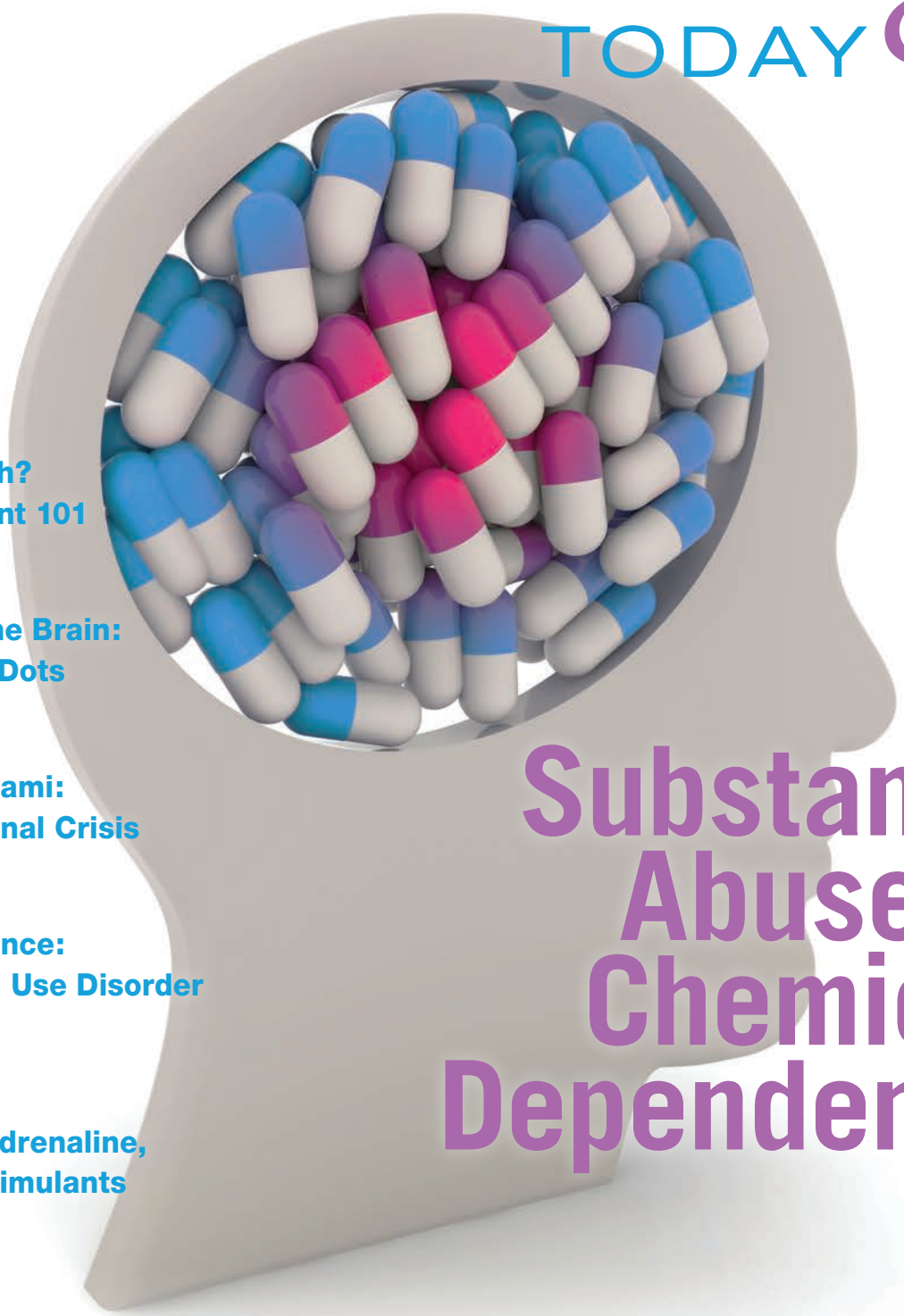
CHRISTIAN
counseling TODAY
VOL. 22 NO. 3



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Karl Benzio, M.D., is a psychiatrist, writer, conference speaker, treatment program consultant, curriculum developer, frequent media guest expert, and social issue advocate. He has worked in Kenya, Uganda, and Iraq, and testified before Congress and the President's Bioethics Committee. Dr. Benzio founded the *Lighthouse Network* ministry and currently serves as Medical Director of *Honey Lake Clinic*, a unique Christian residential treatment center with both dual diagnosis and mood and anxiety disorder programs.

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David Stoop, Ph.D., is the founder and director of the *Center for Family Therapy* in Newport Beach and Los Alamitos, California. He has many years of experience working as a clinical psychologist and directing programs at various psychological centers. Dr. Stoop is a member of the AACC and guest lecturer at *Church of Christ Theological College*.

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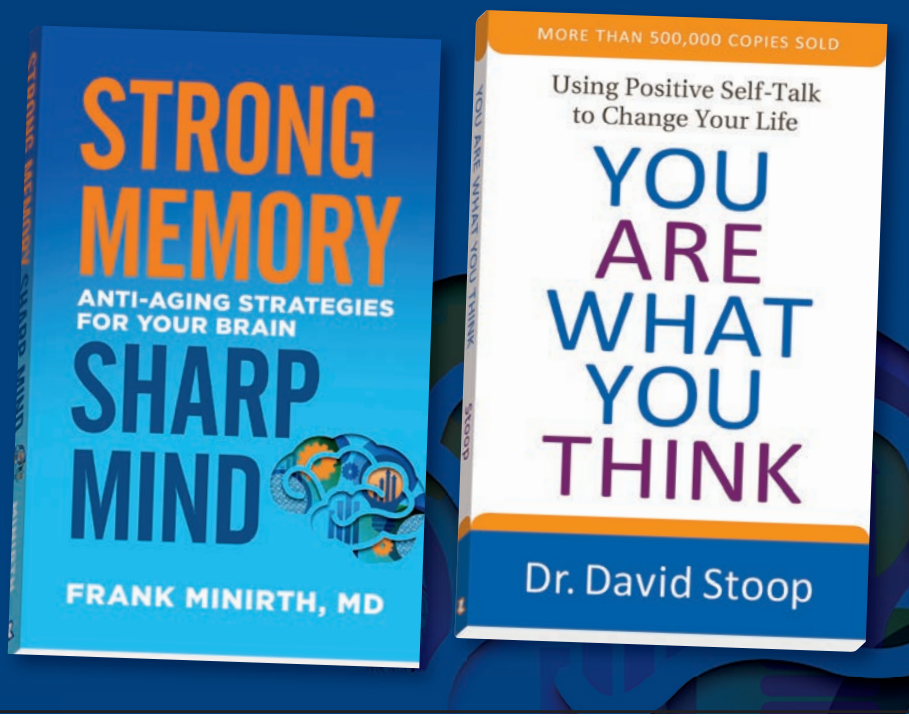

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Out of the Darkness: Addiction, Recovery, and Freedom

There are few things in life that paint a clearer picture of what bondage looks like than when a person is ensnared by addiction, especially to chemicals and other substances. While there may be a *short-term gain*, the end result is almost always *long-term pain*. The reality is that all addictions have certain things in common: they provide a form of escape; they serve the purpose of removing a person from his/her true feelings; they always involve pleasure; they override the ability and/or willingness to delay self-gratification; they result in psychological dependence; they involve obsessive-compulsive behaviors; they lead to a system of denial and/or minimization; they are destructive and unhealthy over time; they totally control the addict, which transcends all logic or reason; and, ultimately, they take priority over all of life's other issues.

Sadly, drug use, abuse, and dependency have now reached epidemic proportions in the United States. They account for a significant percentage of all criminal activities, including robberies, gang violence, and homicide. The impact can be seen and felt in countless suicides, court-related matters, incarcerations, incidents of domestic violence, and DUI accidents and deaths. The tragic toll on marriages and families and the burden on the national economy are staggering and will certainly affect future generations.

According to the National Institute on Drug Abuse (NIDA), the 2013 National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) showed that 9.4% of the national population 12 years of age and up (nearly 25 million) used illicit drugs. A 2015 report by the Surgeon General's Office revealed this figure has increased to over 27 million and more than 66 million admitted to binge drinking in the past month. SAMHSA also estimates the price tag is an incredible $442 billion dollars per year (e.g., medical and mental health treatment, law enforcement actions, lost wages and productivity, etc.). Imagine for a moment what the headlines would look like if nearly 10% of the population had HIV/AIDS or the Ebola virus—we would be in a state of panic, marshalling every resource imaginable to combat the issue. There have been fewer than 15 cases of Ebola in the U.S. since 2014 and, at times, the nation was in an uproar, giving detailed reports and daily news alerts.

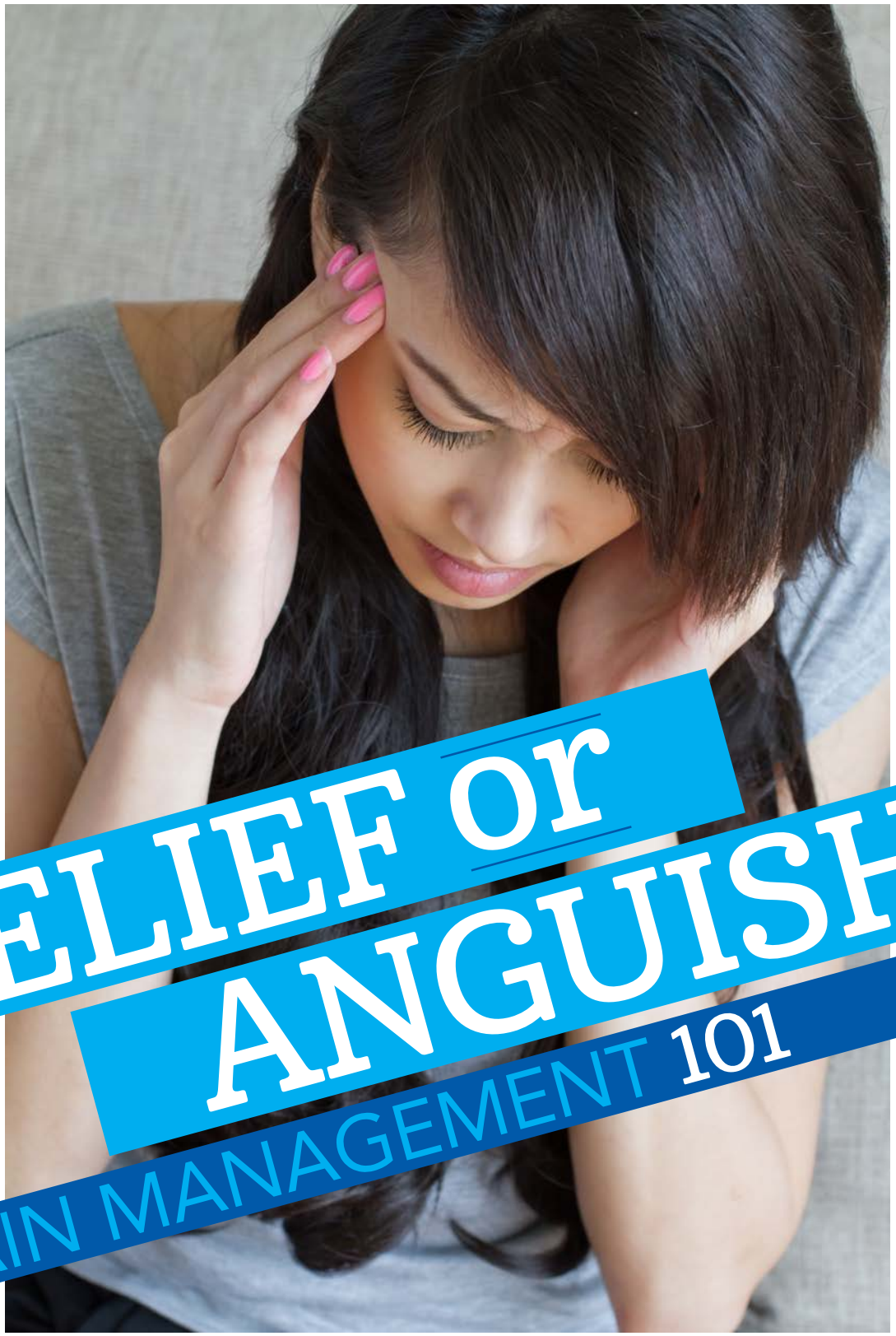
It is rare for most individuals to intentionally and actively have a desire to become addicted to alcohol or other drugs, yet it happens. The danger is that many never see the cycle of addiction beginning to sink its talons into one's soul, emotions, thought patterns, behaviors, relationships, and spirit. While some substances can lead to rapid addiction (e.g., opioids, crack cocaine, etc.), others take time. Experimentation defines the initial stage, which is typically followed by occasional using/abusing, then regular using/abusing and, ultimately, a full-blown dependency. This often results in a "tip of the iceberg" perception that tends to mask the real dangers lurking just beneath the surface.

Sin? Disease? Choice? Genetics? What is the truth behind the growing threats to our society? This issue of *CCT* attempts to tackle these honest questions and provides a broader understanding of a growing phenomenon that is brooding over America and, in many ways, the entire globe. Research consistently shows that every alcoholic or addict has a negative impact on at least five to six other people (e.g., spouses, children, family members, friends, coworkers, etc.). If you were to multiply that number by the nearly 30 million who regularly

abuse substances, this means over half our country is experiencing the toxic fallout that is produced.

Dr. Daniel Amen shares his research on brain imaging and the specific interplay between chemical substances and neurological health and functioning. Adam Bianchini and Karl Benzio examine the growing national prescription abuse and opioid crises, something a number of government agencies, and even the White House, are now placing a greater priority on addressing. In taking a closer look at two, specific drug categories, David Jenkins discusses the prevalence and treatment factors associated with Alcohol Use Disorder, and Chap Clark writes on the effects of caffeine and other stimulants, especially among today's young people. Roy Blankenship provides a comprehensive overview of treatment strategies and protocols from a holistic perspective, while Steve Arterburn and David Stoop review the history of the recovery movement from the early days of Alcoholics Anonymous to current 12-step approaches. Finally, Gregory Jantz addresses the role that codependency plays in addiction and addictive relationships, and Eric Scalise looks at some of the spiritual dynamics and biblical principles that should be considered throughout the counseling process.

We do know Satan, like a thief, comes to steal, kill, and destroy, but that Jesus came to bring life and bring it abundantly (John 10:10). Counselors, caregivers, and life coaches who labor in the fields of addiction are, without a doubt, facing front-line battles in the war on drugs. There have been, and will likely continue to be, many casualties along the way, including those who are impaired practitioners. We must remain informed, vigilant, and determined in our efforts to fight the good fight. The growing body of research and evidence-based interventions offer practical and tangible therapeutic tools. And… the strongholds that are represented are not insurmountable, especially when there is a firm foundation in Christ as Savior and Lord, when we acknowledge that God, in His power, can remove them, and when a person is willing to humble him or herself and seek out help and accountability. Jesus said, "These things I have spoken to you, so that in Me you may have peace. In the world you have tribulation, but take courage; I have overcome the world" (John 16:33). "For whatever is born of God overcomes the world; and this is the victory that has overcome the world—our faith. Who is the one who overcomes the world, but he who believes that Jesus is the Son of God?" (1 John 5:4-5).



RELIEF or ANGUISH?

PAIN MANAGEMENT 101

Non-malignant chronic pain (NMCP) has become an increasingly prevalent health concern among Americans today. The medical profession has addressed this through both narcotic and non-narcotic therapeutic interventions. Table 1 contains examples of non-narcotic pain interventions. Table 2 contains a list of commonly prescribed opiate medications. Table 3 contains examples of reputable scientific resources with significant emphasis on chronic pain for deeper study. The safety and efficacy of opiate therapy for NMCP has come under increasing scrutiny over the past decade, as unintentional overdose deaths have steadily increased, especially in younger patient populations. This article describes current trends in pain management, including screening for high potential risk patients and interventional methodologies of regulatory agencies.

In brief, the promotion by pharmaceutical companies, backed by the acceptance and endorsement of regulatory agencies, led the medical profession to identify and treat pain as the "fifth vital sign." The unfortunate outcome was that the medical profession was coerced into accepting the incorrect notion that opiates could be prescribed with impunity for NMCP. Thankfully, that is now changing, but not before profit to the tune of billions was made at the expense of millions of lives during that era, sadly resulting in an epidemic.

Now that the reality and severity of the side effects and complications of opiate medications have been identified (Table 4), considerable research has embarked to better understand and prevent these phenomena. Driven mostly by financial motivation, the majority of ongoing research in this area is primarily focused on the development of new medications or safer preparations of existing drugs. Some of the research, which is striving to find safer drug preparations, has developed formulations that prohibit the alteration of delivery by the abuser. For example, preparations have been designed that defeat the effect of the medication if the drug is crushed for snorting or injecting. Also, newer medications are being sought with lower risk of abuse or dependency. The most popular example of this is Buprenorphine, which has both agonist (a chemical that activates certain receptors in the brain to produce a biological response) and antagonist (a chemical that blocks opioids by attaching to receptors without activating them) opiate receptor activity.

ADAM BIANCHINI

Table 1: Examples of Non-narcotic Pain Interventions

- Surgery
- Physical Therapy
- Psychotherapy
  - CBT
  - Hypnotherapy
  - Meditation
- Thermal Therapy
- Electrotherapy
  - TENS
  - Interferential Current
- Corticosteroid Injections
  - Epidural Injections
  - Intra-articular Injections
  - Trigger Point Injections
- Holistic Therapy
  - Chiropractic Therapy
  - Acupuncture
  - Massage
  - Laser Therapy

According to statistics published by the American Society of Addiction Medicine (ASAM), there have been parallel increases in opiate prescriptions, admissions into substance abuse treatment, and overdose deaths due to opiates over the past two decades.

Although not as abundant as the aforementioned investigative trials, interest is growing in non-narcotic pain treatment research, originating more often in foreign countries. These studies investigate holistic therapies, such as acupuncture and other nontraditional approaches. In addition, these studies, although promising, have not gained significant momentum or acceptance in the United States due to a combination of design deviation from controlled, double-blinded methodology, the lack of reproducibility, and anecdotal reporting.

According to statistics published by the American Society of Addiction Medicine (ASAM), there have been parallel increases in opiate prescriptions, admissions into substance abuse treatment, and overdose deaths due to opiates over the past two decades. Specifically, 38% of the overdose deaths in 2015 were due to prescribed opiate pain medications, and 25% were caused by heroin overdoses. Thus, opiates were responsible for the majority of overdose deaths in 2015 (63%). Unfortunately, the medical profession has had difficulty in curbing these steadily increasing trends. Consequently, unintentional drug overdose is now the leading cause of accidental death in this country. Although it is estimated that approximately 9% of the American population is addicted to opiates, only 10% of those will ever seek or receive addiction treatment, according to ASAM statistics.

Thanks to increases in both public and professional awareness, the opiate crisis is beginning to be addressed. First, the medical profession, in general, has accepted addiction as a chronic, potentially relapsing disease process, which can be treated, and, in some cases, prevented. Research has led to the development of screening techniques designed to preemptively identify patients at high risk for addictive complications. There is a continuing effort to encourage providers who prescribe opiates to adopt an effective screening protocol to avoid the use of long-term opiates in addiction-susceptible individuals. Although these screening techniques are not entirely effective by themselves, they can be combined with additional safeguarding strategies, which will increase their intended effectiveness. Serial, random urine toxicologies can identify concomitant use of other substances of abuse, as well as routine follow-up investigation of family members for behavioral signs of developing chemical dependency. Use of state run controlled substance reporting can also help identify patients who are "doctor shopping." As always, continuing education of medical providers disseminates safer and more effective treatment and risk-reduction strategies as they become available.

