not. In contrast the individual with sexual addiction or a compulsive behaviour to porn is unable to regulate usage and this can potentially lead to some of the ten criteria (Weiss & Schneider, Closer Together, Further Apart: The effect of Technology and the Internet on Parenting, Work, and Relationships, 2014).

The current state of sexual addiction treatment:

The emergence of more sexual compulsive and extreme behaviour has increased the need for the sexual addiction therapist and structured behavioural approaches to treating the sexual addict. The prevalence of porn use has been escalating year on year for decades, on one site in particular that publishes the data on internet traffic related to pornography, Pornhub experienced over 21.2billion visits last year and 87billion videos were downloaded. The scale of this epidemic could be considered a public health issue, due to the escalation and increasing rates of violence against women. However, not many individuals especially in the UK show up for treatment, which prompts the question, what is happening with pornography use and the individual in the UK?

A recent article Gola et al (2016) examined the nature of pornography with problematic usage. Through exploring the consequences rather than the quantity of usage the problem of pornography was established. In many respects in therapeutic treatment the relationship to the behaviour is one of the fundamental characteristics of an addiction problem. Porn usage is almost immaterial to the nature of addiction, understanding the effect it has and the damaging consequences that can occur is the area the researchers were focused on. The study posits that pornography use is akin to substance abuse disorders in the way that the amount of usage is irrelevant to the damaging consequences it can produce in a person's life. One of the key findings from the study demonstrated that negative consequences were correlated with treatment seeking for problematic porn use. This doesn't necessarily add anything to the subject area although understanding that the amount of pornography someone is using isn't the main issue because as stated before a healthy individual could view porn at high levels and not experience any related negative consequences. Therefore understanding the impact of pornography for 'at risk' individuals is essential as it pertains to treatment for sexual addiction.

> *"Through exploring the consequences rather than the quantity of usage the problem of pornography was established. In many respects in therapeutic treatment the relationship to the behaviour is one of the fundamental characteristics of an addiction problem."*

In conclusion:

It is essential for clinicians to know how to treat and tailor behavioural techniques to working with all aspects of this problematic behaviour. The use of "always turned on" is a great reference point for improving the knowledge and understanding the influence that technology plays in the role of problematic sexual behaviour. Overall, through the exploration of the wider aspects of addiction and the part that technology has to play we are able to understand ourselves better and in the process understand each other.

IN RECOVERY

This new section of intervene goes 'back to basics'. We look at recovery through the eyes of those who are in recovery and explore an approach to well being via a range of, often very personal, perspectives.

In every issue we intend to focus on recovery enhancing activities, healthy eating, mindfulness, relationships, volunteering , yoga and more.

In this issue we take a fresh look at nutrition and healthy eating – what food does the recovering addict need to avoid and what really helps – we follow this with two delicious recipes.

In the spirit of getting back to fundamentals, Noel Mcdermott kicks off our new section with some useful facts and strategies...

RECOVERY STRATEGIES

The US substance abuse department (SAMHSA) defines addiction recovery as 'a process of change through which an individual achieves abstinence and improved health, wellness and quality of life'

They go on to provide 12 guiding principles of recovery

1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery is supported by peers and allies.
8. Recovery emerges from hope and gratitude.
9. Recovery involves a process of healing and self-redefinition.
10. Recovery involves addressing discrimination and transcending shame and stigma.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality. It can, will, and does happen.

I generally wish all my clients a slow and long recovery, hopefully one that lasts a lifetime.
Recovery is at the same time an intensely individual process, a collective endeavor and a well-researched area or personal development. Core to long-term stable recovery is an attitude of open-minded learning and discovery.
Whilst it's very personal and needs to be individually tailored there are some well known ways of improving your recovery.
In addition to thinking about the guiding principles above research also suggest long term stable recovery is helped by:

• Meditation: mindfulness in particular helps in many areas of recovery – impulse control – emotional regulation – stress reduction – improved decision-making – relapse prevention – management of depression and anxiety. Additionally Loving Kindness based techniques help with trauma management
• Yoga: evidence suggests that yogic breath work in particular helps similarly to mindfulness in trauma reduction, anxiety and depression management, and yoga practice also it improves muscle tone, flexibility, joint function, respiration and blood circulation
• Exercise: the mental and physical health benefits of regular exercise are well known. It will help with mod, sleep, and weight management. Currently one of the major relapse points is around over eating. Evidence is suggestive that regular exercise break compulsivity. So it will help in relapse prevention
• Psychotherapy: recovery focused therapy will help with insight, developing new life skills, trauma reduction, relapse prevention, repair of attachment trauma, mood management, improved decision making
• Healthy Eating: unhealthy over eating is a major relapse point particularly amongst men currently. Obesity is also a national public health issues. Learning and maintaining healthy eating habits is crucial for all people in recovery, not just those who identify as primarily eating disordered. Healthy eating not only means a healthy body but it improves your self-esteem
• Volunteerism: Relapse is much harder when connected to others. The sense of duty and obligation is a useful motivation to stay well. Additionally being of service to others less fortunate gives perspective and improves self-esteem and worth. It also does make the word a better place.
• Gather experiences: learn and grow and develop. By this I mean, travel, join adult education classes, learn o play an instrument, make memories. Having a lot of things to look forward to in your diary and life will make using look less appealing! **Noel McDermott**

RECOVERY LIFESTYLE

Intervene 157

RECOVERY COACH DUFFLYN LAMMERS
ASKS DO YOU MANIPULATE OR NEGOTIATE AND
OFFERS ADVICE ON HOW TO TELL AND WHAT TO DO

Negotiating has a tone of "us," as in, how can "we" find some common ground? A tone of goodwill. This involves two or more people having an open discussion of whatever task or issue is at hand and finding a compromise where both parties can take some satisfaction. Manipulating has a tone of "I win, you lose." A tone of convincing. This happens when one or more parties introduce guilt or fear into the conversation as a means of controlling the other's feelings, thoughts, and behaviors.

Many of us in recovery have habits of manipulating that we are not aware of, or we may slip in and out of awareness. Is it any wonder considering what many of us have been through? The first step to negotiating not manipulating is to become aware of one's own behaviour. Begin to notice if you...