Table 2: Commonly Prescribed Opiate Medications

- Hydrocodone
- Oxycodone
- Hydromorphone
- Fentanyl
- Codeine
- Oxymorphone
- Methadone
- Buprenorphine
- Butorphanol
- Morphine
- Meperidine

Table 3: Scientific Research Journals/ Organizations/Resources

- American Academy of Pain Medicine (AAPM)
- The Journal of Pain (American Pain Society)
- The Journal of Pain and Symptom Management
- Anesthesiology (The Journal of the American Society of Anesthesiologists, Inc.)
- Anesthesia and Analgesia (International Anesthesia Research Society)
- Clinical Journal of Pain
- Pain (The Journal of the International Association for the Study of Pain)
- Journal of Pain Research

Through greater neurobiological understanding of nociception (pain transmission and perception), the limitation of long-term opiate therapy becomes apparent. Leaving aside for a moment the bitter experience of chemical dependency and addiction, the brain's innate ability to counter the long-term, chemically-mediated blockade of nociception (the sensory nervous system's response to certain harmful or potentially harmful stimuli) can lead to additional, significant limitations of chronic opiate therapy. Hyperalgesia (the heightened experience of pain due to the lowering of the pain threshold) and allodynia (the experience of pain in response to non-painful stimuli) are two of the most important, yet overlooked, side effects of long-term opiates. As the brain experiences continuous deprivation of pain information, there arises a compensatory response by the central nervous system to retrieve that lost information in order to keep the body safe. This can be best understood as a survival instinct—since pain is a primary indicator of immediate danger, it is easy to understand the brain would covet this information and make great effort to retrieve it if it was lost. With chronic opiate use, the pain threshold decreases with time as the brain compensates by increasing its sensitivity to nociception. Thus, over time, opiates actually augment the need they fill, creating a destructive cycle.

Both federal and state run agencies have been aiding the medical profession in addressing the chemical dependency and addiction issues. Much of this effort has reached the mainstream media. Doctors are having their licenses revoked and, in some cases, being charged with murder in connection with overdose deaths if scrupulous prescribing practices can be proven. The eradication of the "Pill Mills" have dramatically cut down the availability of prescription opiates which, in turn, has resulted in a resurgence in heroin sales, putting added strain on law enforcement officials. Sadly, some of the heroin sold today is intentionally adulterated with potent comparable opiates, such as fentanyl or carfentanil, making it extremely lethal, even with a small "test dose." Recently, the FDA moved to take Oxymorphone off the market because the risk outweighed the potential benefit. The American Board of Preventative Medicine (ABPM) has been tasked with providing training requirements and board certification for addiction medicine physicians to treat the epidemic of addiction and chemical dependency. As previously

Table 4: Opiate Side Effects

- Constipation
- Nausea
- Sedation
- Dizziness
- Sleep Disturbance
- Urinary Retention
- Muscle Rigidity
- Myoclonus
- Hormonal Aberrations
- Respiratory Depression
- Cardiac Conduction and Rhythm Abnormalities
- Immunological Dysfunction
- Hyperalgesia/ Alodynia
- Tolerance
- Physical Dependence
- Overdose
- Death

mentioned, databases are being created to track opiate prescriptions and their recipients in order to maintain integrity.

In summary, the prevalence of non-malignant chronic pain continues to increase in our country, as does the challenge of treating it safely and effectively. There is a change in assessing and treating NMCP due to the recently acquired awareness of the limitations in effectiveness and inherent complications of chronic opiate therapy, which had previously become the treatment of choice. This has helped combat the unwelcomed tide of chemical dependency and unintentional overdose deaths in our country. Moreover, screening tools used to identify patients at higher risk for developing chemical dependency or addiction are being designed and implemented to further reduce complication rates. Newer and safer medications and delivery systems continue to be at the forefront of research efforts. Non-narcotic based treatment alternatives are being tested and instituted, as well. Last, continuing efforts are being made to provide addiction treatment and rehabilitation for those patients who subsequently suffer chemical dependency and addiction as an untoward side effect from opiate therapy. A continued, multi-disciplinary approach, applied with vigilance, will be necessary to meet the challenge of what has become an epidemic within our healthcare system. ✠

ADAM BIANCHINI, M.D., *received his doctoral training from Jefferson Medical College (M.D.), a General Surgery Internship from Wright State University, and an Anesthesiology Residency at Hartford Hospital after completing a Bachelor of Science degree from Brown University. Presently, Dr. Bianchini is the Director of Medicine at The Treatment Center of the Palm Beaches, where he supervises the medical care for both a 140-bed adult and 40-bed adolescent inpatient facility. In addition, he is the Medical Director of the Integrative Pain Medicine and Recovery Medical Associate outpatient practices. Dr. Bianchini facilitates clinical 12-step recovery groups and has been a guest speaker, representing The Treatment Center, at more than a dozen different conferences nationwide.*

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*Understanding Counselor Liability Risk, NSO and CNA, March 2014.

E-11308-0515 AACC

Addiction and the Brain

CONNECTING THE DOTS

Arnie, 56, came to Amen Clinics with his wife, Bella. She was suffering from anxiety and wanted to get an evaluation, but was terribly nervous about having a brain scan. To help calm her fears and be supportive, Arnie decided he would get a scan as well.

When I saw Arnie's scan, it looked like he had been impacted by some kind of toxic exposure. When I asked him what he was doing to hurt his brain, Arnie thought for a moment and said, "Nothing."

I had to find out what was making his scan look so bad. I asked Arnie a few more questions about is daily habits, and the subject of drinking came up. It turned out Arnie was consuming three to four alcoholic drinks every day. He explained that part of his job as a business consultant was to entertain clients, and this included taking them out to dinner and drinks. He said he never felt drunk or out of control, so he didn't think it was a problem.

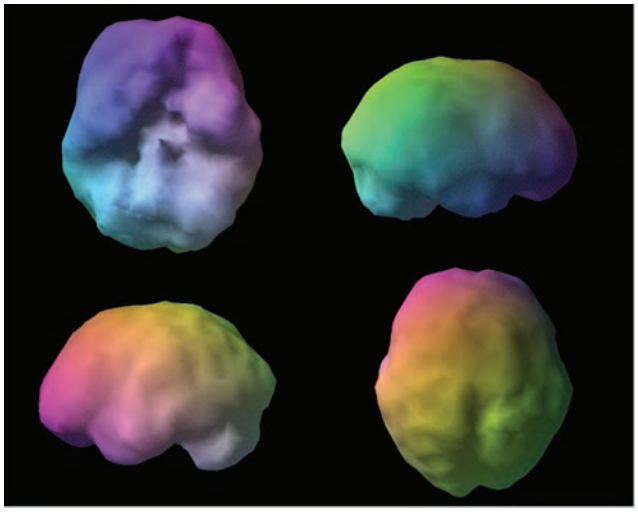
"It's a BIG problem," I said. Consuming that much alcohol on a daily basis can be devastating to your brain and your life. Alcohol is a central nervous system depressant, lowers overall brain function, and decreases judgment, impulse control, memory, and motivation.

Arnie had no idea his daily drinking was harming his brain until he saw his scans. On a brain-healthy plan that included regular exercise, mental exercise, supplements, and abstinence from alcohol, his brain improved greatly. A few months later, he wrote to me saying he felt as mentally sharp as a 20-year-old. His energy and memory had benefitted from a much needed boost, and he felt smarter and more articulate. The changes had translated into increased revenues for his business and a host of new projects. Arnie never realized it, but his drinking had been holding him and his brain back from his full potential.

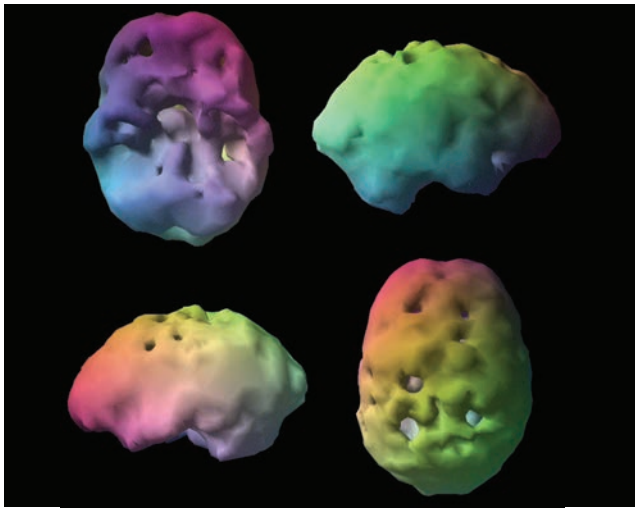
Marijuana is not any better, even though it is currently legalized in 26 states, including 10 states for the treatment of dementia. We recently published a study in the *Journal of Alzheimer's Disease* on nearly 1,000 pot smokers compared to nonusers. As a group, the pot smokers showed lower blood flow in every area of the brain… especially the hippocampus (the center of emotion, memory, and the autonomic nervous system), which is one of the first areas of the brain to die in Alzheimer's disease. We now have visual evidence that getting stoned or drunk can result in lasting brain damage.

Brain scans simply do not lie. Toxic exposure from alcohol (like Arnie), other drugs, nicotine, or excess caffeine are often clearly seen on SPECT scans. These toxins can affect several important brain systems that play a major role in one's ability to have the best life possible.

I want to share what we, at Amen Clinics, have learned about addictions from our brain imaging work; the neurological effects of drug and alcohol use on the brain, including the brain circuits that control healthy and addictive behavior; and potential treatments.



HEALTHY SPECT SCAN



ARNIE'S ALCOHOL-DAMAGED SPECT SCAN

What the World's Largest Database of Brain Scans Reveals about Addictions

At Amen Clinics, we have been doing advanced brain imaging work with single photon emission computed tomography (SPECT), which measures blood flow and activity. It looks at how the brain works. For the past 26 years, we have performed more than 135,000 scans on patients from 111 countries. Among them, we have scanned the brains of thousands of addicted

patients—from drug addicts to sex, gambling, shopping, and food addicts. The scans have taught us three important lessons:

1. All addicts do not have the same brain patterns. In our book, *Unchain Your Brain: Breaking the Addictions that Steal Your Life*, addiction expert, Dr. David Smith (founder and publisher of the *Journal of Psychoactive Drugs*), and I describe six different brain types of addicts:

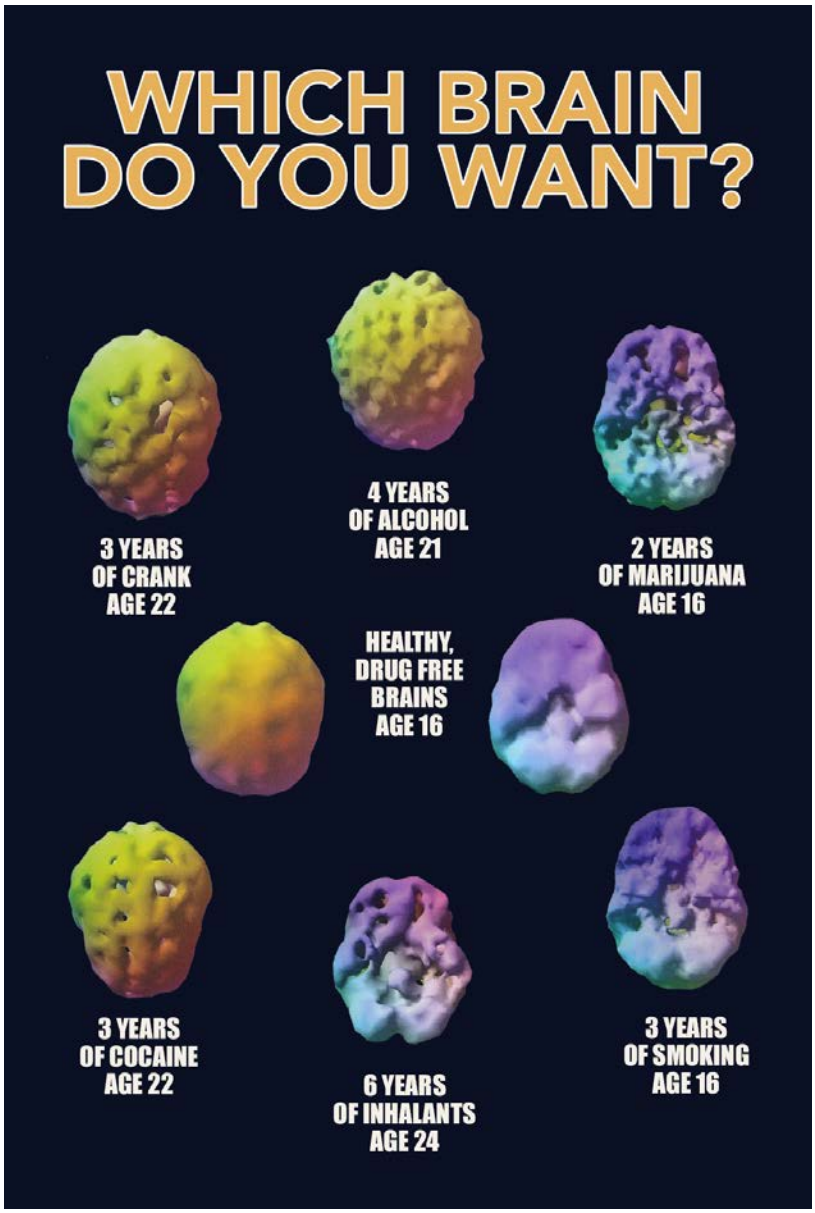
- **Impulsive addicts** have low activity in the front part of the brain and struggle with impulse control. They tend to abuse stimulants in an attempt to turn on their brains with drugs such as cocaine, methamphetamines, caffeine, and nicotine. We recommend boosting their frontal lobes naturally with nutraceuticals (foods containing health-giving additives) such as l-tyrosine or Rhodiola.
- **Compulsive addicts** have high activity in their anterior cingulate gyrus (involved in certain higher-level functions, such as reward anticipation, decision making, impulse control, and emotion) and have trouble letting go of negative thoughts and behaviors. They tend to use substances like marijuana, alcohol or opiates to calm their brains. We recommend calming their brains naturally with nutraceuticals, such as 5-HTP and saffron.
- **Impulsive-Compulsive addicts** have a combination of the first two types. They may medicate with both stimulating and relaxing drugs at the same time. We recommend using a combination of l-tyrosine or Rhodiola, plus 5-HTP and saffron.
- **Sad addicts** have increased limbic or emotional activity in the brain. They normally abuse downers (depressants such as alcohol or benzodiazepines). We recommend taking SAMe (s-adenosylmethionine) to help this brain type.
- **Anxious addicts** show increased activity in the basal ganglia (BG)(associated with a variety of functions, including control of voluntary motor movements, procedural learning, and routine behaviors or habits) and amygdala (plays a primary role in the processing of memory, decision making, and emotional reactions). They tend to use substances to calm their brains. We recommend taking GABA to help with this brain type.
- **Temporal lobe addicts** suffer from a brain injury where there is damage to one or both temporal lobes (involved in processing sensory input into derived meanings for the appropriate retention of visual memory, language comprehension, and emotion association). They tend to use more stimulating substances. We also recommend taking GABA to help this brain type.

Based on our work, it is critical not to have a one-size-fits-all substance abuse program, but rather target treatment to individual patients.

2. Treat other mental issues. Our brain imaging work has also taught us to address other comorbid conditions, such as traumatic brain injuries, ADHD, and bipolar disorder. It is critical to try to understand the underlying reasons *why* people abuse substances.

3. Seeing the brain damage that substance abuse causes helps prevent minors from ever using drugs or alcohol. Children born into families with a history of addiction or abuse are at an increased risk to abuse substances themselves, partly because they mimic behavior. Simply put, they copy what they see or have seen. However, using SPECT scans to show the damage done to an addict's brain can have favorable results. When a young person sees the brain physically damaged, it makes it real. Sometimes that alone can help them overcome the odds and live lives free of addiction.

We also use the scans in preventive education and have a poster that is displayed on the walls of more than 100,000 schools, prisons, and therapists' offices around the world. The poster is titled, "Which Brain Do You Want?" It does a great job of starting conversations with people who are in denial about the impact of drugs and alcohol on the brain.



SPECT SCAN POSTER

Neurological Effects of Drugs and Alcohol on the Brain

From our brain imaging work, it is obvious that alcohol and drug abuse can have profound negative effects on the brain by:

- Decreasing blood flow, especially to the prefrontal cortex (PFC), which impairs judgment and impulse control.
- Delaying development by damaging developmental processes, such as synaptic pruning (the process by which extra neurons and synaptic connections are eliminated in order to increase the efficiency of neuronal transmissions) and myelination (a process that helps form an electrically insulating layer around brain cells).
- Damaging or wearing out the nucleus accumbens or pleasure centers in the brain. Many drugs work in these two, deep structures that help us feel pleasure and motivation. When these pleasure centers are turned on too strongly or too often (impacted by neurotransmitters, such as dopamine and serotonin), it starts to become less active, causing people to need more and more of a substance to feel anything at all.

Why Can't I Just Say No?

The brain systems that drive you to seek out pleasure, along with the prefrontal cortex (handles complex cognitive behavior, personality expression, decision making, and moderating social behavior), work in concert to create your self-control circuit. The PFC puts on the brakes when you are about to engage in risky behavior. In a healthy self-control circuit (see Figure 1), an effective PFC provides appropriate

FIGURE 1:
HEALTHY
SELF-CONTROL
CIRCUIT

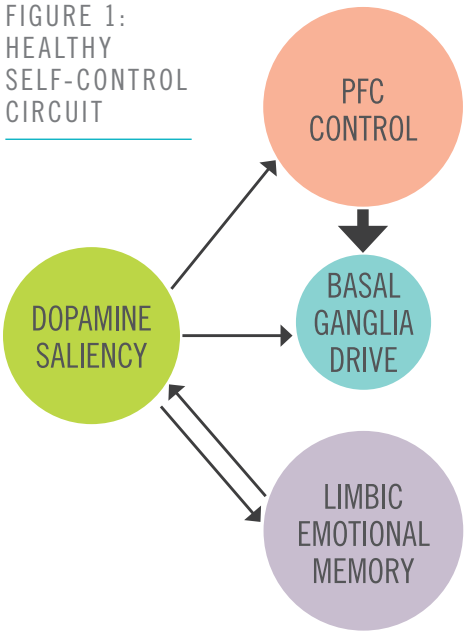
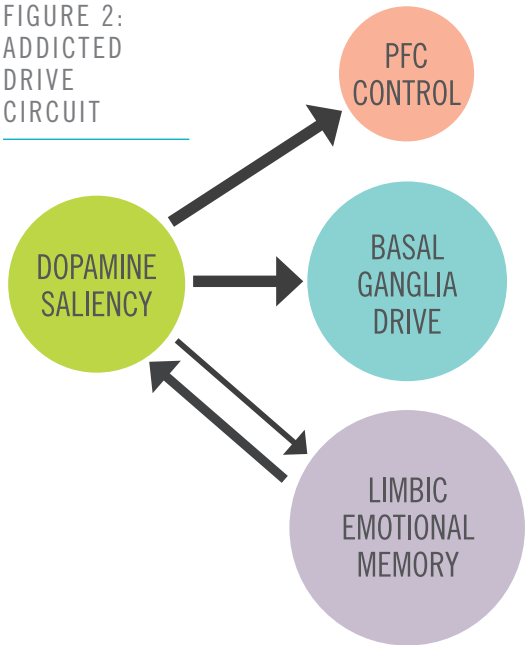


FIGURE 2:
ADDICTED
DRIVE
CIRCUIT



impulse control and good judgment. It also provides an adequate dose of motivation from the deep limbic system so you can plan and follow through on your goals.

Healthy dopamine levels drive you to pursue your passions, while a healthy PFC helps you direct thought, behavior, and control. When these chemicals and brain areas are in balance, you can be focused, goal-oriented, and have better control over your behaviors. You can say no to alcohol, hot fudge sundaes, cigarettes, gambling, inappropriate sexual conduct, and other bad behaviors.