• Guilt others into doing things your way
• Scare people into doing things your way
• Negate your needs in the interest of maintaining closeness with others
• Hold others responsible for choices you have made

Take some time to examine your own style and the style of those you are in relationships with. Remember, you can't change anyone but yourself. Others may respond differently to you, or they may not. This is also great information. Communication is about sending and receiving thoughts and ideas. There is infinite nuance in tone of voice, body language, word choice, rhythm, and so on. When we are authentic in our communication we do not experience any ambivalence because we are being honest with ourselves and with those we are negotiating with.

One clue that someone is manipulating is when their actions do not match their words. Can you observe this in yourself and others? Another clue that we might be manipulating is when we fail to listen.
Sometimes we get so wrapped up in what we will say next (in order to get what we want from the other person) that we do not really hear what the other party has said.

On the other hand have you ever had someone listen to you, and when you've finished speaking repeat back to you what they heard and say something like, "It makes sense you would feel frustrated." Feels much better doesn't it? Once we have become aware of our habits, we are ready to make changes. Here are a few simple steps to becoming a better listener - a negotiator rather than a manipulator.

• Breathe deeply and relax. Trust yourself and others enough to just be present. Give the conversation the time and space it deserves.
• When you are having a conversation, note any tension in your body, any desire to jump in, any urge to "teach" or correct. Stop and ask what your intention is before you speak.
• Make statements of truth. Resist the urge to tell stories or bring up the past. You will connect much more effortlessly if you stay in the moment.
• Once the other person has finished speaking, summarise what they have said aloud, and reflect back to them the feelings they have expressed verbally and/or what you have intuited.

A FRESH PERSPECTIVE ON REHAB FOOD

AMANDA LENNON OFFERS A FRESH PERSPECTIVE ON REHAB FOOD

Three years ago I was treated at Gladstones Clinic for addiction. Research has shown that substance abuse rehabilitation centres typically offer stodgy comfort food that is lacking in nutritional benefits. Thankfully though Gladstones consider nutrition to be a crucial element in recovery from addiction.

On re-visiting Gladstones I discovered a fresh, forward thinking attitude towards healing that incorporates healthful food. They emphasise the importance of healthy eating with their clients and have constructed a dietary menu with Executive Chef Darren Taiwo in order to enhance their clients' experience while undergoing treatment.

They follow a high protein, high plant based diet with pulses and whole grain, which is free from wheat, gluten and sugar. They personalise their menu to meet the specific needs of the individual client. Chef Darren explains: "Many of our clients are divorced from their relationship with food, we re-establish this relationship empowering them to grow and flourish".

Chef Darren explains that they take a holistic approach to recovery and went on to discuss how food is used as a form of therapy. "We are trying to rebuild our clients' relationships with food".

Darren emphasises the importance of food in substance abuse recovery, "food is nourishment, our intention is to lead them along a path of happiness, empowerment and enhanced wellbeing, food is just one way in which we do this".

Clients have embraced Gladstone's nutritional approach and the response has been overwhelmingly positive.

Darren's Delicious Healthy Chocolate Brownies

Darren's Delicious Healthy Chocolate Brownies
These brownies are wonderfully fudgy and decadent whilst being guilt free – a favourite with clients

Ingredients for 12 Brownies
- *2 tins of cooked black beans*
- *230g coconut oil (room temperature) plus a little extra for greasing*
- *4 eggs*
- *85g unsweetened cacao powder*
- *150-180 ml maple syrup*
- *1 ½ tbsp. vanilla extract*
- *1 teaspoon of coffee extract or pure vanilla extract*
- *Pinch of sea salt*

METHOD
- *Preheat the oven to fan 170C/Gas mark 5. Grease the inside baking dish. Rinse the black beans and leave to drain. Melt the coconut oil in a saucepan over a gentle heat then set it aside.*
- *Place the beans, eggs, cacao powder, 150ml of maple syrup and the vanilla or coffee extract into a food processor with the sea salt, then blend until smooth.*
- *Add the melted coconut oil very slowly so as not to cook the eggs, add more of the remaining maple syrup if required.*
- *Pour the brownie mixture into the prepared dish and bake for 40-45 minutes, until the brownie feels firm but springy and the surface is cracked.*
- *Cool before cutting into 12 squares.*

****Refrigerating the brownies makes them wonderfully fudgy****

LIV'S RECOVERY KITCHEN

BY AUTHOR AND NUTRITION AND RECOVERY ADVOCATE, OLIVIA PENNELLE

What if I told you that you could make the early days of your recovery easier?

We arrive into recovery damaged; not only mentally and emotionally, but physically. Physically, my liver was scarred, I had gained ten stone, and suffered with severe skin problems. Mentally, I was numb, wired, drained and in a state of shock. If someone had told me that my body would completely heal itself and I would lose 50 pounds of that excess weight and learn how to gain more energy, I probably wouldn't have believed you. Here I explain how...

First off, the liver is a regenerative organ and, even though some scarring can become permanent with excessive use of drugs and alcohol, I was very fortunate that my body was able to completely repair itself. It did this by my stopping using.

Today, four years in recovery, my life is significantly more stable. I am energised (mostly), I feel great and I have a lust for life. I just wish someone had told me what I know now. So it is my mission to share it freely, and liberally!

How did I create more energy and a sustainable mood? Simple: decent macronutrients - the main food groups: protein, carbohydrates, fruit & vegetables, and fat - is how. And exercise. But in this article, I'm going to talk about the most powerful for repair and energy - protein. Let me explain why...

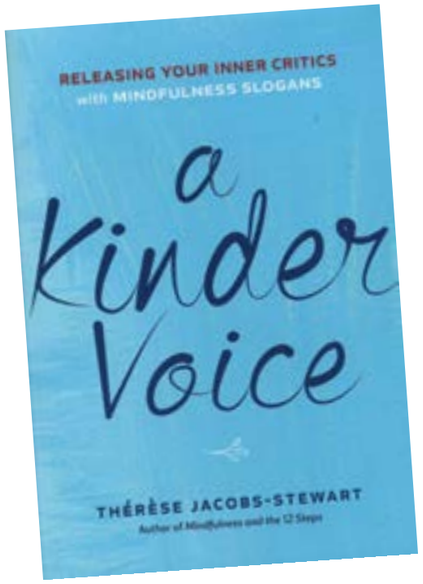
The function of protein, essentially, is for energy production, growth and repair of cells. It is fundamental to cell repair and functioning; the necessity of which is at an all time high when we enter recovery, given the damage we have done to our bodies in using. Another function of protein, is to keep you feeling full - the body requires more energy to digest protein, than, say carbohydrate (rice, pasta, bread, oats etc). Frankly, we don't eat enough good quality protein. It is recommended that we eat a palm sized amount for women, and two palms for men at every meal. This is why when you have a bowl of pasta you don't always feel satisfied - because the body is still requiring protein, especially in the early days when the protein requirement is even higher.

So, in essence, eat less sugar and eat more protein! Take care of your body, you only have one.

How? Here, I have a great recipe for a whopping amount of protein: Pecan & Parmesan Crusted Chicken. For more nutritional information about this recipe, click here (link: www.livsrecoverykitchen.com/all-recipes/category/lunch)

Pecan & Parmesan Crusted Chicken

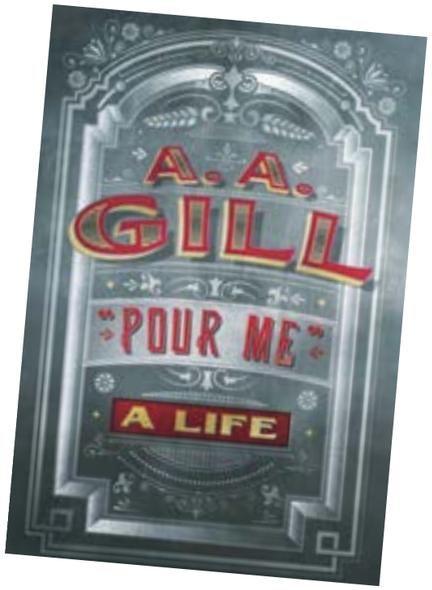
Ingredients
4 chicken breasts
2 eggs
80g pecans
6 tbsp parmesan cheese
4 tsp onion powder
2 tsp dried oregano
to taste seasoning
METHOD
1. Pre-heat the oven to 180. Grind the pecans and parmesan in a food processor until they form a fine crumb. Mix with onion powder, seasoning and oregano;
2. Whisk the eggs and add a touch of milk (optional) and place in a shallow dish;
3. Dip the chicken into the egg wash and then into the crumb mix, covering both sides of the chicken breast;
4. Bake in the oven for 20-25 minutes until brown and cooked through.



A KINDER VOICE – RELEASING YOUR INNER CRITICS WITH MINDFULNESS SLOGANS
Thérèse Jacobs-Stewart
Published by www.hazelden.org
ISBN 978-1-61649-639-5
£12.99

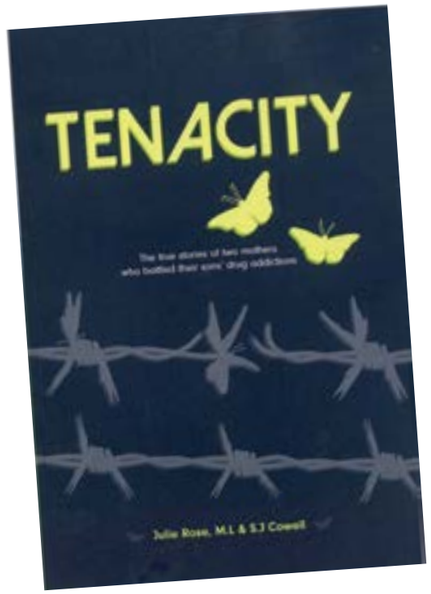
You've probably heard it said, and have maybe spoken the words yourself, "I am my own worst critic." A negative internal commentary contributes to a lack of confidence and low self-worth in many people.
Well-known mindfulness meditation teacher and author Thérèse Jacobs-Stewart offers one of the most effective approaches to calming a self-critical mind: the ancient Buddhist practice of using compassion slogans. Combining thought-awareness, loving-kindness practice, and mindfulness meditation, this simple, time-tested method can be used throughout the day to quiet your critical voices and ease the mind.

Through short, accessible phrases, you will learn to reorient your thinking when your inner critic shows up. Instead of making a negative thought stronger by fighting it, you will learn to let thoughts dissipate through lack of attention. When you remember to "begin kindness with yourself," you will find that keeping a compassionate perspective on all that you do and say will allow you to give your inner critic a kinder voice.



POUR ME A LIFE
AA Gill
Published by www.orionbooks.co.uk
ISBN 978-0-297-87082-1
£20.00

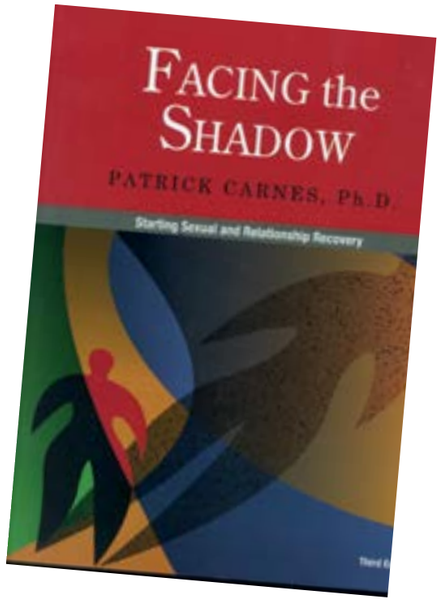
A.A. Gill's memoir begins in the dark of a dormitory with six strangers. He is an alcoholic, dying in the last-chance saloon - driven to dry out, not out of a desire to change but mainly through weariness. He tells the truth - as far as he can remember it - about drinking and about what it is like to be drunk. Pour Me is about the black-outs, the collapse, the despair: 'Pockets were a constant source of surprise - a lamb chop, a votive candle, earrings, notes written on paper and ripped from books,' and even, once, a pigeon. 'Morning pockets,' he says, 'were like tiny crime scenes.' He recalls the lost days, lost friends, failed marriages ...But there was also 'an optimum inebriation, a time when it was all golden, when the drink and the pleasure made sense and were brilliant'. Sobriety regained, there are painterly descriptions of people and places, unforgettable musings about childhood and family, art and religion, friendships and fatherhood; and, most movingly, the connections between his cooking, dyslexia and his missing brother. Full of raw and unvarnished truths, exquisitely written throughout, Pour Me is about lost time and self-discovery. Lacerating, unflinching, uplifting, it is a classic about drunken abandon.