In the addicted brain, the PFC is diminished, and the drive circuits take control. When the PFC is underactive (see Figure 2), it can create an imbalance in the reward system and cause you to lose control over your behavior. When this is the case, you are more likely to fall victim to your cravings. Having low activity in the PFC often results in a tendency for impulse-control problems and poor internal supervision.

Anything that decreases activity in the brain robs you of good judgment and makes it easier to give in to your addictions. Pushing on your brain's pleasure buttons too hard or too often can cause the brain's brakes to fail by decreasing activity in the PFC. Poor sleep, ADD/ ADHD, and head injuries are also associated with reduced PFC activity. Many people don't even realize they have had a head injury that has affected their self-control.

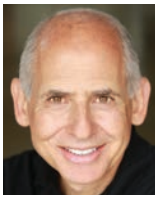
Potential Treatments

The most exciting lesson we have learned at Amen Clinics is that you are not stuck with the brain you have… you can make it better with a targeted treatment plan regardless of how well your brain has been maintained.

Typically, addiction treatment involves structured programs, such as Alcoholics or Narcotics Anonymous, along with cognitive therapy. Research has shown that these programs have been helpful for many addicts. At Amen Clinics, we base our treatment on the individual brain types mentioned previously; plus we add brain-healthy habits, such as diet, exercise, and the targeted use of nutraceuticals.

In a recent article in the *American Journal of Psychiatry*, researchers claimed that nutraceuticals were a low-cost option that should be considered for anyone with chemical imbalances caused by substance abuse or any type of addiction. Our standard protocol is to give all of our patients a multiple vitamin, high dose omega-3 fatty acids (about three grams), and nutraceuticals targeted to the patient's brain type.

Addiction hijacks the brain. The good news is that our brains can be restored to health because they are more flexible than we ever thought. Understanding that addiction involves disease processes that change how the brain functions is helping researchers develop better treatment options… and we know lifestyle affects everything. There is hope. Know your options.



DANIEL G. AMEN, M.D., *is a physician, double board-certified psychiatrist, neuroscientist, founder of Amen Clinics, and a 10-time* New York Times *best-selling author. His book,* Change Your Brain, Change Your Life, *has sold more than a million copies.*

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15 LESSONS | 4 MODULES

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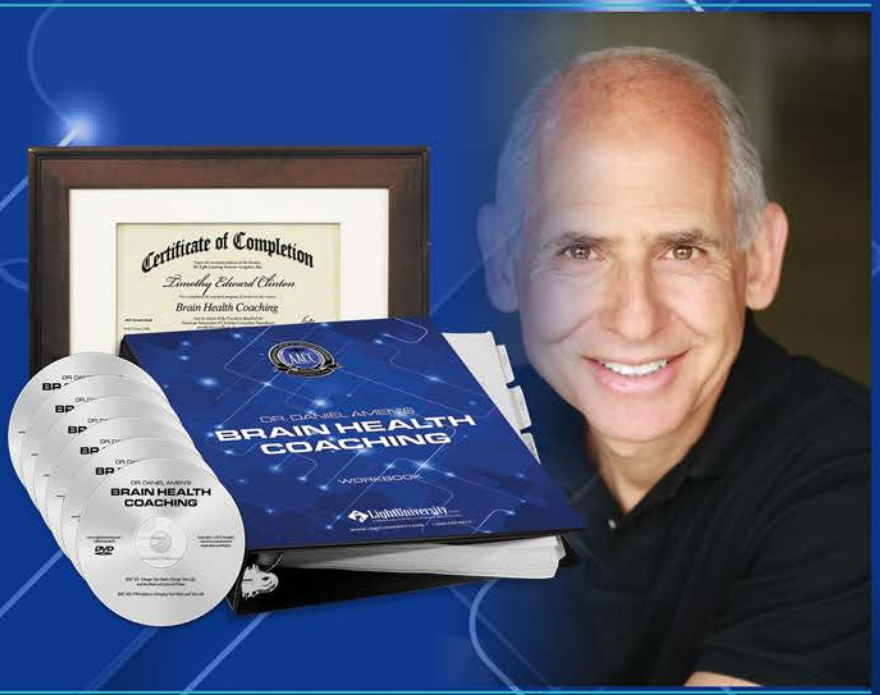

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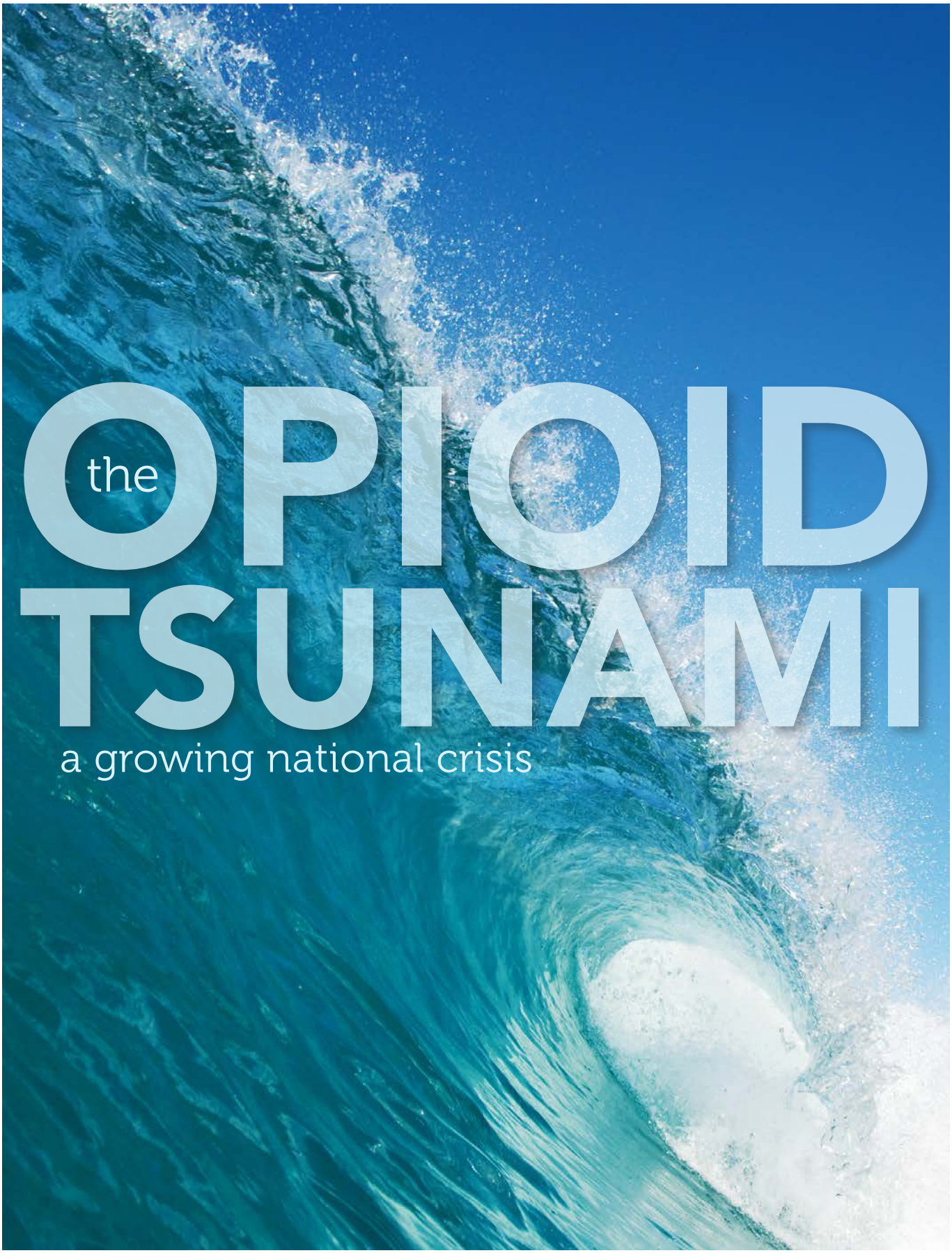

the
OPIOID
TSUNAMI
a growing national crisis

The Worst Epidemic… and Everyone's Involved

In 2016, more Americans died of drug overdoses than in any other year on record—*more than 60,000.* That's higher than the 53,000 who died in car crashes (1972), the 40,000 who died from gun violence (1993), and the 46,000 who died due to HIV/AIDS (1995) during the peak death years of these epidemics. Sadly, 60,000 is not the overdose peak. This particular epidemic's tentacles reach everywhere.

- President Trump created the National Opioid Commission.
- The Prescription Drug Monitoring Program is a state run, but the nationally accessible electronic database is populated by pharmacies when they fill a prescription for a controlled substance so doctors, insurance companies, licensure boards, and law enforcement have instant data.
- The most recent U.S. Surgeon General, Vivek Murthy, M.D., launched the Turn the Tide Rx Initiative to improve opioid prescribing practices and issued the first Surgeon General's Report on Alcohol, Drugs, and Health in 2016.
- Labor force participation has declined since 2007 after decades of growth. The Chair of the Federal Reserve, Janet Yellen, commented, "I don't know if the opioid epidemic is a symptom of the stagnating labor force participation rate or a cause."
- An economist at Goldman Sachs recently stated, "The opioid epidemic is intertwined with the story of the declining prime-age participation, especially for men, and this reinforces our doubts about a rebound in the participation rate."
- The Food and Drug Administration strengthened its own 2016 Opioids Action Plan, trying to balance the suffering from addiction to pain medications vs. these drugs reducing people's suffering from real pain.
- Colleges and universities are developing special opioid certification programs and putting more educated mental health professionals on the front line.
- Narcan® (a prescription medicine that blocks the effects of opioids and reverses an overdose) injectables and nasal sprays are now available for EMT and home use to combat overdoses.
- The U.S. Congress added $1 billion over two years in the Cures Act for addiction care.
- In 2016, 100 people died each day from opioid overdose.
- Dr. Tom Frieden, the former director of the Centers for Disease Control stated, "It's the only aspect of American health that is exponentially getting significantly worse."

What are Opioids and Which Ones are Dangerous?

Opioids are substances that act on opioid receptors to produce morphine-like analgesic effects. They are chemical agents which can relieve pain, bring a sense of euphoria, produce sleep, suppress one's awareness of the environment, and, in large doses, bring stupor, a coma or even death. These substances are highly and rapidly addictive and can result in psychological and physical dependence. The three types of opioids are:

- **Opiates** – Natural chemicals of the opium poppy plant with the main psychoactive compounds being morphine, codeine, and thebaine.
- **Semi-synthetic Opioids** – When naturally occurring opiates are directly manipulated to make heroin (diamorphine), oxycodone (OxyContin®), hydrocodone (Vicodin®), oxymorphone (Opana®), and hydromorphone (Dilaudid®).
- **Synthetic Opioids** – Not using opiates at all, synthetics are totally created in a laboratory. These include methadone, fentanyl, and buprenorphine.

In the 90s, pain was labeled the fifth vital sign for which medical personnel would routinely check. This was because pain, especially chronic pain, became an early indicator for so many other physical and behavioral health problems. So pain meds proliferated and the liberal prescribing of them literally helped more than 100 million who suffered from chronic pain. Sadly, opioids are also highly addicting, so a small percentage of patients started overusing them and opioid abuse and overdose numbers have now created a tsunami effect.

The most deadly of the fentanyl analogues is carfentanil, an elephant tranquilizer 5,000 times stronger than heroin. An amount smaller than a few grains of salt can be lethal.

Around 2010, the Drug Enforcement Agency (DEA), medical licensing boards, medical societies, and other government entities started cracking down on "pill mills." As a result, pill supplies started to dry up, so heroin exploded on the scene in a fury with overdose rates quadrupling from under 3,000 in 2010 to 13,000 in 2015.

Today, fentanyl, a prescription medication prominent in the overdose death of the music icon, Prince, is 50 times stronger than heroin, produced on the black market, and popping up in drug seizures around the country. The overdose death rate for illicitly-obtained opioids like fentanyl is skyrocketing, while the overdose death rate from many other legal prescription opioids is barely rising.

In Montgomery County, Ohio, of the 102 drug overdose deaths recorded in January and February 2017, only three people tested positive for heroin, while 99 tested positive for fentanyl or an analogue. Most of the time, it is sold on the street as heroin, or drug traffickers use it to make cheap counterfeit prescription opioids. Fentanyl is also showing up in cocaine and causing an increase in cocaine-related overdoses.

The most deadly of the fentanyl analogues is carfentanil, an elephant tranquilizer 5,000 times stronger than heroin. An amount smaller than a few grains of salt can be lethal.

> "July 5, 2016—that's the day carfentanil hit the streets of Akron," said Capt. Michael Shearer, the commander of the Narcotics Unit for the Akron Police Department. On that day, 17 people overdosed and one person died in a span of nine hours. Over the next six months, the county medical examiner recorded 140 overdose deaths of people testing positive for carfentanil. Just three years earlier, there were fewer than 100 drug overdose deaths of any kind for the entire year.

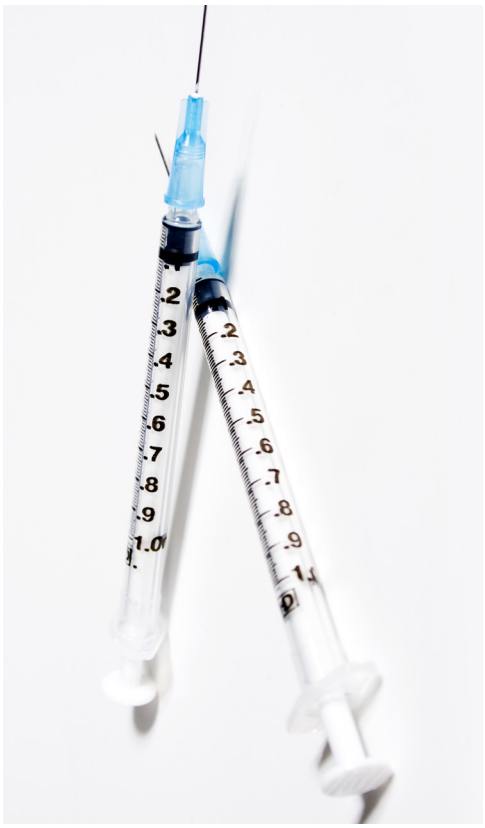
With fentanyl and carfentanil, the overdoses are so severe that they require Emergency Medical Services personnel to use five to 10 doses of naloxone (Narcan®) to pull people out.

Why the Exponential Opioid Addiction Increase?

Many factors have fueled the opioid tsunami we are witnessing today. Here are some major ones.

Systemic

- So many suffer from pain and need legitimate pain relief.
- Insurance companies and other third-party payers ration healthcare, spacing out visits so doctors prescribe more pills and more refills than are usually needed.
- Primary care physicians (including the Surgeon



General), not psychiatrists, treat the majority of addicts and prescribe most of the methadone, buprenorphine, and all the opioids, thus ignoring or devaluing the psychospiritual etiology and treatment aspects of addiction.

Psychological

- There is so much psychological and relational stress in our society… it is a crowded loneliness!
- There is a prevalence of so many "normal" addictions—like pornography, promiscuity, and widespread caffeine overuse—which agitate people, lower frustration tolerances, and undermine coping skills.
- The demand for immediate gratification has increased.
- There is a greater need for comfort and a greater fear of discomfort.
- More people pursue constant stimulation as a way of avoiding boredom.

Spiritual

- The heart's desire is joy and peace, but when we leave God out, we mistake the high for joy and the euphoria for peace.
- Being loved is the key to feeling a sense of belonging, which is the opposite of addiction. Not everyone becomes addicted, but those who feel disconnected often develop a pathological relationship with a substance, behavior, or feeling state.
- We now live in a society that devalues people and life while pushing a "whatever feels good is right" mentality, thereby fueling psychological immaturity and spiritual confusion. Abortion, physician-assisted suicide, euthanasia, divorce, child abandonment, same-sex marriage, and viewing transgender and same-sex attraction as immutable, born-with traits undermines a person's sense of value, accountability for decisions, and connection with the true God. This leads to disconnection and a lack of belonging, which is fertile ground for self-medicating addictions as an attempt to escape or soothe.

Who Becomes Addicted?

Twenty years ago, opioid addiction was mainly for the urban down-and-out—the "lower class." As you can imagine from the progression described earlier of pain meds to heroin and now fentanyl, anyone who has pain or pain pills in his or her house is now a candidate. The spectrum is wide, from teens to those in their 60s, rich or poor, white or minority, urban or rural, and male or female.

In fact, soccer moms, females 25-44 who can have stressful lives juggling kids and careers, are one of the fastest growing heroin using demographics, as women have more pain syndromes and take more pain medications than men. Adolescent drug use is also on the rise. In 2015, 276,000 adolescents were using/abusing pain relievers for nonmedical purposes, with 122,000 having an addiction to prescription pain relievers, and 21,000 using heroin.

The hardest hit areas are in the Southwest, Arkansas to Pennsylvania Appalachia, and the Rust Belt states. While overdose death rates increased for all age groups, the greatest increase was in adults aged 55-64. Still, the group with the highest overall rates of fatal overdose was slightly younger—adults aged 45-54. The highest rate of non-fatal overdose was ages 25-34.

Why Use Opioids?

If something is so harmful and deadly, running the opposite direction should be clear. However, opioids bring a rush, high, euphoria, and escape felt within minutes, even seconds, when injected intravenously or smoked. Those with unmet psychospiritual needs are drawn to opioids because of the powerful effects they mistakenly think are the cure for their discomfort, hurt or pain.

Sadly, continued pursuit of this temporary fix causes many short and long-term complications, especially these two main problems:

1. Unbeknownst to the user, opioids are depressants that increase long-term anxiety. So the person falsely believes more opioids will self-medicate his or her growing depression and worsening anxiety, but the vicious cycle just spirals downward.
2. Physical dependence and tolerance happen quickly for most, so the user needs a higher dose to get the same effect, and when he or she stops using opioids, the only intervention to alleviate the terrible withdrawal symptoms is using again.

Like all addictions, devastation occurs in all spheres of life. Physical, psychological, relational, financial, legal, occupational/

educational, and spiritual consequences further increase the pain and call the addict to use an opioid to escape or distract from the always growing pile of damage and injury.

Breaking the Chains of Opioid Bondage

The American Society of Addiction Medicine (ASAM) defines addiction as a primary, chronic disease of the brain, and the recent Surgeon General agrees. Sadly, labeling addiction as a chronic disease limits our understanding of why people use/abuse drugs and develop a dependency, which truly puts a lid on the healing that can be achieved, resulting in the revolving door and low ceiling of treatment success we currently see. Although finally becoming cognizant of an addict's defective brain and classifying addiction as a disease have been helpful, what has been left out is even more important—the psychological and spiritual aspects of addiction.

Contrary to the utilization review departments of many insurance companies and their attempt at psychological insight, no addiction is ever primary or comes out of the blue. As Canadian psychologist, Bruce Alexander, showed with Rat Park (a study of drug addiction conducted in the late 1970s), and we see it so often, some get addicted and some do not. Those who get addicted unconsciously connect the object of their addiction to temporary relief for some underlying psychological or spiritual stressor. In the five stages of addiction, this is the dangerous stage three, circumstantial use. The addiction object benefits a certain circumstance. Unless consequences come quickly, the quick slide to intensified, and then compulsive use occurs for many.

Yes, addiction is a disease, a psychological defect, and sin… all three. That means all three spheres need to be addressed in order to progress through the process of sobriety, recovery, a renewed mind, maturity and, ultimately, full-life transformation. When people are worshipping God and getting their needs met, they do not need a substance for peace, power, joy, or freedom. Addiction is misplaced worship, worshipping, or relying on the created, and not the Creator, for peace. Simply, addiction is pursuing something other than God in a repetitive, habitual or patterning way in order to get our needs met.

People do not become addicted to opioids overnight, and they rarely, if ever, are cured overnight either. Addressing all three spheres is the key. The first step is the physical sphere. Just getting separated from the opioid by placing them in a structured and supervised residential situation is critical so their access is limited. The next step is helping them through the detox process via Medication Assisted Therapy (MAT) to minimize the pain, soften the detox, extend grace and compassion, and allow the brain to begin healing. Nutrition, sleep, and exercise should be incorporated to restore and strengthen the brain, especially because they tend to be neglected for years. Finally, evaluating for an underlying medical (pain, disability, etc.) or psychiatric condition (depression, anxiety disorders, PTSD, etc.) is important when considering needed biological intervention.

Once the detox process is completed and the brain develops increased cognitive capacity, the next step, and really the most powerful, is starting their psychological equipping while connecting them to God and His love, grace, forgiveness, and instructional truths for healing and peace. Integrating divine power by growing someone's connection and understanding of God, and then harnessing these to grow their psychological apparatus to manage life and make godly decisions, takes time. Time is necessary to let the brain heal, learn, process new ways of thinking, and then practice applying what has been learned

with intentionality, expertise, and supervision.

The intersection of these three spheres is the spiritual discipline of being a godly decision maker, exercising the brain to make good decisions, renewing the mind, re-circuiting the brain, bringing psychological maturity and, ultimately, experiencing a transformed life.

Jesus Started a Behavioral Health Revolution… We Are Called to Continue It!

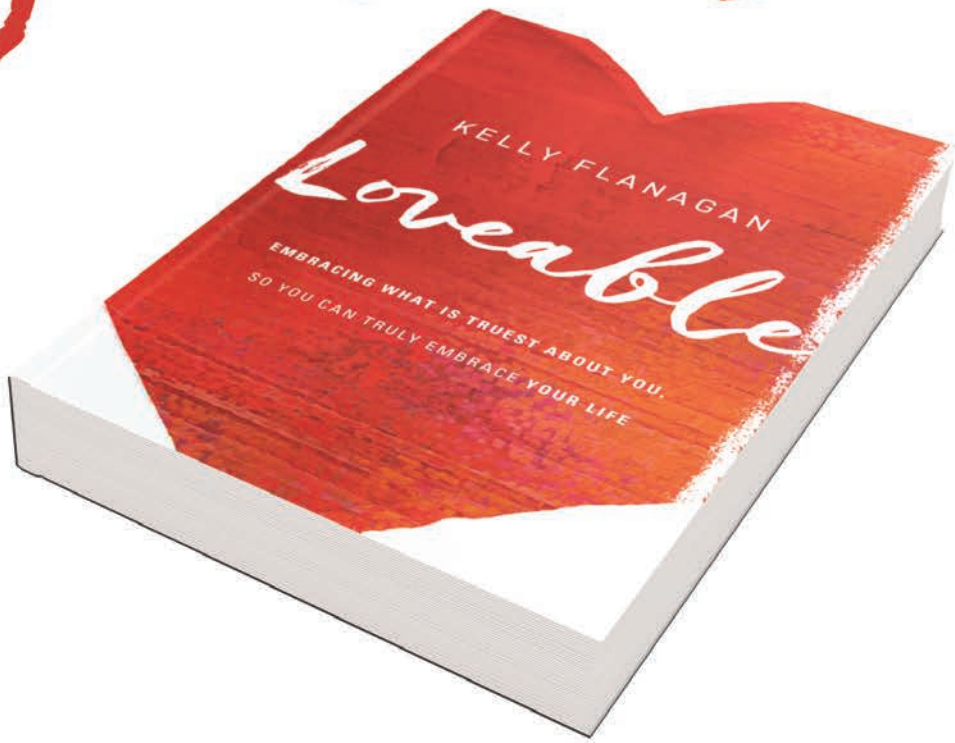
Jesus is the Wonderful Counselor and the Great Physician. Together, that makes the perfect psychiatrist. Jesus came to heal the brokenhearted and set the captives free, giving His prescription for the psychospiritual healing of abundant life He taught, role-modeled, and died for us to experience. "… they might see with their eyes (see reality, the truth of their situation), hear with their ears (hear God's answers, instruction, character, promises), understand with their hearts (connect what they hear to what they see), and turn (turn, act, trust, apply what they intellectually understand), and I would heal them" (Matthew 13:15).

True healing is possible. Not just sobriety, but real, lasting healing—transformation—shalom… in this life. Only by bringing God, Jesus, and the Holy Spirit into treatment will we see this tsunami squashed, because it's not about the chemical, it's about the heart. ✠

(*Editor's Note: Statistics and data retrieved for this article are from the Centers for Disease Control, the American Society of Addiction Medicine, and news agency Web sites.*)

KARL BENZIO, M.D., *is a psychiatrist, writer, conference speaker, treatment program consultant, curriculum developer, frequent media guest expert, and social issue advocate. He has worked in Kenya, Uganda, and Iraq, and testified before Congress and the President's Bioethics Committee. Dr. Benzio founded the Lighthouse Network ministry and currently serves as Medical Director of Honey Lake Clinic, a unique Christian residential treatment center with both dual diagnosis and mood and anxiety disorder programs.*

Worthiness is not a group project



Why do so many Christians feel unworthy of love and live lives that often seem empty? In ***Loveable***, clinical psychologist Kelly Flanagan answers the "why" encouraging readers to truly embrace their truest, worthiest self, and to remember the name they were given before all other names: Loveable.

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For good reason, the opioid epidemic (more appropriately, the opioid "use" epidemic) has demanded our national attention for the past several years. On an average day, more than 650,000 opioid prescriptions are dispensed and over 75 people die from an opioid-related overdose (HHS, 2016), or somewhere around 32,500 deaths in 2015 (NIDA, 2017). In terms of sheer numbers, however, the more than 88,000 alcohol-related deaths each year are nearly three times greater than those from opioids (including prescription and illicit) and 1.5 times greater than all drug overdoses combined. Excessive alcohol consumption costs our nation over $250 billion every year, more than all other drugs combined (CDC, 2016).

UNDER THE INFLUENCE:
TREATING ALCOHOL USE DISORDER

Short-term risks of excessive alcohol use include injuries, violence, alcohol poisoning, risky sexual behaviors, and devastating impacts on the unborn. Long-term risks include high blood pressure; heart disease; stroke; liver disease; digestive problems; cancer of the breast, mouth, throat, esophagus, liver, and colon; learning and memory problems, including dementia and poor school performance; mental health problems, including depression and anxiety; social problems, including lost productivity, family problems, and unemployment; and alcohol use disorders (CDC). Given that the statistics from excessive alcohol use have not surged in recent years like those related to opioid use, some tough questions have to be asked. Have we been numb to the "alcohol epidemic" that has been going on for decades? How do we best treat those who use alcohol excessively? Better yet, how can we prevent Alcohol Use Disorder (AUD) from developing in the first place?

Alcohol Use Disorder

In the recent update to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013), the distinction between alcohol abuse and dependence was eliminated. Instead, AUD is now on one spectrum with severity specified as mild (two to three symptoms), moderate (four to five symptoms), or severe (six or more symptoms). Diagnostic criteria in A. can fit within groupings of impaired control (Criteria 1-4), social impairment (Criteria 5-7), risky use (Criteria 8-9), and pharmacological criteria (Criteria 10-11). This basic organization is important to keep in mind because the number of symptoms and grouping of criteria can be useful in developing individualized treatment approaches. For example, if someone meets criteria for Alcohol Use Disorder, Moderate, and most of the symptoms are in the impaired control grouping, the recommended treatment would likely need to be different than for someone with the same severity of AUD, but whose symptoms were spread equally across three groupings.

Treatment of AUD

The good news is that recovery from AUD is possible, and even likely, for many. Just as there is a range of AUD in terms of criteria grouping and severity, there is a range of treatment options. Settings can range from long-term residential, short-term residential, medical detox, intensive outpatient, general outpatient, facilitation of 12-step attendance, and self-help strategies. It is important to remember, however, that most people who meet criteria for AUD recover on their

DAVID E. JENKINS

Alcohol Use Disorder is the most common of the substance-related and addictive disorders. The number of people who have AUD, not to mention others who are affected, far exceeds the number of those who struggle with other addictive drugs and behaviors.

own without engaging formal treatment, including mutual help groups (MHG) (Bischof, Rumpf, & John, 2012). Factors such as problem severity, degree of social support, unsuccessful quit attempts, and behavioral economic analysis are important considerations that could be effectively enhanced to support natural recovery. Relapse triggers related to natural recovery broadly involved stress resulting from loss and related to problems with health, relationships, finances, and employment, but also included lifestyle changes, changes in perspective regarding substance use, and religious reasons (Bischof et al., 2012).

Unfortunately, fewer than 25% of those who need treatment access it at all, much less early in the development of AUD. For those who do want or need treatment for AUD, there is a continuum of options that reflects severity of the disorder, intensity and duration of treatment, the degree to which counselors (lay, pastoral, and professional) are involved, and whether medical aspects need to be addressed. Tucker and Simpson (2011) described this recovery spectrum from self-change to seeking treatment. Screening and brief interventions, guided self-change, and Internet resources have all demonstrated some effectiveness and are consistent with a public health approach. Counselors must remain humble and keep in mind that nearly three-fourths of those with AUD recover without formal treatment. And, although very controversial, there is substantial evidence that a number of those who no longer have symptoms of AUD, and were untreated, are able to drink in moderation without further problems. Those who seek treatment for AUD, though, tend to have more severe problems, so abstinence is the more appropriate goal (Tucker & Simpson, 2011). Often, treatment helps individuals consolidate changes that are already happening in their lives. Wise counselors will tap into this naturally occurring change process, even when people decide to engage treatment for AUD.

A recent review identified nine evidence-based treatments for AUD, which included: cognitive behavior therapy, contingency management, cue exposure therapy, community reinforcement approach, behavioral couples and family treatment, brief interventions, motivational interviewing and motivational enhancement therapy, 12-step-based therapies, and case management (Hallgren, Greenfield, Ladd, Glynn, & McCrady, 2012). Therapist and relationship qualities important in AUD treatment outcome include therapeutic alliance, empathy, directiveness, and confrontation. It is important to note that while positive therapeutic alliance and greater empathy are associated with better outcomes, counselor directiveness and confrontation are associated with poorer outcomes, including more client resistance, which is linked with greater frequency and higher quantities of alcohol consumption (Hallgren et al., 2012).

In addition to competence in specific treatments, Glasner-Edwards and Rawson (2010) recommend counselors possess the following four skill sets: use of contingency management principles; motivational interviewing techniques; cognitive behavioral coping skills/relapse prevention strategies; and couples/family counseling techniques. Maintenance and practice of these skills are enhanced through supervisor-facilitated demonstration and rehearsal (Glasner-Edwards & Rawson, 2010).

Prevention of AUD

As important as it is for counselors to be skilled in the treatment of AUD, even more important is for counselors to meaningfully contribute to its prevention. Ultimately, the best hope of mitigating the impact of AUD is to prevent it from occurring in the first place. Since the onset of first alcohol use is as low as 11 years of age, and because earlier age of onset greatly heightens the risk of developing

AUD, targeted prevention efforts are important. These include prevention programs for youth, school-based interventions, engaging communities to prevent underage drinking, family-focused interventions, college drinking and prevention, workplace interventions, and prevention in the military (NIAAA, 2012).

Conclusion

Alcohol Use Disorder is the most common of the substance-related and addictive disorders. The number of people who have AUD, not to mention others who are affected, far exceeds the number of those who struggle with other addictive drugs and behaviors. Recent evidence-based practice research requires counselors to adapt their own beliefs, perspectives, and treatment traditions to this accumulating body of knowledge. Broadly, we must serve those struggling with AUD with competence, compassion, and commitment. We need to treat individuals with the inherent, God-given dignity of being His image and likeness bearer, honoring their autonomy to bear the freedom and responsibility to make their own choices, especially when those choices might concern or challenge us. May God continue to richly bless you and those you counsel! ✠

DAVID E. JENKINS, PSY.D., *is Professor of Counseling and the Director of the M.A. in Addiction Counseling program in the Department of Counselor Education and Family Studies at Liberty University in Lynchburg, Virginia. He has worked extensively with addictive, mood, and anxiety disorders in the context of individual, marital, group, and family therapy.*

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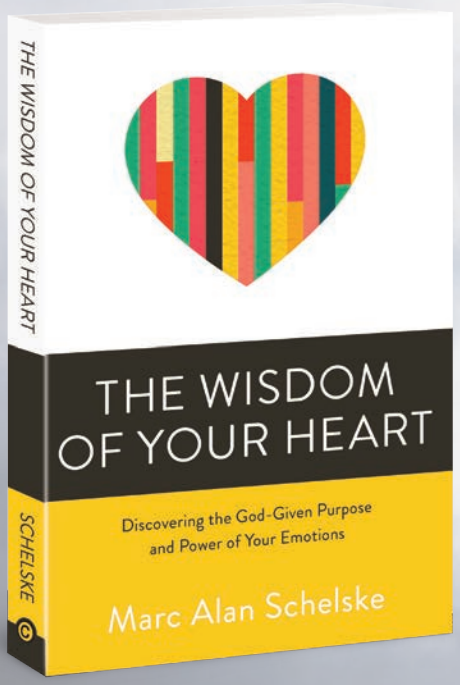

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Marc Alan Schelske is a writer, speaker, husband, father, and tea-drinking pastor who rides a motorcycle. He is the teaching elder at Bridge City Community Church in Milwaukie, Oregon, where he has served full time for eighteen years. Marc writes about intentional spiritual living at www.MarcAlanSchelske.com.

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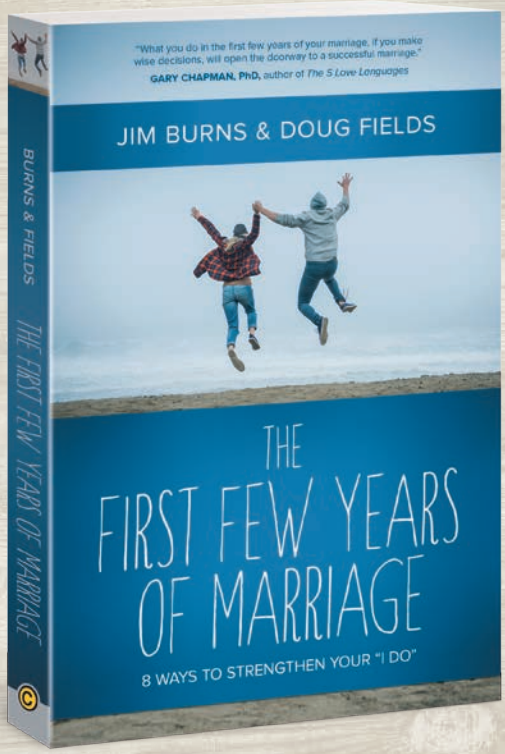
DOUG FIELDS is the senior director of HomeWord Center for Youth and Family and the cofounder of Download Youth Ministry. He speaks to thousands of leaders, teenagers, parents, and couples each year, and is the author or coauthor of more than 60 books. Doug has been married for 32 years to his wonderful wife, Cathy, and they have three grown children.



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"A café latte, a large Diet Mountain Dew©, and an energy drink" in two hours and a 16-year-old South Carolina teen was gone. A "caffeine-induced cardiac event" took his life.[1] There may be evidence that caffeine is relatively harmless, but don't tell that to Davis Allen Cripe's family. For some, at least, caffeine and stimulants are dangerous.

Davis was an adolescent. You're an adult.

Tired after a late night, while on your way to work you stop for a triple shot with your Venti drip. Later after lunch, you grab a couple of Red Bull's® to keep you awake for afternoon meetings. At 4:00 p.m., you take a break to enjoy that regular double espresso for the final workday push. During the day, you have consumed approximately 575mg of caffeine, to say nothing of the other additives and enhancements that boost the effect.

Experts vary, but on this one day your caffeine intake is 50-100% more than what is considered safe for even the healthiest of adults.[2] Add in the additional chemicals that often accompany caffeine, like sugar and other "energy-boosting" additives, and the caffeine equivalent can easily reach three times what is considered safe. And this is if you are not in one of the "at risk" categories for over-the-counter stimulants (Note: caffeine and the other additives in energy drinks, for a variety of reasons, are not considered drugs), which includes young people, the elderly, those with heart issues, those who are pregnant or breastfeeding, people who are prone to anxiety, nervousness, and the list goes on.

This may not be you, but according to the Food and Drug Administration (FDA), Mayo Clinic, and other respected neutral researchers, this is a typical day for many of the people with whom you live with, work with, and know. The truth is, caffeine is a stimulant—and like all chemicals that are part of this drug category (e.g., cocaine, amphetamines, crystal-meth, etc.), caffeine increases alertness, attention, and energy, as well as elevates blood pressure, heart rate, and respiration… sometimes to dangerous and life-threatening levels.

The positive effects of caffeine and other "natural" (non-drug) stimulants have been well-known for centuries. In every culture, people have found a way to develop beverages and foods that enhance their lives.

The Vital Stats

- 90% of people in the world use some form of caffeine.[3]
- In the United States, 80% of adults consume caffeine daily, with the average amount being about 200mg (a large cup of coffee or four cans of Coke®).[4]
- From 2003-2008, prior to the exponential rise of the popularity of energy drinks, adolescents and young adults consumed on average 100mg a day. In 2016, more than 80% of teenagers drank caffeinated beverages "regularly," and at least 96% "consumed them occasionally."[5]
- The global energy drink industry recorded sales of $50 billion in 2014 and $55 billion in 2017.[6] Coffee is the number two commodity in the world, after crude oil, and in 2015 was worth more than $100 billion.[7]
- Caffeine and other "natural" (non-drug) stimulants have recently become staples in such non-beverage foods as marshmallows, sunflower seeds, potato chips, jerky ("Perky Jerky"®), and even waffles. "Energy lifting foods in the U.S. soared to more than $1.6 billion in 2012."[8]

What is the Draw?

The positive effects of caffeine and other "natural" (non-drug) stimulants have been well-known for centuries. In every culture, people have found a way to develop beverages and foods that enhance their lives. The draw to coffee, tea, and energy drinks today is no different. We enjoy, and many have come to rely on, that slight to even jolting boost that caffeine and other additives provide. It is commonly known that caffeine, and similar natural stimulants, increases alertness, the ability to concentrate, and blocks the receptors that signal being tired.[9] While we know that these benefits are short-lived, generally a few hours, most of us still appreciate what a cup of coffee can do to jumpstart a morning.

When it comes to the allure that energy drinks offer adolescents and young adults, there are even stronger factors at play. Research shows that reasons include, "… providing energy, taste, accessibility, and image enhancement. Influences for caffeine use most noted by (teenagers) included parental role modeling, media and advertising, and social norms. Statistics show that adolescents are the fastest growing population of caffeine users."[10]

When Too Much is Too Much: The Effects of Excessive Stimulants

There is no firm consensus on how much caffeine and other energy stimulants are considered safe for adults. Sadly, there have been instances where a person appears to be "healthy," but still experienced a concerning to serious reaction, and even death, to caffeine intake. For the most part, however, no evidence exists for the general population that there is any cause of concern. Yet, there is agreement that children (infants to 11 or so) should avoid all caffeine and energy drinks, and adolescents and young adults (11 to early 20s), as well as people in high-risk categories, only consume it in severe moderation (100mg/day). Even then, the death of young Davis, while tragic, is considered a rarity among researchers.