TENACITY: THE TRUE STORIES OF TWO MOTHERS WHO BATTLED THEIR SONS' DRUG ADDICTIONS
By Julie Rose, M.L & S.J Cowell
Published by CreateSpace Independent Publishing
ISBN 978-1-523665983

Friends, Julie and Marilyn individually depict their long and painful struggle to overcome their sons Heroin addictions. The fight which spanned over a decade, took them to some of the darkest places they never knew existed. Both homely with family values and morals, they found themselves mixing in a world of unsavoury characters and drug dealers. It was the late 1990's and just prior to the explosion of a user epidemic.

Alone and frustrated their tenacity kept them going, never losing sight of the one common denominator to 'get them right'. Scott and Stephen, born with faces of innocence and raised on a council estate, had the world at their feet and every opportunity of a bright future. However nobody could have predicted the path they would go down when reaching their late teens…. Against the backdrop of the harrowing catalogue of events that occurred, seeping through is support, love and unity. The writers have delved deep into their backgrounds to identify whether a connection from their past led to their sons' addictions.



FACING THE SHADOW
Patrick Carnes PH.D
Published by Gentle Path Press
ISBN 978-0-9850633-7-5
$34.95

For all addicts, a moment comes when they realize they have a problem. There is sudden clarity—the insight that life has become unmanageable. That moment, however, is fragile. It is easily lost to craving and denial. People struggling with sex addiction find the old refrains creeping back into their thinking: My situation is different. . . . This will all blow over. . . . People are over-reacting to my behavior. Or, This is hopeless. I'm just too perverted to change.
"If any of those thoughts occur to you, you are exactly where you should be," notes Dr. Patrick Carnes in the introduction to Facing the Shadow. Starting with those gentle words, he guides readers through a series of reflections and exercises that pierce denial and light the path to healing from sex addiction.
Facing the Shadow, used by thousands of therapists with their clients, is based on the thirty-task model of recovery from addiction that forms the basis of Carnes's work. This newly revised and expanded edition takes readers through the first seven of those tasks, including specific performables that are built in to the exercises. The model also supports Twelve Step recovery programs.

Horse/Human Trauma Exchange

Mike Delaney Describes the Early Days of Equine Therapy and Details the Dynamic of the Horse/Human Trauma Exchange

In 2004, the early days of introducing equine therapy to the addictions industry, we witnessed very exciting times – in fact we had a captive audience; individuals who were in residential treatment. Initially it was about feeling our way and following the EAGALA manual, which gave a variety of therapeutic exercises proving very effective with this client group.
The types of groups that this therapy works well include clients who have experienced, abandonment, control, impatience, anger and more commonly fear of failure and resignation.

As I worked more and more with this form of therapy I began to understand horse behaviour, albeit very slowly and tentatively and began to witness similarities in behaviours between client and horse.
My very first experience of witnessing a horse/human trauma involved a client, a very frail lady in her 30s, who had battled anorexia for many years. She had been struggling with her failing health and her inability to change her behaviours.
Along with another horse professional who had completed equine training we introduced the client to the horses. One of the fields had five mares with three or four foals. Upon opening the gate, the herd rushed up to great the client, ignoring myself and the other professional. At the time I lacked experience in working with so many horses and relied on the other therapist to translate what was happening.

The adult horses stayed close to the client, even pushing the foals towards her so she could interact and touch them. The professional working with us had not witnessed this behaviour in his years working with horses; the client became very relaxed and looked happy. Whilst the herd had wandered off (although staying in close proximity) one adult mare remained. As the client stroked the horse's face I asked what was going on for her at that time? The client's response was that she hadn't felt the breath of another living being so close to her in many years; she began to experience an array of emotions, and then angrily asked why men became so rough during sex? The client disclosed a major sexual trauma that she had never spoken of previously, she stated this directly to the horse, in full knowledge that myself and the other therapist could hear her. Upon making this disclosure the client began to engage with a full programme of recovery and eventually regained weight. She later returned to the rehab to re visit the horses that instantly recognised her.

One of the companies LEAP has worked with is London Underground. They realised that equine therapy could help to unblock some of their more complex clients. The bulk of the clients who benefited from this therapy had suffered the trauma of witnessing 'jumpers' on the underground and the people employed to retrieve and clean up after the trauma of the tragedy. I learned of the trauma through equine work after we had some clients come through following the 7/7 bombings. They'd begun to abuse and drugs as a means to "forget" what had happened on that terrible day. The stress of continuing to work, not knowing whether there would be another attack, not knowing if there was another suicide bomber on the trains or the platforms was overwhelming. In sessions the horses would simply approach them and "be" which was enough to trigger an emotional response on most occasions. Clients would cry which seemed to be cathartic, reporting that they felt lighter, less depressed and generally better. After several sessions they were much happier and more confident around the horses. Without prompting or exploring areas, the client would release their feelings and then state that "the horse knows…it's gone!"

Anxiety and addiction

Kathryn Starron and Elisabeth Escobar consider the connection between anxiety & addiction: A complex yet common problem

It is difficult enough to cope with a mental health disorder but when dealing simultaneously with addiction – known as dual diagnosis - it can be even more challenging. In such cases, the clinician must ascertain if the anxiety was prevalent prior to the substance abuse - an important component to treating this particular dual diagnosis issue.

Treatment must begin with assessing the client for a previous anxiety disorder. This could be as simple as asking the client if he or she felt anxious before using on a regular basis. Most people experience anxiety at different times, (in childhood, separation anxiety, adolescents with social or performance anxiety, or adults with generalised anxiety) and for different reasons (trauma, loss/separation, aging or career issues). Having a client reflect back on anxious times in their life, using the traditional metrics such as frequency, duration and intensity, can help clarify just how prevalent an anxiety disorder is in the client's life. On occasion, clients are unable to accurately identify anxiety. In cases as such, administering the Beck Anxiety Inventory (BAI) may prove helpful. Whether you obtain data from the client's verbal history or from the self-reported BAI, the therapist can begin to accurately assess the client.

From there, a clinician has three alternatives:

1. If a client states they had little to no anxiety, or they do not see any connection between anxiety they have experienced and their onset of use, then one could move forward with addressing the addiction as the primary diagnosis.
2. If, however, the client states he or she has suffered with anxiety for 6 months or longer, then it is important to help the client see these disorders as separate disorders that have overlapped.
3. For the client who reports feeling anxious only after stopping using (as he or she is no longer able to "self-medicate") it will be important to help the client focus on recovery, as these feelings frequently disappear.

A treatment program that includes a Twelve-Step process, CBT and/or Buddhist thinking can help people cope with both addiction and anxiety. Additionally, overcoming fears by talking about them and perhaps using an Exposure/De-sensitisation approach can benefit clients by introducing new ways to think about their feelings, cravings and traumas.

Clients often display anxiety about the pain they have caused others while using. Another prominent fear relates to relapsing and leaving treatment. An additional factor is that addicts often suffer from Post-Acute Withdrawal Syndrome; therefore, helping clients understand how anxiety is manifested, both psychologically and physically, is important. Often, once clients understand anxiety, they are more likely to cope with it. They don't feel like they are "going crazy" or that anxiety will be with them forever.

Stephanie Morich, a licensed social worker from Monroe, Michigan, has worked with addiction and anxiety in clients for almost 30 years. She states, "often addicts seek a secondary diagnosis because they thought that once they got clean and sober, they would no longer experience these feelings. It is important to help addicts understand that by working their program, the uncomfortable feelings of anxiety will usually abate. If they do not, then we can discuss what it means to have a bona fide anxiety disorder".

Robyn Brickel, a licensed marriage and family therapist, based in the Washington D.C. area, notes, "Underlying issues accompany addiction. Addicts use to cope, survive, and feel less badly and so addressing the underlying issues is a must or else the client is likely to relapse or just continue using. Often, anxiety is part of having a trauma history and the client is in a chronic state of hyper arousal". Ms. Brickel, who has studied Judith Herman, Janina Fisher and other's work on trauma, understands that stage one of the treatment of trauma is "stabilization". It is what must be done first when working with this population. She refers to it as "Trauma Informed Care (TIC)." While the anxiety may be a chemical imbalance, it may also just be a chronic emotional state, the underlying causes and issues must be dealt with. Often there is an attachment issue or other trauma at the heart of the anxiety that keeps the nervous system actively in hyper-arousal – prepared for danger. The therapist can look at this from a TIC perspective, understanding that, according to Ms. Brickel, "the nervous system is still prepared for danger. My goal is to help clients learn to calm their own arousal states".

Active addiction, by nature, creates anxiety. Clients often report increased anxiety as they come down from the high or, increased levels of anxiety when trying to find ways to sustain their high. It was

once said that alcoholism is only 10% alcohol and 90% "Ism", meaning that addiction is more than just "getting high" or "straight with the world." It is about all of the behaviours and cognitive distortions, including obsessions that come along with active use. For many, addiction has an overlap with OCD criteria. For example, the obsessive thinking about use, how to use, when to use, as well as the compulsion TO use, even when the client experiences reservations. The internal conflict can create or amplify pre-existing anxiety. The unfortunate outcome for many is to use the substance to decrease the level of anxiety, which, in turn, starts the cycle over.

Individuals with social anxiety are often reluctant to attend Twelve-Step meetings. Encouraging clients to attend despite their anxiety is important. Clinicians can explain to these clients, that many first timers do not realise they can "pass" or state "I'm only here to listen". Educating clients on these options may decrease their anxiety. One can gain accurate information and strength, simply by attending twelve-step meetings. Once their anxiety is lessened, and then they can begin to share, which is a crucial aspect of recovery.

We have seen many clients over the years struggle with anxious thoughts in relation to their use. Recovery is not only recovery from the disease of addiction, but from the diagnosis that may accompany the addiction, whether it is a previous condition or a new diagnosis. Freedom from worry, fear and negative thinking is helpful in relapse prevention too. Clinicians should acknowledge their clients fears so that clients feel safe to explore these fearful thoughts. That is often the hallmark for working through cognitive distortions; exploring the type of thinking that most likely started the vicious cycle that keeps people stuck in dysfunction. Therapy with a trained professional can help make the process a bit smoother and a lot healthier, resulting in long lasting recovery.

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
cardiffhopefortoday@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.