However, there are adults who are sensitive to the effects of caffeine and other stimulants and are not paying attention to the potential negative consequences. For them, and developing adolescents and young adults, the following risk factors are real:[11]

- Lethargy or tiredness, generally a few hours after consumption
- Headaches and migraines
- Stomach aches
- Nervousness, anxiety, and physical "jitters"
- Insomnia
- Alcohol and drug interactions
- Cardiac issues, including hypertension and even heart attacks
- Addictive by some
- Evidence related to manic episodes, panic attacks, and delusions

While most adults are aware of these potential side effects, few adolescents have any idea.[12]

CHAP CLARK



What Do We Do?

Most adults have been acculturated to seek out energy and stimulation from a cup or a can. It is part of the global culture. While there is evidence to remind us to be cautious, as a society we have deemed this to be a safe, and even positive, lifestyle choice; the same is true among our kids. Still, the signs are strong enough to cause mental health professionals, parents, and even pastors concern. Some people simply cannot handle the amount of caffeine they are consuming, some should be careful, and some should simply abstain.

To help those who need to be careful with their love of coffee or energy drinks, we can take the following steps:

- Advise parents to avoid any caffeine in their children's diets, at least until puberty (researchers are unanimous on this). This includes foods that contain caffeine to boost their appeal, like new forms of drinks and candy.
- For adolescents and young adults (and their parents), we should help them understand the downsides to excessive use of caffeinated beverages and foods, and what the medical community advises the average use should be during this season.
- For adults who tend toward excessive amounts of caffeine and energy stimulants, or who experience side effects, help them be proactive to address what their bodies are telling them (like maintaining a journal of consumption and recording possible side effects).

Davis Cripe didn't mean to stop his heart; he just wanted to stay awake for class. May his life be a wake-up call to us all.

CHAP CLARK, PH.D., *is professor of Youth, Family, and Culture at Fuller Theological Seminary, President of ParenTeen, Inc., and co-interim preaching pastor at St. Andrews Presbyterian Church in Newport Beach, California. He is also a speaker, trainer, consultant, as well as the author or co-author of 24 books, including the award-winning* Hurt 2.0: Inside the World of Today's Teenagers, Sticky Faith, Deep Justice in a Broken World, Adoptive Youth Ministry: Integrating Emerging Generations into the Family of Faith, *and the forthcoming* Practicing Adoptive Youth Ministry.

Endnotes

1 As reported by CNN, accessed on July 29, 2017 at http://www.cnn.com/2017/05/15/health/teen-death-caffeine/index.html.

2 The Mayo Clinic advises the maximum adult caffeine intake is 400mg a day, and the FDA says it should be somewhere around 200.

3 Federal Drug Administration (FDA), "Caffeine and Your Body," accessed July 29, 2017 at https://www.fda.gov/downloads/ucm200805.pdf.

4 FDA claims that four cans of Coke (referring to a 12-ounce can) add up to 200mg (Ibid.), and the Mayo Clinic reports "Cola" as having 24-46mg in an 8-ounce can, "Nutrition and Healthy Eating," mayoclinic.org, accessed on July 29, 2017 at mayoclinic.org.

5 Turton, P., Piché, L., & Battram, D.S. (2016). "Adolescent attitudes and beliefs regarding caffeine and the consumption of caffeinated beverages," *Journal of Nutrition Education and Behavior. Vol 48(3)*, 181-189.

6 "The Energy Drinks Industry," accessed on July 25, 2017 at http://www.investopedia.com/articles/investing/022315/energy-drinks-industry.asp, and "The Energy Drinks Market – Global Trends, Competitive Landscape and Sector Forecasts to 2022," Mordor Intelligence, accessed on July 29, 2017 at https://www.mordorintelligence.com/industry-reports/energy-drinks-market.

7 "Global Coffee Industry Facts & Statistics of 2014-2015," Wevio, accessed on July 29, 2017 at http://www.wevio.com/global-coffee-industry-facts-statistics-of-2014-2015/.

8 Hartel, K. "7 foods that are infused with caffeine," *Fitday.com*, accessed on July 22, 2017 at http://www.fitday.com/fitness-articles/nutrition/7-foods-that-are-infused-with-caffeine.html.

9 Walsh, B. "Coffee and hormones: Here's how coffee really affects your health," in *Precision Nutrition*, accessed on July 26, 2017 at http://www.precisionnutrition.com/coffee-and-hormones.

10 Turton, Ibid.

11 This list represents a summary of the references used in this article and reflects a consensus of the literature on potential side effects of excessive caffeine use.

12 Visram, S., Cheetham, M., Riby, D.M., et al. (2016). "Consumption of energy drinks by children and young people: A rapid review examining evidence of physical effects and consumer attitudes," *BMJ Journals Open*, *6*(10), accessed on July 29, 2017 at http://bmjopen.bmj.com/content/6/10/e010380.

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As a wife or as a masterpiece?

As a person you live with or
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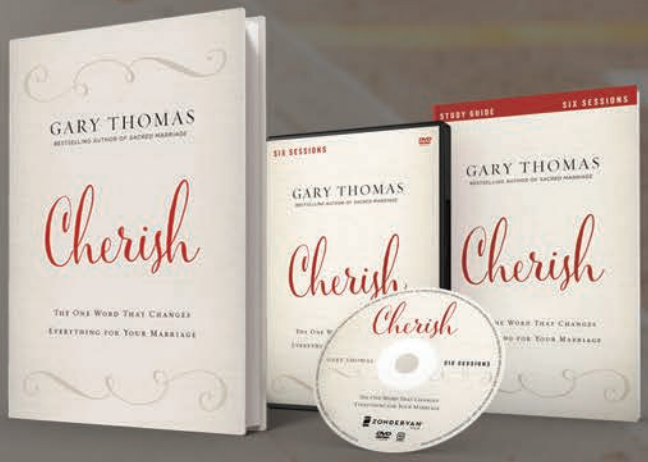

When it comes to marriage, we talk a lot about love—but what does it mean to cherish? Why do we say it once at the wedding and then rarely even mention it again? These are the questions Gary Thomas answers in *Cherish*. In it, you'll discover why relationships excel and joy skyrockets when we choose to cherish the person we married. Available wherever books are sold.

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In our world today, treating addiction has never been more important or challenging. While it is true that one's only hope in overcoming addiction lies in the professional community's ability to integrate effective psychological theory, along with the life-changing reality of a relationship with God, this integration is not as simple as we might think. At our Christian rehab center called HopeQuest, and through the practical application of scientific evidences documented in research outcomes, we have developed a unique approach to integrative addiction treatment that has documented effectiveness.

Effective Addiction Treatment:

A MODEL OF CLINICAL PRACTICE

A casual review of scientific literature will demonstrate there are many different models and theories that exist in an attempt to describe the cause of addictive behavior and guide the development of targeted treatment interventions. Programs employing these varying models and theories may be limited in treatment outcomes if they are uninformed by these very models and theories.

Some very comprehensive models are beginning to emerge in the area of neuroscience. One specific model is by Oliver George and George Koob (see George & Koob, 2010; Koob, 2008; Koob & Le Moal, 1997; Koob & Le Moal, 2006; Le Moal & Koob, 2007; & Koob & Volkow, 2010). A central tenant of Koob's model is a principle called "hedonic homeostatic dysregulation." This conceptualization describes the way that *impulsive* behavior related to drug use and positive reinforcement transforms into *compulsive* behavior and negative reinforcement. Because of such models, a greater understanding is available to professional clinicians concerning how mental functions, supported by different neural substrates and cognitive modules, are involved in the addictive process.

Specifically, Koob's work helps bring a more objective scientific base to the idea of a "disease model of addiction." Particularly, it is now possible to demonstrate how neurological substrates undergird addictive behavior. In addition, greater insights are emerging concerning how addictive behavior involving alcohol and substances can result in alterations to brain structures that perpetuate an addiction.

While the causal relationship between genetics and neurological changes is not yet fully understood, other researchers are making advances in understanding the influence of genetics (see Leeman & Potenza, 2013). It is likely that genetics make one more susceptible to addiction, while neurological changes resulting from addictive behavior lead to brain structure alterations that perpetuate an addiction.

Not all treatment programs today are informed by the available science related to addiction. While modalities—such as individual therapy, group therapy, psychoeducation, couple therapy, and family therapy, along with other approaches such as equine therapy and art therapy—are often helpful, the most effective treatments will be able to utilize specific, targeted interventions based on the assessed need of the patient.

In the residential treatment center at HopeQuest, a majority of those admitted are experiencing deficiencies in their capacities for tolerating distress (see Zvolensky, Vujanovic, Bernstein, & Leyro, 2010). Such capacity deficiencies likely exist due to a developmental trajectory where, for some reason, the development of mature distress tolerance capacities was hindered. For such an individual, addiction programs that focus primarily on stress coping strategies (i.e., "skill building") may not have the best results.

Because of the complex nature of addiction, a multidisciplinary approach to treatment planning may be the most effective. The Oxford English Dictionary (n.d.) defines multidisciplinary as: "Combining or involving several academic disciplines or professional specializations in an approach to a topic or problem." This is beyond simply an integrative approach. An effective treatment program will be informed by medical and mental health science, along with the support and understanding that come from the addiction recovery and spiritual communities.

When considering effective treatments, it is important to find approaches that are not limited by a particular program developer's experiences. Look for programs that are informed by those from the addiction recovery community, but are also advised by streams of thought in psychology beyond just cognitive psychology. For example, to understand deficiencies in distress tolerance capacity building, a perspective from developmental psychology is needed. Successful treatment will not only integrate pharmacology in treatment planning, but also utilize current medical science beyond merely using pharmacology.

Look for programs that are informed by those from the addiction recovery community, but are also advised by streams of thought in psychology beyond just cognitive psychology.

It is likely that dual diagnosis enhanced programs will come to be considered as the most effective treatment programs in our current day. According to the American Society of Addiction Medicine (2013), "When two or more disorders co-occur and are concurrent, they all need to be addressed simultaneously as 'primary' conditions in order to provide the most effective integrated and holistic care" (p. 46).

Finally, effective treatment strategies will incorporate not only programs and services targeting the management of symptoms along with achieving sobriety, but also support systems and services that help those in recovery rebuild

ROY A. BLANKENSHIP

their lives in their communities (see Davidson, Evans, Achara-Abrahams, & White, 2014). As our industry moves forward, effective treatment approaches will consist of service providers who collaborate and work together on client cases and "possess common values, a consistent approach, and a shared vision for the people they serve" (Davidson, Evans, Achara-Abrahams, & White, p. 185).

ROY A. BLANKENSHIP, LPC, LMFT, CSAT, CAADC, *is the CEO and Chairman of The HopeQuest Ministry Group in Woodstock, Georgia. He created HopeQuest to help individuals and their families impacted by addiction experience hope, freedom, and life. Roy is currently pursuing his Ph.D. in Addiction Psychology.*

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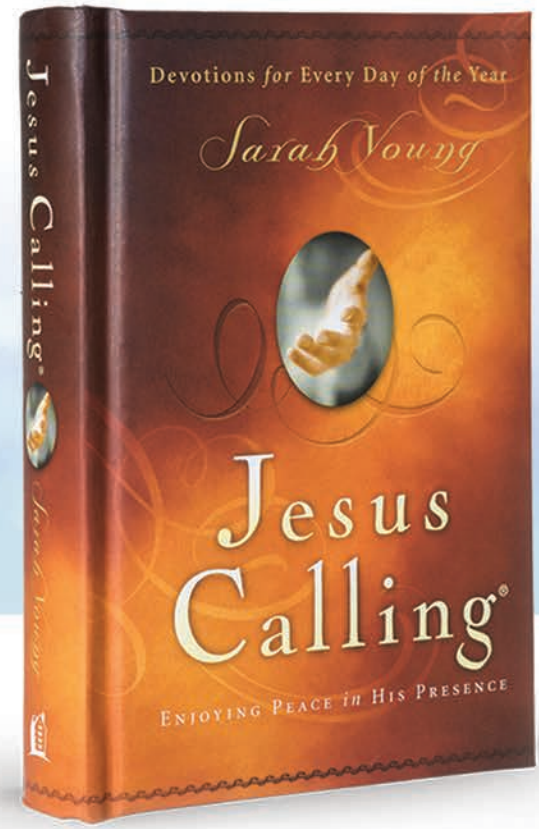

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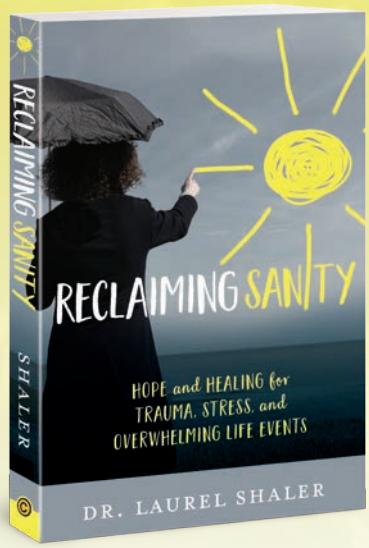

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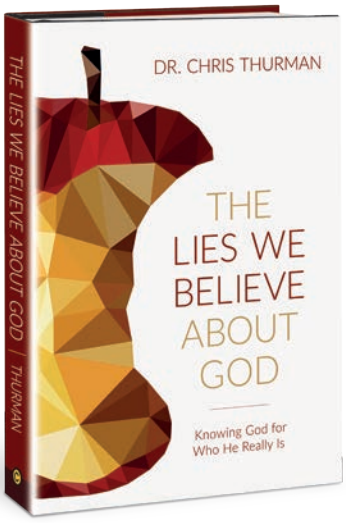
Photo by Heather Kitchen

Laurel Shaler, PhD, is a professor at Liberty University and a speaker on faith and emotional well-being. A national certified counselor and social worker, Dr. Shaler is a former psychotherapist for the Department of Veterans Affairs, where she specialized in treating trauma. She and her family live in Greenville, South Carolina.

HOW YOU VIEW GOD IS THE MOST IMPORTANT THING ABOUT YOU



Your view of God—and your assumptions about His view of you—affect you every moment of the day. That's why it's so important that you know the truth about who God is and why He wants you to know Him intimately.

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DR. CHRIS THURMAN is a psychologist, bestselling author, and highly sought-after speaker. He has a doctorate in counseling psychology from the University of Texas and has been in private practice for over twenty-five years. Chris has authored numerous books, and conducted hundreds of personal growth seminars for churches and corporations around the country.

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RECOVERY

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In a meeting in 1991, Tyndale House Publishers partnered with us to create *The Life Recovery Bible*, a unique combination of a study and devotional Bible. It is designed for fellow strugglers who never knew about the powerful principals and biblical foundation of the 12-steps, or perhaps knew, but never actually "worked" them. Some have even resisted looking into how the steps help transform lives out of whatever it is that has broken and kept them stuck in a place which God never intended. This Bible is also designed for those who are involved in 12-step recovery programs and longed for an effective integration tool. Alcoholics Anonymous (AA) and, eventually, the 12-steps were birthed by Dr. Bob (Smith) and Bill W. (Wilson), who were deeply involved with the Oxford Group movement (a faith-based organization founded by American Christian missionary, Dr. Frank Buchman). They were living out the four Absolutes defined by the Group—*absolute honesty, absolute purity, absolute unselfishness,* and *absolute love*—as they helped others find the sobriety they, themselves, were experiencing.

STEVE ARTERBURN AND DAVID STOOP

Even more astonishing than those early results when Christ was clearly at the center of recovery, is how long it has taken to reestablish those Christian truths and values again today as the foundation for successful recovery.

In those beginning days of the program, there were no 12-steps. Bill W. wrote that all they had, before the 12-steps, were six precepts relayed to him by Ebby T. (Thacher), who was a former drinking partner and Bill W's sponsor. Here are the six precepts:

1. We admitted we were licked.
2. We got honest with ourselves.
3. We talked it over with another person.
4. We made amends to those we had harmed.
5. We tried to carry the message to others with no thought of reward.
6. We prayed to whatever God we thought there was.

From these precepts, the steps emerged from hours of discussions between Dr. Bob, Bill W., and Rev. Sam Shoemaker (helped start an Oxford Group chapter in Akron, Ohio), as they studied portions of the Bible that also lined up with their Oxford Group experiences and supported their own recovery journeys.

The three portions of Scripture specifically identified as foundational in the development of the 12-steps were the Sermon on the Mount, (which included the Beatitudes); the book of James (which focuses on several 12-step fundamentals, such as *confession*); and I Corinthians 13 (also known as "the love chapter"). All three of these portions of Scripture from the New Testament clearly establish the Christian and biblical roots of AA and the 12-steps. Coming out of their study of the Bible, these early pioneers only included the truth we find in God's Word.

In the early days of AA, when conservative Christian values and truths were unapologetically used to help others in recovery, the success rate was quite amazing. In the Akron, Ohio, group, the book, *Dr. Bob and the Good Old Timers*, tells how Dr. Bob took every newcomer to what was called "the surrender room," and there, they were urged to surrender their lives to Jesus Christ at the very beginning of their recoveries. Nearly 93% of those in the Akron group never relapsed. For a problem that had resulted in hopelessness and helplessness for centuries, this was truly inspiring.

Imagine what it was like to hear of alcoholics being "cured" (as the unknowing world called it) at a time when anyone getting better was considered the result of a rare, divine miracle. We can compare that period with what it would be like if 93% of people with Stage IV incurable and inoperable brain cancer went to Akron, Ohio, and miraculously found healing. Every media outlet would send someone there to discover what was going on. Back then, the significant number of alcoholics getting better caused such a stir that the wealthy John Rockefeller sent his son to find out what was producing this wonderful miracle. When he reported back, he told his father they all had undergone a conversion experience with God.

Even more astonishing than those early results when Christ was clearly at the center of recovery, is how long it has taken to reestablish those Christian truths and values again today as the foundation for successful recovery. We are honored to be part of that movement with the publishing of *The Life Recovery Bible*, the additional accompanying resources, the creation of The Life Recovery Institute, and the establishment of Life Recovery groups around the world.

The big question in most people's minds is, "Does recovery really work?" As AA grew and expanded, research on its effectiveness became limited, and almost non-existent, due in large part to the "anonymity" of its membership. However, with the development of treatment centers, a base for research became available. Now there are ample numbers of identifiable people as research participants, and much of the results are reported in Joseph Nowinski's book, *If you work it, It Works!*[1] In reviewing the research, he found four factors that led to success in sobriety. One insight was that four meetings per week, instead of three, made a significant difference. He also found the success that many studies reported was related to whether or not a person had a sponsor.

Nowinski, however, also noted there were two variables believed to be even more important to a person's recovery and more critical to success. Surprisingly, one of them had to do with getting outside of one's self in order to help others, even if it simply meant helping set up a room for a meeting or staying after to clean up. It is a simple expression of the 12th step, which, in part, says, "Having had a spiritual awakening… we tried to carry this message to others…."

The other significant factor was that in the recovery process, many of those who were successful at maintaining their sobriety had developed a personal relationship with God. They had not only made a decision to turn their wills and lives over to the care of God (Step 3), they had also developed a personal relationship with the Lord that positively impacted their daily lives. It is the expression of the 11th step that says, "We sought through prayer and meditation to improve our conscious contact with God…." These two variables, in particular, are what give recovery its

foundation and very essence.

Using *The Life Recovery Bible* as the primary tool, along with attending 12-step meetings and working the steps, one can transform his or her life and join millions of people who have allowed God to take over what they could not previously control and believe in what was once so hard to accept.