Where to find... treatment

England	Telephone	Website	Email	Alcohol	Drugs	Eating disorders	Gambling	Dual diagnosis	Detoxification	Sex Addiction
ACORN TREATMENT & HOUSING AKA ADAS 130 Mile End Lane, Stockport. SK2 6BY	T 0161 484 0000	www.acorntreatment.org	ed.smith@acorntreatment.org	●	●					
ADDICTION RECOVERY CENTRE 20 Landport Terrace, Portsmouth, Hampshire, PO1 2RG	T 0800 6199 349	www.arcproject.org.uk	info@arcproject.org.uk	●	●				●	
ADDICTIONS UK home-based addictions treatment Based throughtout the United Kingdom and the Republic of Ireland	T 0845 4567 030	www.addictionsuk.com	info@addictionsuk.com	●	●			●	●	
ANA TREATMENT CENTRES Fleming House, Waterworks Road, Farlington, Portsmouth, PO6 1NJ	T 023 9237 3433	www.anatreatmentcentres.com	info@anatreatmentcentres.com	●	●			●	●	
ARK HOUSE TREATMENT CENTRE 15 Valley Road, Scarborough, YO11 2LY	T 01723 371869	www.arkhouse2005.com	ark.house@virgin.net	●	●	●	●			●
BLUE SKIES RECOVERY 50 South Street, Farnham GU9 7RN	T 203 151 7811	www.blueskies-recovery.com	info@blueskies-recovery.com	●	●	●	●	●	●	●
BOSENCE AND BOSWYNS TREATMENT SERVICES 69 Bosence Road, Townshend, Hayle, Cornwall, TR27 6AN	T 01736 850006	www.bosencefarm.com	jeremy@bosencefarm.com	●	●			●	●	
BROADREACH 465 Tavistock Road, Plymouth, Devon, PL6 7HE	T 01752 790000	www.broadreach-house.org.uk	enquiry@broadreach-house.org.uk	●	●	●		●	●	
BROADWAY LODGE 37 Totterdown Lane, Weston super Mare, BS24 9NN	T 01934 812319	www.broadwaylodge.org.uk	Mailbox@broadwaylodge.org.uk	●	●	●	●	●	●	
CASSIOBURY COURT Richmond Drive, Watford, Hets, WD17 3BG	T 01923 804139	www.cassioburycourt.com	info@cassioburycourt.com	●	●		●	●	●	
CHY COLOM Agar Road, Turo, Cornwall. TR1 1JU	T 01872 262414	www.addaction/chy.org.uk	chycolom@addaction.org.uk	●	●			●		
CLOSEREACH Longcause, Plymouth, Devon, PL7 1JB	T 01752 566244	www.broadreach-house.org.uk	enquiry@broadreach-house.org.uk	●	●	●	●	●		
CLOUDS HOUSE East Knoyle, Salisbury, Wiltshire, SP3 6BE	T 01747 830733	www.actiononaddiction.org.uk	cloudshouse@actiononaddiction.org.uk	●	●			●	●	
CASSIOBURY BLACKPOOL CENTRE Queen's Promenade, Blackpool, United Kingdom , FY2 9NS	T 01923 804 139	www.cassioburycourt.com/locations-blackpool	darren@cassioburycourt.com	●	●		●	●	●	
COMMUNITY RECOVERY ESSEX 9 Coggeshall Road, Braintree, CM7 9DB	T 01376 349237	www.actiononaddiction.org.uk	info@actiononaddiction.org.uk	●	●					
GLADSTONES CLINIC Lexham House, 28 St Charles Square, London W10 6EE	T 02089648516	www.gladstonesclinic.com	admin@gladstonesclinic.com	●	●	●	●		●	
GLOUCESTER HOUSE TREATMENT CENTRE 6 High Street, Highworth, Swidon, Wiltshire, SN6 7AG	T 01793 762365	www.gloucesterhouse.org.uk	Ros.rolfe@salvationarmy.org.uk	●	●			●		
HEBRON HOUSE 12 Stanley Avenue, Thorpe Hamlet, Norwich, NR7 0BE	T 01603 439905	www.hebrontrust.org.uk	info@hebrontrust.org.uk	●	●			●		
HOPE HOUSE 52 Rectory Grove, London SW4 0EB	T 020 7622 7833	www.actiononaddiction.org.uk	hopehouse@actiononaddiction.org.uk	●	●	●		●		
KENWARD BARN Kenward Road, Yalding, ME18 6AH	T 01622816086	www.kenwardtrust.org.uk	admissions@kenwardtrust.org.uk	●	●	●		●		
KENWARD HOUSE Kenward Road, Yalding, ME18 6AH	T 01622816086	www.kenwardtrust.org.uk	admissions@kenwardtrust.org.uk	●	●	●		●		
KENWARD (THE MALTHOUSE) Church Street, Ukfield, TN22 1BS	T 01622816086	www.kenwardtrust.org.uk	admissions@kenwardtrust.org.uk	●	●	●		●		

Where to find... treatment

England	Telephone	Website	Email	Alcohol	Drugs	Eating disorders	Gambling	Dual diagnosis	Detoxification	Sex Addiction
LIBERTY HOUSE 220 Old Bedford Road, Luton, United Kingdom,	T 0203 1310 727	www.libertyhouseclinic.co.uk	info@libertyhouseclinic.co.uk	●	●	●	●	●	●	●
LEY COMMUNITY Sandy Lane, Yarnton, Oxon, OX5 1PB	T 01865 373108	www.ley.co.uk	karen.dale@leycommunity.co.uk	●	●		●	●	●	
LIFE WORKS The Grange, High Street, Old Woking. Surrey. GU22 8LB	T 01483 745066	www.lifeworkscommunity.com	enquiries@lifeworkscommunity.com	●	●		●	●	●	
LONGREACH 7 Hartley Road, Plymouth, Devon, PL3 5LW	T 01752 566246	www.broadreach-house.org.uk	enquiry@broadreach-house.org.uk	●	●	●	●	●		
NARCONON Grange Court, Maynards Green, United Kingdom TN21 0DJ	T 01435 512 460	www.narconon.org	info@narconon.org	●	●				●	
MOUNT CARMEL 12 Aldrington Road, Streatham, London, SW16 1TH	T 020 8769 7674	www.mountcarmel.org.uk	info@mountcarmel.org.uk	●	●	●		●		
NELSON TRUST, THE Port Lane, Brimscombe, Stroud, Gloucestershire, GL5 2QJ	T 01453 885633	www.nelsontrust.com	office@nelsontrust.com	●	●	●		●		
LEAP Equine Bournes Green, Stroud, United Kingdom GL6 7NW	T 0 776 0776 500	www.leapequine.com	info@leapequine.com							
PROMIS Hay farm, Hay Lane, Kent, United Kingdom CT14 0EE	T 0207 581 8222	www.promis.co.uk	enquiries@promisclinics.com	●	●	●	●	●	●	●
OPEN MINDS Chester House, 11 Grosvenor Road, Wrexham, LL11 1BS	T 01978 312120	www.openminds-ac.com	info@openminds-ac.com	●	●		●		●	
PASSMORES HOUSE (WDP) STABILISTION SERVICES Third Avenue, Harlow, Essex, CM18 6YL	T 01279 634200	www.stabilisationservices.org	enquiries@stabilisationservices.org	●	●	●	●	●	●	
RECOVERY LIGHTHOUSE 18 Winchester Road, Worthing, West Sussex, BN11 4DJ	T 020315119l4	www.recoverylighthouse.com	info@recoverylighthouse.com	●	●	●	●	●	●	
SANCTUARY LODGE Hedingham Road, Halstead, United Kingdom, CO92DW	T 0203 151 8101	www. www.sanctuarylodge.com	info@sanctuarylodge.com	●	●	●	●	●	●	●
PRINSTED Prinsted, Oldfield Road, Horley, Surrey, RH6 7EP	T 01293 825400	www.prinsted.org	info@prinsted.org	●	●	●	●	●		●
PROVIDENCE PROJECTS, THE Providence House, 17 Carysfort Road, Bournemouth, Dorset, BH1 4EJ	Freephone 0800 955 0945 T 01202 393030	www.providenceproject.org	info@providenceproject.org	●	●	●	●	●	●	
RAVENSCOURT 15 Ellasdale Road, Bognor Regis, West Sussex, PO21 2SG	T 01243 862157	www.ravenscourt.org.uk	info@ravenscourt.org.uk	●	●			●	●	
SEFTON PARK 10 Royal Crescent, Weston-super-Mare, Somerset, BS23 2AX	T 01934 626371	www.sefton-park.com	enquiries@sefton-park.com	●	●	●	●	●	●	
CENTRE FOR ADDICTION TREATMENT STUDIES Manor House,, Ash Walk, Warminster	T 01985 843780	www.actiononaddiction.org.uk	info@actiononaddiction.org.uk							
COMMUNITY RECOVERY LIVERPOOL 1 Rodney Street, Liverpool, L1 9EF	T 0151 703 0679	www.actiononaddiction.org.uk	info@actiononaddiction.org.uk	●	●					
SOBER SERVICES Letchworth Garden City, United Kingdom SG1	T 0207 993 8598	www.soberservices.co.uk	info@soberservices.co.uk	●	●					
SOMEWHERE HOUSE LTD 68 Berrow Road, Burnham-on-sea, Somerset, TA8 2EZ	T 01278 795236	www.somewherehouse.com	info@somewherehouse.com	●	●	●	●	●		●
WESTERN COUNSELLING SERVICE Whitecrosse, 18 Whitecross Road, Weston-super-Mare, North Somerset, BS23 1EW	T 01934 627550	www.westerncounselling.com	admissions@westerncounselling.com	●	●	●	●	●	●	