One of the first people who obtained a *Life Recovery Bible* was suicidal and addicted to crack cocaine. After six months, she had totally transformed her life and was helping other women find recovery. When asked what had happened, she replied, "I stopped believing the lies of Satan and started believing the truths of Jesus Christ." She was the first person we met in our history to use this tool with God's truth to transform her life. History has repeated itself with countless others since that time. Those truths are now available to you and we are praying that this reality will become the foundation and ongoing basis for a deeply fulfilling life of recovery and restoration. ✠

(*This article was adapted from the* Life Recovery Bible, *2nd Edition*)

STEVE ARTERBURN, M.ED., *is the founder and chairman of New Life Ministries and host of the #1 nationally syndicated Christian counseling talk show, New Life Live!, heard and watched by more than two million people each week on over 150 stations nationwide, SiriusXM Satellite radio, and NRBTV. He is also the host of New Life TV, a Web-based channel dedicated to transforming lives through God's truth. Steve also serves as a teaching pastor in Indianapolis, Indiana.*

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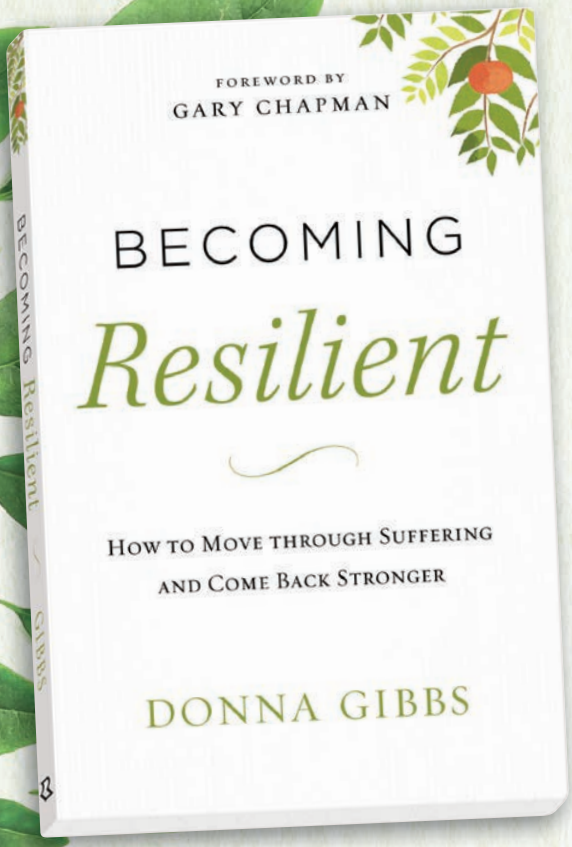
Endnote

1 Nowinski, J. (2015). *If you work it, it works! The science behind 12 step recovery.* Hazelden Publishing, Center City, MN.



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—From foreword by **GARY D. CHAPMAN**, PhD, author of *The Five Love Languages*

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THE NATURE OF THE BEAST:

Addiction and Grace in an Imperfect World

A common debate centers on whether or not chemical dependency is disease-based (primarily genetic/biological) or choice-based (primarily habits/social environment). Christians often incorporate the sinful nature of fallen man into the equation, and Paul's commentary in Romans 7:15-25 is a poignant reminder of this, "… but I see another law at work in me, waging war against the law of my mind and making me a prisoner of the law of sin at work within me" (vs. 23).

Even though children of alcoholics are said to be four times more likely to become addicted themselves, initial theories of a single alcoholism gene—or any addiction gene for that matter—have been disproven. Nevertheless, biological determinants cannot simply be ignored or discarded out of spiritual convenience. Years of qualified research have demonstrated that addiction is influenced both by multiple genetic traits, called "polygenic" or addictive inheritance, and a complex array of psychosocial dynamics. However, it is important to keep in mind that *susceptibility* does not necessarily imply *inevitability*.

Most practitioners who work in this field understand the needs-based aspect of addictive behavior that seems to fuel the dynamic. On a human level, this includes the need to be insulated from worry and anxiety, the need to reduce manipulating guilt feelings, the need for approval and acceptance, the need to maintain a sense of control and power in one's environment, the need to avoid pain (physical, emotional, psychological), and the need to be a perfect person and measure up to the expectations of others. The problem lies in the fact that these needs, while perhaps legitimate, are being met in an illegitimate way.

From a biblical vantage point, addiction in all its various forms, results in the formation of spiritual strongholds and bondage in the life of the addict. The Greek word, *pharmakon*—a feminine noun where we derive the words like pharmacy, pharmacist, and pharmaceutical—is used to describe a curative or medicinal drug. Interestingly, a derivative with the same root, *pharmakeia*, relates to sorcery, the occult, witchcraft, illicit drugs, and incantations associated with drugs (Galatians 5:20-21, Revelation 9:20-21). The body is remarkably (even divinely) balanced chemically, and it is interesting to note when that balance is disrupted (either by introducing chemicals into the system that are not necessary/appropriate or through other conditions such as psychosis and schizophrenia), spiritual doors (mostly destructive) seem to be opened within a person's soul. This is why treating addictions is often accompanied by spiritual battles with our clients.

Consider the following passage (2 Kings 17:16-17) during a time in Israel's history when the people, by-in-large, had deserted their singular devotion to God and began committing what the Bible refers to as spiritual adultery. Several words (highlighted) speak to an important process.

> "They *forsook* all the commands of the LORD their God and *made* for themselves two idols cast in the shape of calves, and an Asherah pole. They *bowed* down to all the starry hosts, and they *worshiped* Baal. They *sacrificed* their sons and daughters in the fire. They practiced divination and sought omens and sold themselves to do evil in the eyes of the Lord, arousing his anger."

From a faith perspective, addictions are sometimes referred to as *spiritual strongholds*. It may not sound overly profound, but a good definition is that they represent something which has a *strong hold* on a person. In the passage above, a progression can be seen, beginning with a choice the Israelites made and ending with a generational impact.

1. ***The first choice*** – to *forsake* God. In this context, it means the Israelites engaged in a volitional act of the will to turn their backs on Him and walk in a manner that was contrary to what He desired. All addictions involve moral choices. While the research clearly indicates a genetic predisposition for some individuals, as in the case of alcohol dependency, it does not mean a person will be automatically compelled to take the first drink. Choices are still made. In a pure disease model, choice would not be a factor. For example, if a person had cancer, he/she typically would not merely wake up one morning and say, "I choose not to have cancer" and it would then disappear. However, when it comes to an addiction, people can make choices one day at a time (Step 3 in the 12-step process) to live differently. If choice was not an option, no one would ever move from addiction to sobriety and into the recovery process.
2. ***The second choice*** – to *make* idols. In other words, the Israelites took what was already in their hearts, minds, and spirits and then brought these objects into their tangible reality. When it comes to addiction, a person first makes a choice in the heart and mind and then "brings" the bottle, the line of cocaine, the pornographic image, the food item, the slot machine, etc., into reality. They set it before them for the purpose of engaging the object or behavior.
3. ***The third choice*** – to *worship* what was made. Worship at its most basic level is simply giving someone or something one's time and attention in such a way it is elevated in prominence and priority. People can worship many things other than God. In an addictive progression (from experimentation to occasional using to regular using to dependency), individuals begin to spend more and more time and give more and more attention to the object or behavior they have set in front of them.
4. ***The fourth choice*** – to *serve* Baal (the idol the Israelites fashioned and then worshiped). The Hebrew word for "serve" used here is "*abad*," and it does not mean to serve in the positive connotation of assisting or helping another. The literal translation is "to be in bondage to" or "enslaved by" something. The progression from an

If choice was not an option, no one would ever move from addiction to sobriety and into the recovery process.

act of the will, to bringing something into one's life, to giving it greater priority may then result in bondage and enslavement (addiction and dependency) to the object or behavior.

5. ***The fifth choice*** – to *sacrifice* their children as a result of their disobedience and, in essence, *passing* the problems to the next generation. Baal worship at the time included human sacrifice, among other abominations. With addiction, we often see the negative impact for an addict's family members and loved ones who are being sacrificed on the altar of the drug being consumed.

Now, let's go back to the beginning of the process. If forsaking God is the first step down a path leading to destructive consequences, then Scripture beckons to a place of *confession*, *repentance*, and *godly sorrow* as the first steps back to sanity and a healthier lifestyle (1 Corinthians 7:10-11). Counselors and caregivers need *humility* to approach the one who is addicted, *discernment* to understand what God is doing, *wisdom* to know what to do with what He reveals, *grace* to apply His solution in the matter, *power* to push through the resistance of the "evil one," and *love* to "cover a multitude of sins."

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WHEN WE TRY TO **RESCUE**, **FIX**, AND **ENABLE** OTHERS

"Do nothing out of selfish ambition or vain conceit. Rather, in humility value others above yourselves, not looking to your own interests but each of you to the interests of the others."
— Philippians 2:3-4, NIV

codependency

noun | co·de·pen·den·cy | \ˌkō-di-'pen-dən(t)-sē\

excessive emotional or psychological reliance on a partner, typically a partner who requires support due to an illness or addiction.[1]

That passage of Scripture is divine… while the definition that follows is dysfunctional. In the middle lies a vast field of choices, behaviors, motivations, and attitudes. Both the Scripture verse and definition appear to involve caring for people; however, the first centers on others and the latter centers on self. For those who try to rescue, fix, and enable, especially others with addiction, knowing where the divine stops and the dysfunctional starts becomes imperative.

Unhealthy Reliance

For a codependent relationship to exist, both parties must have an unhealthy reliance on the relationship. In codependency with addiction, there is an additional relationship at play. The codependent partners have an unhealthy relationship with each other, but both also have an unhealthy relationship with the addiction. The addict's primary relationship is to the addiction, leaving the codependent person unable to avoid a collateral relationship with the chemical substance or destructive behavior, which further entwines and complicates the codependent relationship.

Codependent relationships that involve addiction agree to an unholy alliance, as the true definition of care for others is exchanged for a false distortion of self-care. The one partner says, "If you agree to love me addicted more than you love me healthy, I agree to stay so you can feel worthwhile and needed," to which the other partner agrees. "You need me," becomes "I really need you."

In an odd way, these types of codependent relationships with addiction seem to be a sort of Munchausen's syndrome by proxy (MSBP). In MSBP, a caregiver (usually a parent) either causes or falsifies the illness or injury of a person under his or her care for personal reasons. In codependent addictive relationships, each person doesn't falsify, but facilitates injury to others through the addiction for personal reasons.

Facing the Truth

The addict's reason for staying in a dysfunctional relationship is often straightforward, to continue the addiction. The codependent's reasons can be harder to pinpoint, especially when natural sympathy can fall upon that partner for "putting up" with the addict's behavior. That partner can be showered with sympathy, compassion, and praise for "loving" the person so much and trying so hard in the relationship. The addiction, then, produces a collateral benefit for the codependent partner, who may struggle with issues of worthlessness and low self-esteem. Each partner can perceive a "benefit" from the addiction.

Who would want to live this way? How can you know you have crossed that line from divine love to dysfunctional codependency? This can be especially challenging if you grew up attempting to please a difficult parent. Giving in to others or engaging in passive-aggressive behavior to fill your needs may come as second-nature, so this line is blurred. Sometimes, to understand our own behavior, it is helpful to view that behavior through the lens of others. Over the years, I have seen the following codependent responses to addiction:

- Refusal to confront the addiction for fear of losing the relationship
- Accepting the presence of the addiction, either overtly or covertly
- Organizing the relationship to accommodate or conceal the addiction
- Attempting to minimize the damage done by the addiction to self and others
- Placing blame for the addiction's consequences onto self and others, but not the addict
- Attempting to control others in the family in an effort to manage the addiction
- Competing against the addiction, either overly or covertly
- Attempting to bargain with the addiction to "save" the relationship
- Accepting responsibility for solving problems arising out of the addiction
- Personalizing the reasons for the addiction
- Accepting the role of victim
- Expecting positives for remaining in the relationship

GREGORY L. JANTZ

When Love is Tough

Love, as we learn in 1 Corinthians 13, has amazing, resilient attributes. Love, however, is not always straightforward or comfortable. It is not always saying "Yes" to the other person, when "Yes" means injury. Love can be, at times, confrontational… what has come to be known as "tough love."

Rescuing, fixing, and enabling may seem loving, but each is a heady, powerful pursuit. A person with codependent tendencies may have difficulty recognizing or accepting such underlying reasons for attempting any or all.

- To rescue someone, you need to be able to alter his or her circumstances. In the case of addiction, the condition you need to be able to alter is the addiction itself, and the only person who can do that is the addict.
- Similarly, as much as you might desperately wish, you are not able to fix another person. You can encourage and support, but people must, ultimately, be responsible for themselves and the first step is admitting they are "broken."
- Enabling is either good or bad, depending upon what you are enabling. With an addict, unless you are very careful, you may end up enabling the addiction instead of recovery, including the addiction of codependency.

We are not able to change another person; we can only change ourselves. We are not responsible for the actions of another person; we are only responsible for our own actions. Scripture tells us to examine ourselves[2] and refrain from judging others.[3] We have enough trouble dealing with our own issues, let alone attempting to take on the mantle of Savior. Who can truly rescue a person from such a powerful enemy as addiction?[4] Who can fix and restore a person out of the pit of codependency?[5] Who enables us to return to a safe place in relationships?[6] The answer is God, the One truly able to save our spouses, parents, children, family members, or close friends. Our responsibility is not to try to rescue, fix, enable or attempt to take His place. Our responsibility is to lovingly point to the Lord and then trust Him to do His work.[7]

GREGORY L. JANTZ, PH.D., *is founder and CEO of The Center • A Place of HOPE, a whole-person healthcare facility combining mental health, chemical dependency, medical, nutritional and spiritual treatment. Along with Dr. Tim Clinton, he is the author of* Don't Call It Love: Breaking the Cycle of Relationship Dependency, *as well as the newly released book,* Healing the Scars of Childhood Abuse, *and the upcoming release,* Healing the Scars of Addiction, *both from Baker Publishing Group.*

Endnotes

1 http://oklahomacc.com/signs-of-codependency-2/.

2 1 Corinthians 11:28, NIV and 2 Corinthians 13:5, NIV.

3 Romans 14:4, NIV.

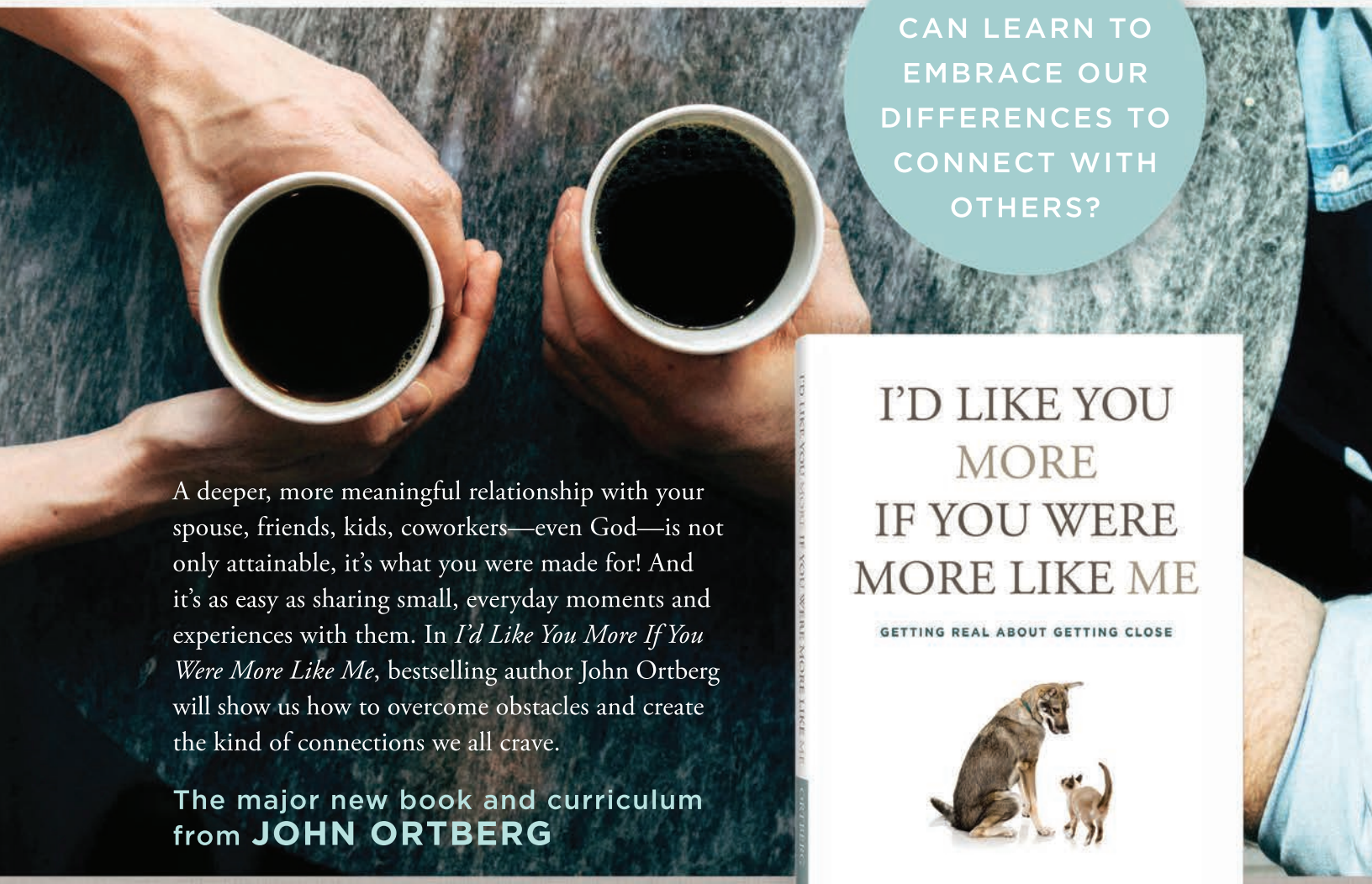
4 Psalm 18:17, NIV.

5 Psalm 71:20, NIV.

6 Habakkuk 3:19, NIV.

7 Romans 8:28, NIV.

SOMETIMES GETTING CLOSE IS A CHALLENGE



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plans to give you hope and a future."

Jeremiah 29:11

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Christianity Addiction

When the editors sent out their assignments to writers, I knew what they wanted me to do was outside of my comfort zone. I wrestled with it a bit and then finally asked them to let me write on a subject I had not done before, Christianity addiction. I am not sure the wording even makes sense because I have not seen much on the subject. Let me see if I can put it into a perspective with which you can identify.

Addiction of any kind simply means you are controlled, or your life is dominated, by an influence, substance, or mental condition that is more in charge of you than you are of yourself. However, Christianity addiction is something much like a drug-induced addiction, but more subtle.

First Illustration: When I was an executive at Focus on the Family, my assignment was that of Pastor to Pastors. I loved my 20 years in that position. I served the clergy in well over 100 different denominations and church groups. One of those was the Missouri Synod Lutherans… great people. I was speaking to their group in Idaho and, when I was introduced, I noticed there was some restlessness and a few of the men walked out. It was distracting. Later when I was able to get some clarity, I learned they were upset because of my stand on Holy Communion. They were closed. I was open. I was able to meet with the ones who were disgruntled and assured them I would not be taking communion. That was all they needed to hear.

Second Illustration: For a long time, there has been a battle for the purest Bible translation. It is a battle that will never be won. I have actually walked up on the platform of an event and subsequently asked by the leader what translation I would be using. More than once, I was handed a translation other than my own to use as a reference. Kind of embarrassing.

Third Illustration: Well, you might imagine that it would surround music. I remember the pastor at one large church who was fighting the "music wars" saying they tried everything to satisfy what people wanted. They went from Bach to rock to easy listening to standard hymns. They alienated everyone. Eventually, they chose a style of music that fit their worship personality and now that is what they use. Making everyone like what you want them to is simply impossible.

The Addicted Christian

The Apostle Paul wrote in Romans 12:3, "Do not think of yourself more highly than you ought, but rather think of yourself with sober judgment…." You, like me, have known lots of church folk who had

the last word on every Scripture reference. Who knew more about the working of a church than the pastor? I call them "righteous know-it-alls." In other words, some of us overestimate ourselves… addicted to one's own self-knowledge. We are so busy trying to impress everyone else that we miss our own intimacy with the Lord.

And then there was Jesus talking about the hypocrites in Matthew 6 who wanted to be seen as better than anyone else, so they prayed in a manner that would bring attention to themselves. They were addicted to their own righteousness… big mistake!

When I was a young pastor, we would have pastor meetings and the older guys would come and gather in their corner until it was time to pray. Then, when it was time to pray, it was like an earthquake had hit the room. Man, they were yelling and pacing and calling on God as though He was in another room. I never felt good about that, but that was their way of showing spirituality. The louder the better. I'm not so sure their real audience was God, but instead others in the room. Don't do that.

What I know is that prideful Christianity usually ends in a shipwreck. The Proverb writer said it like this, "Pride comes before destruction, and an arrogant spirit before a fall" (Proverbs 16:18, HCSB). Proud people never see their own weaknesses, so they become addicted to their selfish opinions, theologies, and ideas. Bad thinking.

Bottom Line

Do not sacrifice truth for any reason, but be tolerant and understanding with those who may not have been raised in your world or educated by your tutors or indoctrinated by your influencers. There are many ways that will take us to the great truth that God loves us all as though we are the only ones in all the world to love. Be aware of Christianity addiction. Be blessed!

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« DIANE LANGBERG, PH.D.

Addiction: Death by Hanging

I had a grandmother from West Virginia who used to say, "You get used to hanging if you hang long enough." The saying perplexed me as a child because I could not understand why someone would want to get used to hanging! It kills you. When I asked, the answer was, "But then it does not bother you anymore." Many decades later, and with much of that time spent as a clinician, the saying makes a great deal more sense to me. I have often seen it in action. Hanging is bad. It will hurt you. However, if you stick with it long enough, it will not hurt anymore because you will be dead. That is a pretty good summary for what an addiction or any kind of repetitive, damaging behavior can do to a life.

From God's perspective, human beings do all sorts of things repeatedly that are damaging and destructive to themselves and others. We have tolerated slavery, violence, and poverty (at least for "them"). We consume excess food, alcohol and drugs, and destroy our bodies and minds. We sexually abuse and assault others, ruining their lives and our own. We support the world of abuse by devouring pornography as if it were good for the soul. We are servants to our rage, killing with guns and fists, beating spouses and children, and often snuffing out our own lives in the process of ruining theirs. Most horrifying of all—we do, indeed, get used to it.

We normalize the abnormal—it simply is what it is. We sanitize the filthy and diminish or deny the impact. If we face such abnormalities, evils, and destructions in truth, we would either despair or use every ounce of energy we had to change. Instead, we often anesthetize and deceive ourselves for one more round. Whatever we do not face in truth and fight against, we feed. And what we feed grows… always. The actress, Jane Fonda (a non-theological source) said this, "It's hardest to see what's wrong about what seems normal."

As counselors, you know this from working with those enslaved to what is hanging them—whether they hang themselves with substances or pornography or have normalized a horrific history in order bear it (e.g., saying brutal sexual abuse for more than 15 years is no big deal). When someone else is hanging you, you have to tell yourself something. Whether it is an abusive history, a violent marriage or a life-swallowing addiction, you know the light and truth can only be let in little by little. If it is not, the light makes life unbearable and overwhelming and the need for deception increases and will be fed yet again.

Drawing people into the light and inviting them to step into truth is a call to face our deceptions about who God is, how He names things, and who He says we are. Waking up the anesthetized who fear the pain of awakening is not easy. It requires patience, knowledge of the truth in your own life, persistence, and the awareness that though the feeling of the pain is frightening, it offers life. Anesthetized hanging results in death. To feel the pain of hanging is to desperately want to get down onto the solid ground of truth.

It is easy to forget that we cannot name truth or expose deception for others unless we are willing and able

Whenever we excuse in ourselves what God does not excuse, we have normalized hanging; we have deceived ourselves and our work with others will be contaminated.

to do so in ourselves. You will have the thinking that anesthetizes the anger leading to violence if you normalize a verbally abusive tongue in yourself. You will not clearly see truth for a cocaine addict if you go home and use pornography. You will be off in your judgments of one who exploits others sexually if your exploit those in your life by arrogance. Whenever we excuse in ourselves what God does not excuse, we have normalized hanging; we have deceived ourselves and our work with others will be contaminated.

Self-deception is powerful. God says we are so good at self-deception that we cannot even comprehend our own capacity. The longer we deceive ourselves, the more we normalize "hanging." It is crucial, in studying or working with anything that is the antithesis of God's character, to steadily immerse ourselves in Him at the same time. The very study of sin (which is a necessary part of counseling) can either seduce us into tolerating it in ourselves and others or so paralyze us that we sink into despair—deceived into believing that God is not able. If we despair, we will fail to fight evil in ourselves and lose the courage to work for the deliverance from it for others.

May we never normalize hanging—our own or another's. May we always seek God's truth and what He calls good. May we never feed what is against Him to others or ourselves. May we never hang long enough to get used to it. ✠

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« GARY W. MOON, PH.D.

Trusting a Still, Small Voice

My mother was hard at work in the room where she spent most of her waking hours. It was the large kitchen of what had been a farmhouse that dated back to the late 1800s. Like the rest of our home, the kitchen featured a 10-foot ceiling; but it also had two large windows that faced a barn, a walk-in pantry, expansive fake-wood countertops, and avocado-green appliances.

All around the center of my mother's feverish activity were papers bags, plastic tubs, baskets and metal pots, all overflowing with corn, which she had in some stage of preparation—from garden to freezer. Somehow I had been unable to avoid getting caught up in the production line. I hated summer in rural Georgia. I think my mother hated it more.

Then, all of a sudden my mother appeared the same color as the corn she was blanching. "Did you hear that?" she asked.

"No," I said. "Shhh!" she said.

I had heard nothing other than the loud and constant roar of a window unit air conditioner that was moaning and perspiring great water drops in its unsuccessful battle against Georgia's natural sauna.

"I heard someone whisper, 'Momma, Momma,'" she said.

"No one can whisper over that air conditioner," I tried to reason with her.

But she started walking toward the side of the house, passing through two closed doors and the room that separated them, and then out into the yard. Then she walked a long way across our yard to where my older sister and her husband had temporarily set up a small trailer for their first couple of years of married life.

When my mother knocked on the door of the trailer, no one answered. When she pushed it open, she saw a frightening site. The curtains over the sink in the trailer were blazing. My sister was lying unconscious on the floor. Apparently when she tried to light the gas stove, there had been a buildup of propane that exploded and knocked her across the room. My sister's 10-month-old daughter was crying hysterically from her crib in another room.

My mother sprang into action. She pulled the burning curtains from the wall and stuffed them in the sink. Then, she gathered up my niece and my sister and helped them outside to fresh air and safety.

That story has remained with our family as a special mystery. My mother

and I had been working in an enclosed kitchen in a sealed off house. We could barely hear our own conversation over the roar of the air conditioner. The trailer was a long football toss away. We did not hear the explosion of gas. We did not hear a crying child. My sister had been blown across a room and was unconscious. She does not remember screaming, calling or, more to the point, whispering for help.

To this day, my mother claims that her attention was grabbed away from the noises of a summer corn production operation by a voice that was not from this world. Although I have learned to be very skeptical of such claims (assuming that p is rarely less than .05), after five decades of thought, I have not been able to come up with a better explanation than a Divine whisper.

Another Child in Trouble… Another Voice

I have a friend who was pushed back twice by an explosion of theodicy—the vindication of divine goodness and providence in view of the existence of evil.

The first time, he was a teenager. He lost his father to a tragic accident. Then he lost his way and spent a few years displacing his anger with God onto others and experimenting with ways to numb his senses.

He passed through that season and blossomed into a wonderful student, husband, friend, teacher, and father. He gave credit to the prayers of his mother for the dramatic change in the direction of his life. Later, he found out that she, too, had been hearing a "whisper" that her son would be okay.

A couple of decades passed and then there was an explosion. More theodicy. My friend lost his mother in such a way that his witness of her passing resulted in what some might call post-traumatic stress. He lost his way again. Tragically losing one parent is too much, but for it to happen twice caused him to begin to call the love and presence of God into question. He cried out to a God whom it seemed to him did not bother to whisper back.

"... after five decades of thought, I have not been able to come up with a better explanation than a Divine whisper."

Things got worse. At the insistence of someone who knew him well and loved him better, he agreed to see a therapist. He made a systematic search for just the right person. He *did not* want to see someone who was a Christian—he was too angry with God and feared he would only receive answers that he had already dismissed 1,000 times.

He *did* want to see someone with more than two decades of experience and preferred to see a female therapist who was skilled in practical, no-nonsense approaches to therapy. My friend wanted a wise, experienced, non-Christian therapist. He wanted someone about the age of his mother to tell him what to do. Through an online search, he located a therapist who he thought met his strict criteria.

The first session was used to pour his heart out and make his case against a universe where very bad things keep happening to very good people; and then he asked her for a "prescription."

"So," he challenged, "tell me exactly what to do to stop being so depressed and angry."

Then it happened. Perhaps responding to an internal whisper, his therapist made a shocking disclosure.

"You know," she began, "I used to tell people what to do. I used to be like most every other mental health professional in this city… very liberal, hovering somewhere between an atheist and an agnostic, certain in my psychological advice. However, something changed several months back. I realized the forms of psychology that do not recognize the spiritual aspects of a person are just chasing their tails. The most powerful program for change does not exist inside of psychology. The most powerful program for real change is the 12-step program. If you are ready to give up and turn your life over to a higher power, to God, I think I can help. If you can't, then I can't."

Another potential tragedy, another soft whisper heard amidst all the noise. The therapist had heard it and changed her approach to how she went about her job. And in that moment, my friend heard it too, and decided to change his approach to life.

Maybe you can also trust what you think you are hearing, and the One who is whispering. ✠

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« MICHAEL R. LYLES, M.D.

Opiates: Death by Overdose

The U.S. Surgeon General estimates that 20.8 million Americans met the criteria for a substance use disorder in 2016.[1] This is 1.5 times the combined numbers of all cancer patients in this country. More people are now using prescription opiates than are using tobacco. The direct and indirect costs of this "epidemic" are estimated to exceed $420 billion annually, surpassing the yearly costs of diabetes. Heroin use tripled in the U.S. from 2003-2014 to more than one million users.[2] Deaths from heroin-related overdoses have quintupled (5X) with medical examiners having storage problems for the bodies.[3]

This problem began in the early 1990s when physicians began to believe patients would not get addicted to opiate pain medications if they truly had pain. Prescription opiate abuse gradually spiraled out of control until there were enough opiate prescriptions written in 2013 for every adult in the U.S. to have a one-month supply. Regulators took action to limit physician opiate prescribing and reduced drug company manufacturing. However, the problem had already transitioned to cheap and readily available heroin, which became increasingly altered by fentanyl to accentuate the "high." Fentanyl is a synthetic opiate that is 50 times more potent than heroin and often sold as heroin to unsuspecting addicts, who can overdose before injecting the full syringe into their veins. Death by overdose was further facilitated by the introduction of carfentanil, which is 100 times more potent than fentanyl and can cause an overdose with a simple touch. Death by overdose may happen when drugs like Xanax® (used in the treatment of anxiety disorders) or Klonopin® (used in the treatment of certain seizure disorders) are mixed with opiates, resulting in accentuated respiratory depression and potential death.

Medications are incorporated as part of a larger treatment protocol that addresses social, spiritual, and psychological contributions to addiction. Medications are also used to prevent withdrawal, decrease craving, and minimize the risk of overdose by respiratory depression. There are three types of medications: agonists, antagonists, and partial agonists. An agonist is a chemical that binds to a cell receptor and activates the receptor to produce a biological response. Methadone is an agonist that fits like a key into a lock at opiate receptors and replaces opiate "cravings." It is used for detoxification and maintenance treatment in highly specialized clinics (especially for heroin addiction). Methadone has abuse and overdose potential and is not considered a first-line treatment.

An antagonist blocks a receptor without stimulating it—akin to putting gum in a lock (receptor) so the key (opiates) will not fit. Narcan® is a short-acting form of the opiate antagonist, naloxone. It is used to reverse respiratory depression in opiate overdoses. Naltrexone is a long-acting form of naloxone, binding to opiate receptors more intensely than opiates, thus blocking their effects. It does not have any intrinsic opiate (i.e., addictive) effects, so there is nothing to

abuse. However, this drug can trigger opiate withdrawal by kicking opiates rapidly off the receptors without providing any opiate effect of its own. Thus, a patient would need seven to 10 days of sobriety before taking the medication, reducing the practical utility of this drug.

Buprenorphine is a partial agonist that amounts to using a key that partially fits the lock, but will not fully open it. It stimulates the receptor enough to prevent withdrawal, but not enough to produce mood alteration. This "ceiling effect" on its stimulation limits the risk of overdose or respiratory depression. It does have enough stimulation (agonism) to reduce withdrawal risks if a patient starts this medication without first detoxing. Buprenorphine was originally orally administered as Subutex®; however, it could be abused if injected intravenously, so naloxone was added and it was renamed, Suboxone®. The naloxone would trigger withdrawal if injected, but is poorly absorbed from the mouth if used correctly. The ingredients in Suboxone® have been released in two different delivery systems since 2013 to improve efficiency. Zubsolv® is a sublingual (under the tongue) tablet, and Bunavail® is a film strip that sticks to the mucosa of the mouth. Probuphine® is an example of future research.[4] It is a pure buprenorphine product that is delivered in a skin implant that lasts for up to six months.

Treating chemical addictions, especially pertaining to opiates such as heroin, oxycodone, etc., as well as cases involving alcohol or amphetamine detoxification, can be complex and difficult. It is, therefore, critical to utilize a multi-team approach with competently trained mental health and medical experts. A holistic orientation that addresses physical, biological, emotional, cognitive, relational, and spiritual factors is often essential for successful outcomes. ✠

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« JOHN SANDY, J.D.

The Evolving Ethics of Counselor Values-based Referrals

In recent years, there has been a notable shift in ethical considerations regarding a counselor's referral of a counselee to another counselor due to a values conflict. In 2003, Ford and Hendrick reported that when presented with a sexual values conflict with a client, 40% of therapists responding to a survey referred the client, while only 4% engaged in self-examination, sought additional knowledge or looked at the issue from the client's viewpoint, and 1% helped the client explore the issue.[1] A lawsuit filed in recent years by a Christian student enrolled in a secular university counseling program helped initiate dialogue regarding values-based referral ethical considerations.

The Ward Litigation

In Ward v. Polite, et al., 667 F.3d 727 (2012), the federal 6th Circuit Court of Appeals reversed a lower court summary judgment ruling in favor of defendant school officials and personnel of Eastern Michigan University (EMU). The case involved Julea Ward, a student in the EMU counseling program. While participating in a student practicum course, Ms. Ward was expelled from the program as a result of seeking a faculty supervisor's approval to allow her to refer a homosexual person to another student or permit her to begin counseling but then make a referral if the session required discussion about relationship issues. EMU prohibited students from discriminating against others based on sexual orientation. The school also taught students to affirm a client's values during counseling sessions. The court explained in its opinion that Ms. Ward "frequently expressed a conviction that her faith (Christianity) prevented her from affirming a client's same-sex relationship, as well as certain heterosexual conduct." An EMU professor claimed that Ms. Ward was in violation of the ACA Code of Ethics, which prohibited a counselor from "imposing values that are inconsistent with counseling goals" and "engag(ing) in discrimination based on sexual orientation." The ACA Code of Ethics was incorporated into the counseling program student handbook.

Ms. Ward subsequently filed suit against school officials and personnel for violation of her First Amendment rights of freedom of speech and free exercise of religion. In Ward v. Polite, et al., the Court of Appeals, citing the U.S. Supreme Court in Hazelwood School District v. Kuhlmeier, 484 U.S. 260 (1988), explained that public educators may "limit student speech in school-sponsored expressive activities so long as their actions are reasonably related to legitimate pedagogical

"Christian counselors do not withhold services to anyone of a different race, ethnic group, faith, religion, denomination, or value system."

– *Code of Ethics*, American Association of Christian Counselors

concerns." However, the court emphasized that a university cannot control curricular speech "as a pretext for punishing (a) student for her… religion." The court concluded that the case deserved to be heard by a jury to decide the facts. In explaining its opinion, the court specifically noted that: 1) the ACA Code of Ethics allowed for a values-based referral by counselors who choose not to work with terminally ill clients who wish to explore end-of-life issues; 2) EMU could not point to any policy in its student handbook or elsewhere that prohibited practicum students from making referrals; and 3) the ACA Code of Ethics did not prohibit values-based referrals like the one Ward requested. The parties subsequently settled the case.

Secular Ethics Trends Relating to Values-based Referrals

Following the Ward litigation, the ACA modified its Code of Ethics in 2014, in part, by: 1) deleting the end-of-life referral option for counselors; and 2) clarifying in new section A.11.b "Values Within Termination and Referral:" "Counselors refrain from referring prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs and behaviors. Counselors respect the diversity of clients and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature." According to members of the 2014 ACA Ethics Revision Task Force, "It used to be that if a counselor was uncomfortable with a client, an immediate referral would take place. We now know that it is not in the best interest of the client because it can lead to feelings of abandonment."[2] A number of states have adopted the ACA Code of Ethics to regulate licensed counselors.

The AACC Code of Ethics and Cultural Regard in Christian Counseling

The American Association of Christian Counselors (AACC) modified its Code of Ethics in 2014, in part, by providing detailed guidelines discussing the importance of cultural competency for Christian counselors. The AACC Code makes clear that, "Counselors share their own faith orientation only as a function of legitimate self-disclosure and when appropriate to client need, always maintaining a posture of humility. Christian counselors do not withhold services to anyone of a different race, ethnic group, faith, religion, denomination, or value system" (ES1-530). Christian counselors "may *expose* clients and/or the community at large to their faith orientation (but) do not *impose* their religious beliefs or practices on clients" (ES1-530-a). If a counselor's value differences with a counselee interfere with the counseling process, Christian counselors "work to resolve problems—always in the client's best interest" and actions may include: "1) discussion of the issue as a therapeutic matter; 2) renegotiation of the counseling agreement; 3) consultation with a supervisor or trusted colleague or, as a last resort; 4) referral to another counselor if the differences cannot be reduced or bridged (and then only in compliance with applicable state and federal law and/or regulatory requirements)" (ES1-550).

Notable Recent Legislative Action

A few states in recent years have taken legislative action to protect the religious rights of licensed counselors or counseling students, including the following:

- Arizona passed a law in 2011 that shields counseling, social work, and psychology students at universities under the jurisdiction of the Arizona Board of Regents and community colleges from discipline or discrimination if they refuse to counsel a client about goals that conflict with their sincerely held religious beliefs, as long as they consult with the supervising instructor to determine the proper course of action to avoid client harm.[3]
- Tennessee law was modified in 2016 to specify in §63-22-302 of the Tennessee Code, in part, that no licensed counselor or therapist must serve a client whose "goals, outcomes, or behaviors conflict with the sincerely held principles of the counselor or therapist" if the individual is referred to another counselor or therapist, and the individual is not in imminent danger of harming himself/herself or others.[4] Also, §63-22-110(b)(3) of the Tennessee Code was amended to prohibit licensing board disciplinary action for violation of Section A.11.b of the 2014 ACA Code of Ethics (previously noted) unless the situation involves a person in imminent danger of harming himself/herself or others.[5]

- The Arkansas Board of Examiners in Counseling adopted the 2014 ACA Code of Ethics. In 2016, the Arkansas Board of Examiners in Counseling modified the rules and regulations to protect licensed counselors and MFTs from sanctions by the Board for current or potential client transfers based on conscience. Conscience is defined as "the ethical, moral or religious principles sincerely held by the counselor or MFT." The rule, Ark. Admin. Code 122.00.1-10.1, also states that the referral clause does not absolve the counselor or MFT from adhering to nondiscrimination, clients must not be abandoned, referral shall only occur after careful consideration and consultation, and referrals shall only occur as a result of conscience if the counselor or MFT is unable to effectively serve the client.[6]

Licensed Christian counselors and counseling students in university programs preparing them for state licensure are encouraged to consult with an attorney in situations where there is a values conflict with a counselee and the Christian counselor is considering referral options. The law is ever-evolving, and legal guidance may vary depending on the specific legal jurisdiction and counseling fact scenario at issue.