Where to find... treatment

	England	Telephone	Website	Email	Alcohol	Drugs	Eating disorders	Gambling	Dual diagnosis	Detoxification	Sex Addiction
Scotland	**ALEXANDER CLINIC** King Street, Oldmeldrum, Aberdeenshire, AB51 0EQ	T 01651 872100	www.alexanderclinic.co.uk	enquiries@alexanderclinic.co.uk	●	●		●	●	●	
Scotland	**CASTLE CRAIG HOSPITAL** Blyth Bridge, West Linton, Peeblesshire, EH46 7DH	T 01721 722763	www.castlecraig.co.uk	enquiries@castlecraig.co.uk	●	●	●	●	●	●	
Scotland	**PRIORY HOSPITAL GLASGOW, THE** 38 Mansionhouse Road, Glasgow, G41 3DW	T 0141 636 6116	www.priorygroup.com	glasgow@priorygroup.com	●	●	●	●	●	●	●
Wales	**BRYNAWEL REHAB** Llanharry Road, Pontyclun, Mid Glamorgan, South Wales, CF72 9NR	T 01443 226864	www.brynawel.org	info@brynawelhouse.org	●	●			●	●	
Ireland	**CARLISLE HOUSE** 2 - 4 Henry Place, Cifton Street, Belfast, BT15 2BB	T 028 90328308	www.carlislehouse.org	carlislehouse@pcibsw.org	●	●	●		●		
Ireland	**AISEIRI TREATMENT CENTRES** Townspark, Cahir, Co. Tipperary, Ireland, and Roxborough, Wexford, Ireland	Cahir 00353 527441116 W'ford 00353353914 1818	www.aiseiri.ie	infocahir@aiseiri.ie infowexford@aiseiri.ie	●	●		●			
Ireland	**HOPE HOUSE** Foxford, Co Mayo, Ireland	T 00353 949256888	www.hopehouse.ie	hopehouse@eircom.net	●	●		●			
Channel Islands	**SILKWORTH CHARITY GROUP** Silkworth Lodge, 6 Vauxhall Street, St Helier, Jersey, JE2 4TJ	T 01534 729060	www.silkworthlodge.co.uk	info@silkworthlodge.co.uk	●	●					
Europe	The Kusnacht Practice Switzerland Himmelistrasse, Küsnacht, Switzerland	T +41 43 541 11 52	www. kusnachtpractice.com	info@kusnachtpractice.ch	●	●	●	●	●	●	●
Europe	**CAMINO RECOVERY** PO Box 16, Linda Vista Baja, San Pedro De Alcantara, 29670, Malaga, Spain	T 00 34 952 78 4228	www.caminorecovery.com	meena@caminorecovery.com	●	●	●	●	●	●	●
Europe	**SAN NICOLA CENTRE** Via Anita Garibaldi 64, Senigallia, Ancona, 60019. Italy	T +39 0731 9142	www.sannicolacentre.co.uk	info@centrosannicola.com	●	●		●	●	●	●
South & East Africa	**OASIS COUNSELLING CENTRE** Suite 27, private bag X1006, Plettenberg bay, 6600, South Africa	T +27 44 533 1752	www.oasiscentre.co.za	info@oasiscentre.co.za	●	●	●	●	●		●
South & East Africa	**RIVERVIEW MANOR SPECIALIST CLINIC** PO Box 506, Underberg 3257, South Africa	T +27 33 7011911	www.riverviewmanor.co.za	malcom@riverviewmanor.co.za	●	●	●	●	●	●	
South & East Africa	**STEPPING STONES CLINIC** Main Road, Kommetjie, Cape Town, 7975, South Africa	T +27 (0)21 783 4230	www.steppingstones.co.za	info@steppingstones.co.za	●	●	●	●	●	●	●
South & East Africa	**CHOOSE LIFE RECOVERY SPECIALIST** 97 Windmill Road, Berea, KwaZulu-Natal, South Africa, 4001	+27 0 31 201 2181	www.chooselifesa.co.za	michael@chooselifesa.co.za	●	●			●	●	
USA	**COTTONWOOD TUCSON** 4110 W. Sweetwater Drive, Tucson, Arizona. 85745 USA	T 001 529 743 0411	www.cottonwoodtucson.com	info@cottonwoodtucson.ltd.uk	●	●	●	●	●	●	
Asia	**LANNA REHAB** Chiang Mai, Thailand	T 00 669095142	www.lannarehab.com	info@lannarehab.com	●	●				●	
Asia	**HOPE THAILAND** Soi Ban Rai Din Daeng 7, Thailand Si Racha 20110	T 0066895291297	www.hoperehabthailand.com	simon@hoperehabthailand.com	●	●		●	●	●	●
Asia	**SIERRA TUCSON** 39580 S. Lago del Oro Parkway, Tucson, Arizona 85739, USA	T 0800 891 166	www.sierratucson.com	outreach@sierratucson.com	●	●	●	●	●	●	●
West Indies	**CROSSROADS CENTRE, ANTIGUA** PO Box 3592, St Johns, Antigua, West Indies	T 1 (268) 562-0035	www.crossroadsantigua.org	info@crossroadsantigua.org	●	●				●	
Asia	**DARA THAILAND** 113 Moo 1, T. Koh Chang Tai, A. Koh Chang, Trat 23170, Thailand	T +66 8 7140 7788	www.alcoholrehab.com	info@alcoholrehab.com	●	●					
Asia	**THE CABIN CHIANG MAI** Chiang Mai, Thailand 50300	T 66 80 446 8850	www.thecabinchiangmai.com	info@thecabinchiangmai.com	●	●	●	●	●		●
	SOLACE SABAH Sabah Malaysia, Malaysia 88000	T 60 19 715 4686	www.solacesabah.com	mail@solacesabah.com	●	●	●	●	●	●	●

An entry in this Treatment Directory costs just £534 for a WHOLE YEAR - VAT-free for UK charities, VAT-registered EU facilities (outside the UK), and all facilities outside the EU.

To find support, training and more treatment centres please go to our online resource at **www.intervene.org.uk** - celebrating life in recovery

Music Support

New addiction charity for music industry

"We provide help and support for anyone in the UK music industry suffering from alcoholism, addiction, emotional and mental health issues. "Anyone" means anyone, not just artists, but road crew and touring personnel, DJ's, producers, promoters, agency personnel, independent promotions and public relations personnel, label personnel, travel agents, caterers, and so on."

Launched at UKESAD 2016 Music Support (www.musicsupport.org) is a new charity that has been set up to provide help and support for anyone in the UK music industry suffering from alcoholism, addiction, emotional and mental health issues.

"Anyone" means anyone, not just artists, but road crew and touring personnel, DJ's, producers, promoters, agency personnel, independent promotions and public relations personnel, label personnel, travel agents, caterers, and so on.

The founders of the charity know from personal experience, that the industry is a breeding ground for addictions in all their forms due to the lifestyle demands in many areas, the enabling environments, the camouflage provided by peers and colleagues, and the high levels of tolerance that exist within the industry.

"We were all aware of the enormous need for a service like this. Everyone seems to know at least one person in the industry who has either died as a result of their addiction or committed suicide as a result of mental health issues" says co-founder Matt Thomas. "One day we realized that rather than talking about it, we should be actively doing something about it, because if we didn't do it no-one else would. And it's a life or death situation for too many people. So we kind of had to do it."

Music Support offers 3 levels of help: an 0800 helpline for anyone who needs a chat, therapy and counselling and assessment and treatment.

If their clients do not have sufficient funds Music Support can also arrange for a part, or full bursary.

"It's going really well, and we've already helped a lot of people" says Thomas "but we're not setting ourselves up as the saviours of the industry or anything like that. We're just a bunch of recovering drunks and addicts, some of us with experience of mental health issues, trying to help other people like us."

For more info – contact Matt Thomas
07968 626 987 www.musicsupport.org
HELPLINE: 0800 030 678940

10% Card payments discount*

15% Group booking discount**

Smoking Cessation in Mental Health

Improving the Physical Health of People with Mental Health Conditions

Friday 21 October 2016 **De Vere W1 Conference Centre London**

Speakers Include

Prof Jonathan Campion *Director for Public Mental Health and Consultant Psychiatrist*
South London and Maudsley NHS Foundation Trust
Visiting Professor of Population Mental Health
University College London

Supporting Organisations:

National Counselling Society · psychotherapy excellence · bpf British Psychotherapy Foundation · RSPH Royal Society for Public Health · Good Governance Institute · CPD Member The CPD Certification Service · ash action on smoking and health · intervene · Healthcare Conferences UK

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#SeeYouThere

‘O brave new world, that has such creatures in it!’

Nick Mercer on the crucial importance of the first encounter in a treatment setting

In the light of June’s EU referendum my thoughts turned to the importance of cooperation, connection and engagement, especially in that crucial first encounter with a prospective client.

How do we create conditions propitious to a successful experience for someone asking for help, perhaps for the first time, for whom any kind of connection or joining – intimacy, in short - is a perilous endeavour fraught with anxiety?

Simply, we have to kindle a spark of hope in those whose predominant mood is often resignation or despair. We have to give them a glimpse of a world that is better than the one they currently inhabit… and we have to convince them of their eligibility for inclusion in that world. You can only do that successfully if you can produce a microcosm of that world in the treatment environment. Therefore, the initial aim of treatment is to produce a safe and healing environment that makes concrete the concept of recovery as a passage to freedom and a richer life, accessible to all who have exhausted the validity of self-medication as a meaningful life choice. It is a place where the inhabitants can begin to taste the fruits of recovery for themselves.

Most addiction counsellors would agree that ‘the therapeutic value of one addict helping another’ is the single most powerful component of primary treatment. It is the immersion in an active peer group imbued with ideas of service and selfless action (the antidote to the narcissism of addiction) – that holds the client in the crucial first day of treatment. This is especially important in a day programme where the onus is on the client to return. It is the ultimate manifestation of service user involvement. I often refer to this initial immersion as the swamp effect. It is an essential part of the orientation process.

For a mirror of the above we need look no further than the organic world of 12-step fellowships where total abstinence from drugs, alcohol or a damaging addictive behaviour like gambling is simply an aspiration or desire (rather than the essential requirement it has

to be in formal 12-step treatment) and ‘the desire to stop using or drinking’ is the only requirement for inclusion. Successful meetings demonstrate this swamp effect very well from the greeters at the door to the newcomer’s representative to time set aside for the newcomer to share. All these factors and more create a hospitable atmosphere that allays anxiety and encourages participation and makes real the principle of ‘attraction rather than promotion’.

I would suggest that if we can successfully replicate the spirit of this philosophy in treatment centres, be they residential or day programmes, then we will be more likely to hold people on that tenuous perilous first step of their journey when they are at their most vulnerable. And if we are mindful of those same principles in our individual work then we create the same sense of safety and welcome that pervades in those communities above. Such practice can have a profound impact for the good on the society in which we live.

Save the Date!

Caron Treatment Centers Presents...

Fifth Annual UK Workshop

Friday, November 4th and Saturday, November 5th, 2016

10:00am–6:00pm

Marriott London Kensington
147c Cromwell Road, SW5 0TH

Hosts and Presenters

Lee FitzGerald
Caron Treatment Centers

Phoenix Adams
Caron Treatment Centers Florida

Kimberly James
The Beach House Malibu

John Southworth
Southworth Associates

Alastair Mordey
The Cabin Chiang Mai

Judy Crane
CEO, Spirit2Spirit Trauma Counseling
CEO, The Guest House Ocala

Paula Hall

Noel McDermott

Mandy Saligari

Louise Lebentz

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