The information is current as of the date it is written. This article is provided solely for general educational purposes and does not constitute legal advice between an attorney and a client. The law varies in different jurisdictions. Consultation with an attorney is recommended if you desire legal advice.

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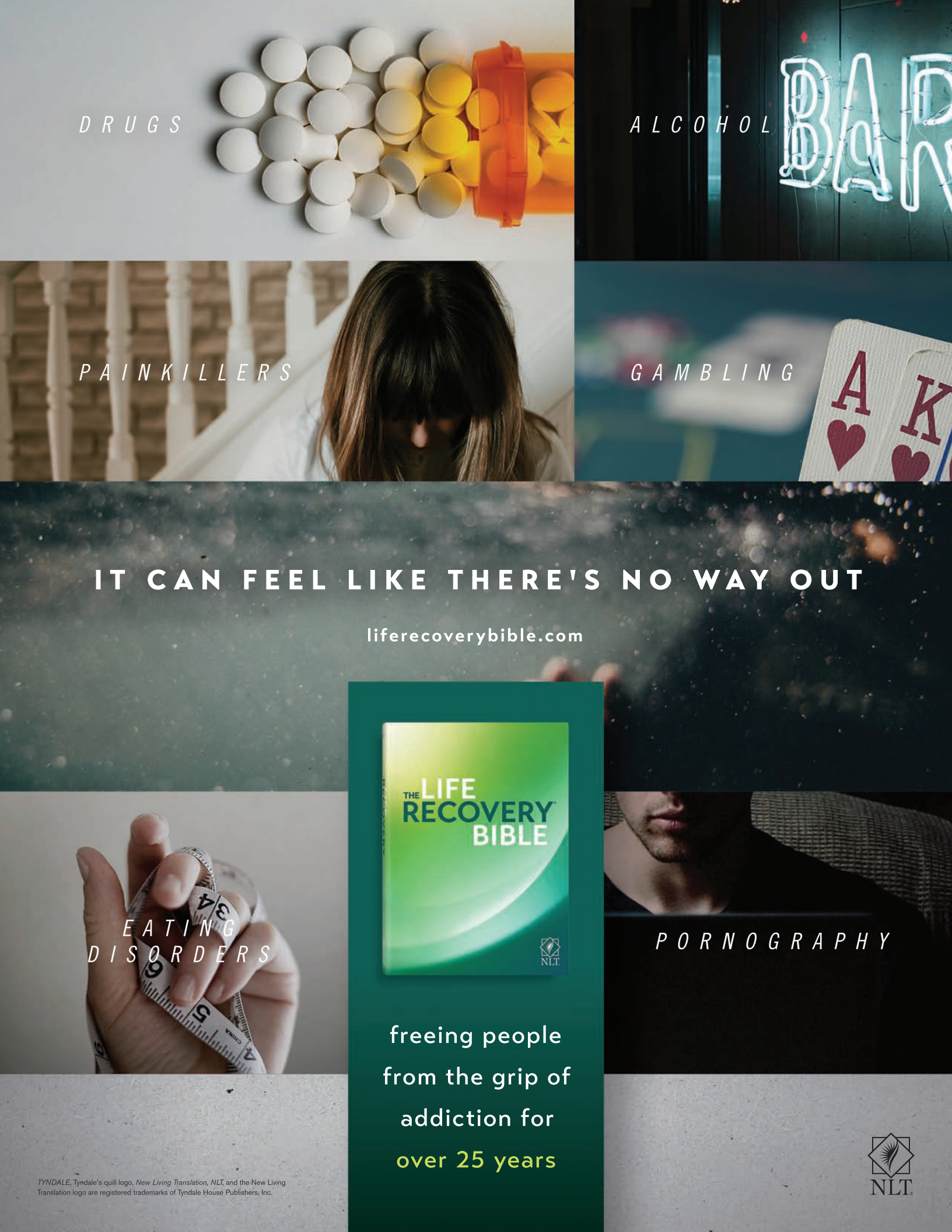

« REV. JARED PINGLETON, PSY.D.

Addiction and Idolatry

All addictions are idols and all idols are addictive.

The term "idolatry" is an old-fashioned word we seldom think about in our modern, fast-paced, secularized, technologically-oriented society. When we think of an idol, we generally envision an artistically-carved, perhaps somewhat chubby, little guy fashioned out of stone or wood, whose head someone may rub for "good luck."

However, our idols are usually much more subtle, sophisticated, substantive, and serious than a sculpture. What is an idol? An idol is simply anything or anyone we depend or rely upon instead of God. An idol is also anything or anyone who comes between us and God. This means most of our idols are functional, not literal.

As leaders, we typically have many idols… and many potential addictions. Most leaders are busy, stressed, isolated, and personally accountable to no one. In short, these vulnerabilities often result in leaders becoming an addictive accident waiting to happen.

Idols and addictions are what we use to temporarily medicate distress or pain, or what we turn to other than God when we're hurting. Consequently, they can become something or someone we implicitly worship (consciously or otherwise) in place of God. The object(s) of our idolatry can be something which is not inherently bad or sinful, but what we prioritize above our relationship with God. Yet, the first of the Ten Commandments warns us clearly: "No other gods, only me" (Exodus 20:3, MSG).

As humans, we are frequently tempted to "worship" people, places or things (i.e., the creation) instead of

the Creator. However, nothing and no one deserves that level of prominence or priority in our lives. We tend to live for and serve whoever or whatever we worship, but only God is worthy of our highest devotion and deepest love.

You may be thinking, "What does all this abstract stuff have to do with me?" Ask yourself this question: "What are the idols I worship?" To what, where or whom do you turn when you are hurting, lonely, frustrated, bored, sad, and/or stressed?

Many people become classically addicted to mood-altering chemicals, substances or prescription medication in an effort to soothe or escape from their pain. Other people's "drugs of choice" include the relentless accumulation of materialistic possessions, gambling, sex/pornography, thrill-seeking activities, overeating, codependent relationships, sports, entertainment, hobbies, and shopping. In addition, many leaders are also prone to workaholism, along with greed-driven pursuits of fame and fortune, power and prestige, stature and status, and clout and control.

When we cave in to temptation and rely on a substitute or counterfeit for God in order to cope with our pain and/or distress, we inadvertently begin our precipitous slide down the proverbial slippery slope of addiction. Because all idols are artificial and illegitimate—not satisfying our needs, while deceptively promising more than they deliver—they leave us subject to the law of diminishing returns.

Thus, in addictions parlance, idols become habit-forming because they create tolerance or habituation, requiring progressively more stimuli for the brain to derive the same physiological and/or emotional response. Over time, we become so desensitized that what used to medicate the pain no longer does the trick. As a result, our idolatrous "gods" insidiously and viciously grab us by the throat, insatiably demanding more and more until we end up being hooked. The idol that used to serve us now ironically demands that we serve it.

Unfortunately, we have learned from recovery work that most addicts will not acknowledge the painful reality of their enslavement until they hit rock bottom. These humbling dynamics are encapsulated in the first three of the 12-steps. We are powerless over our sin to the point that our lives become out of control and unmanageable. As the Apostle Paul explained in Romans 7:15-20 (ESV): "For I do not understand my own actions. For I do not do what I want, but I do the very thing I *hate*. Now if I do what I do not want, I agree with the law, that it is good. So now it is no longer I who do it, but sin that dwells within me. For I know that nothing good dwells in me, that is, in my flesh. For I have the desire to do what is right, but not the ability to carry it out. For I do not do the good I want, but the evil I do not want is what I keep on doing. Now if I do what I do not want, it is no longer I who do it, but sin that dwells within me."

We must believe that God is greater than we are… greater than our addictions. And as we decide to turn our wills and our lives over to Him, we exercise faith that He can and will deliver us from our bondage.

Steps 4-6 describe the realities of our sinfulness. From 1 John 1:8-9 (NKJV), we understand that, "If we say that we have no sin, we deceive ourselves, and the truth is not in us. If we confess our sins, He is faithful and just to forgive us our sins and to cleanse us from all unrighteousness." When we make a searching and fearless inventory of ourselves, admit our wrongs to God, ourselves, and others, and humble ourselves to ask God to change our defective character, we begin to be transformed.

The process of this transformation is outlined specifically in Steps 7-9. The internal changes necessary for lasting change and growth are profoundly

"For I do not understand my own actions. For I do not do what I want, but I do the very thing I *hate*. Now if I do what I do not want, I agree with the law, that it is good. So now it is no longer I who do it, but sin that dwells within me. For I know that nothing good dwells in me, that is, in my flesh. For I have the desire to do what is right, but not the ability to carry it out. For I do not do the good I want, but the evil I do not want is what I keep on doing. Now if I do what I do not want, it is no longer I who do it, but sin that dwells within me."

– Romans 7:15-20 (ESV)

articulated in 2 Corinthians 7:10 (AMP), "For [godly] sorrow that is in accord with the will of God produces a repentance without regret, leading to salvation; but worldly sorrow [the hopeless sorrow of those who do not believe] produces death." By asking God to remove our shortcomings and listing people we have offended and then making amends, our idols topple and we are never the same.

Finally, the nature of our ongoing recovery process is emphasized in Steps 10-12. A relatively obscure, yet absolutely profound, passage in Titus 2:11-14 (NIV) offers positive, power-packed principles for our struggles with addictive idols. Paul explains, "For the grace of God has appeared that offers salvation to all people. It teaches us to say 'No' to ungodliness and worldly passions, and to live self-controlled, upright and godly lives in this present age, while we wait for the blessed hope—the appearing of the glory of our great God and Savior, Jesus Christ, who gave himself for us to redeem us from all wickedness and to purify for himself a people that are his very own, eager to do what is good."

Through the powerful indwelling Spirit of Christ, we can say no to our idols and yes to God and worshipping Him only. We, thereby, exercise self-control over our controlling habits, hurts, and hang-ups. Humbly admitting our brokenness, communicating with God and others about our wrongful attitudes and actions, and then living in such a transparent and transformative way lead to freedom from our addictive idols. Consequently, we can lead, mentor, and disciple others with this great news with power, passion, and purpose!

(This article was adapted and used with permission from *Be Strong and Surrender: A 30 Day Recovery Guide* (2016) by Philip Dvorak, Jared Pingleton, and Paul Meier.)

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Substance Abuse and Chemical Dependency

Mentoring, Spiritual Transformation, and Recovery from Substance Abuse

Williamson, W.P., & Hood, Jr., R.W. (2015). The role of mentoring in spiritual transformation: A faith-based approach to recover from substance abuse. *Pastoral Psychology, 64*, 135-152.

This is a fascinating look at the role of mentoring in a faith-based model of care for the treatment of substance abuse. Specifically, the researchers examined the role of mentoring in spiritual transformation. Mentors ranged in age from 44 to 65 years. Five of the mentors were men; one was a woman. They had been mentors with the Lazarus Project for an average of 5.33 years (SD=2.25).

The researchers interviewed six mentors from a Pentecostal-based recovery program called the Lazarus Project. Using a semi-structured interview, they asked questions about their mentoring relationship and invited each to share about his or her most successful relationship. Using hermeneutic-thematic analysis, the researchers identified five themes that appear to capture what a successful mentoring relationship looks like in this context. The five themes were connection, compassion, encouragement, spiritual change, and parental pride.

Mentoring relationships begin with *connection*. One participant shared: "… He became more like a son than some others…. A lot of them were younger than him, but he just had a lot of father issues, and he just one evening opened up and started sharing, you know, that he never really had a father…. He was telling me how I had taken his [father's] place" (p. 144).

Compassion was another important theme. This involved being genuinely emotionally responsive to the mentee, to feelings of concern and empathy. One person shared, "… I have a heart for these guys… when I heard this new friend cry out, the Lord just quickened me that I had something to share…. I made a commitment to him and to the program…" (p. 145).

Successful mentoring also entailed *encouragement* or being a source of support to a mentee. One participant shared: "I talked to him about finishing [the program]… that it's so important…. 'Finishing it is very important, whether you think you need it or not.' I think that was probably the most meaningful conversation [with him] that I can remember" (p. 145).

Spiritual change was another component of successful mentoring. One person retold the story of providing a person with a word of knowledge and prophesy (two of the spiritual gifts listed in 1 Corinthians 12): "The question I asked was, 'Why are you here?… And the Lord showed me what he could say and what I was supposed to answer, and he [the mentee] said, 'You know, I could have said… [many different things, but]… I guess, because I don't trust God and I'm angry.' And I said, 'Oh! Actually, you could go a little deeper than that, but you did really well. You've got about 10 layers [of deceit], and go down to layer number 8…. The reason why you were rebelling against God is you hate hypocrisy, and you have seen hypocrisy, and you've seen compromise in your own life, and you will not do that because you will not be a hypocrite'" (p. 145).

The final theme in successful mentoring identified in this study was *parental pride*. This refers to the pride mentors expressed in thinking of their mentees and observing growth. One person shared, "Well, it's rewarding because I'm proud of him for making the right choices, because I've said similar things to other people, maybe not as prophetic…. When he made the change, I could see it right there" (p. 146).

The researchers observe that in models of mentoring, these mentors are in the *intensive* category, which is characterized by "a significant investment of time in a mentee's life" (p. 147). It is interesting to read about the potential for mentoring to factor into spiritual transformation in the lives of those participating in a substance use recovery program, and perhaps such partnerships will continue to be explored and studies by Christian counselors and others interested in the relationship between religious faith, healing, and recovery.

Pathways to Substance Abuse

Lindberg, M.A., & Zeid, D. (2017). Interactive pathways to substance abuse. *Addictive Behaviors, 66*, 76-82.

Marc Lindberg and Dana Zeid conducted a study to examine pathways that would suggest people who may be particularly vulnerable to substance addiction. They reported on a sample of 480 individuals (302 females, 175 males, and three who identified as "other"). The sample primarily consisted of emerging adults at an undergraduate university in which 90% were between ages 17-21. Participants completed measures on attachment, alcohol misuse, a measure of adverse childhood experiences, and a peer alcohol and drug use measure.

The researchers used path analysis in analyzing their data. Path analysis is a variation of structural equation modeling that uses hypothesis testing in relationship to an analysis of a structural theory (Lindberg & Zeid, 2017). It looks at the "overall fit of all the model's

predicted relationships" (p. 79).

What Lindberg and Zeid (2017) found was that "the significant path model began with insecure parent attachments" and then other "mechanisms of action" played a role (p. 79). Especially important were adverse childhood events. It appears as though "insecure parental relations increased vulnerability to higher frequencies of adverse childhood events" (p. 79). In other words, more avoidant and ambivalent children (by attachment style) likely did not turn to their parents when experiencing stress, which would make them that much more vulnerable to future adversity (Lindberg & Zeid, 2017).

An additional finding was that insecure parental attachment predicted insecure partner attachments, which is consistent with the literature in that area. Other pathways to substance use included peer use of substances and partner insecurity.

Counseling services for substance abuse remain tied to important case-specific considerations. However, having an understanding of the role of insecure parental attachment and adverse childhood experiences may be an important enhancement to the provision of services for the Christian counselor.

Integrating Religion and Spirituality into Substance Abuse Counseling

Giordano, A., Prosek, E., & Hastings, T. (2016). Examining college counselors' integration of religion and spirituality into substance abuse counseling. *Journal of Addictions & Offender Counseling, 37*, 102-115.

Amada Giordano and her colleagues examined college counselors' experiences integrating religion and spirituality into counseling for substance abuse. The researchers contacted prospective participants through e-mail obtained from the American College Counseling Association. They were able to reach 489 potential participants, and ended up with 77 usable surveys for analysis.

The mean age of participants was 44.19 years (SD=12.06). Most identified as female (76.6%) and white (81.8%), and 6.5% identified as black, 6.5% as Latina/o or Hispanic, 1.3% as Asian, 1.3% as multiracial, 1.3% as Native American, and 1.3% as other.

The researches asked participants to complete the Religious Commitment Inventory and then a measure that was developed by the researchers themselves called the Religious/Spiritual Clinical Elements Index. This measure was intended to assess some of the religious and spiritual aspects of substance abuse

counseling. Items looked at frequency of behavior (e.g., "When addressing substance abuse issues with college students, how often have you done the following?" with options that included asking about religious/spiritual beliefs, distinguishing between healthy and unhealthy forms of religiosity/spirituality, etc.), as well as importance (e.g., "When addressing substance abuse issues with college student clients, how important do you believe it is to do the following?") (p. 108).

Perhaps not surprising, participants who scored higher on personal religious commitment scored higher on the importance rating and the frequency rating (of religious/spiritual aspects of substance abuse counseling). Overall, however, participants tended to rate the importance of religious and spiritual elements in substance abuse counseling at above three, or slightly important, on a seven-point Likert scale that ranged from one (not important) to seven (extremely important), but none rated as moderately (five) important.

As for frequency of use of religious and spiritual elements in substance abuse counseling, study participants did not tend to incorporate most of the elements. Of the eight items that were asked about, the average frequency ranged from 1.81 to 4.14 on a seven-point Likert-like scale that ranged from *never* to *always*).

The researchers also looked at the differences between importance and frequency ratings. Consistent with previous research, researchers found that participants tended to rate higher the importance of utilizing religious and spiritual elements in substance abuse counseling than their actual use of such elements.

For Christian counselors, it may be important to consider religious and spiritual elements and the proper way to incorporate such elements in the treatment of people seeking services for substance abuse. It is also a timely reminder that what we think is important and what we do in counseling may not always match up.

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counsel quiz

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Addiction and the Brain... – Daniel Amen

1. Which of the following is NOT an important lesson learned from SPECT scans?
   - O a. all addicts do not have the same brain patterns
   - O b. substance abusers may have comorbid conditions to address
   - O c. addictive personalities are found primarily in males
   - O d. seeing brain damage on a scan can prevent minors from abusing drugs or alcohol

The Nature of the Beast… – Eric Scalise

2. The final choice in the progression of Israel's spiritual stronghold was
   - O a. to worship what was made
   - O b. to sacrifice their children
   - O c. to serve Baal
   - O d. to make idols

Modern-day Insanity – Tim Clinton

3. Dr. Clinton contends that there is good news for opioid addicts because
   - O a. the brain has a quality known as plasticity
   - O b. family and friends can persuade addicts to recover
   - O c. we are winning the battle against drugs in America
   - O d. all of the above

You Need Me... – Gregory L. Jantz

4. The codependent's reasons for staying in the relationship may be
   - O a. worthlessness and low self-esteem
   - O b. fear of losing the relationship
   - O c. sympathy and praise from others for loving so much
   - O d. all of the above

Under the Influence... – David E. Jenkins

5. Relapse triggers related to natural recovery broadly involved
   - O a. friends who encourage drinking at meals
   - O b. feeling left out of social gatherings and work-related events
   - O c. stress resulting from loss and related problems
   - O d. living near an ABC store or having easy access to alcohol

Effective Addiction Treatment... – Roy A. Blankenship

6. Regarding deficiencies in distress tolerance capacity, Blankenship says
   - O a. pharmacology is the best treatment
   - O b. a perspective from developmental psychology is needed
   - O c. one should avoid dual diagnosis approaches to recovery
   - O d. the main focus should be on symptom management

Hot-wired: The Effects of... – Chap Clark

7. Which of the following is true about caffeine?
   - O a. 90% of people in the world use caffeine
   - O b. caffeine is becoming a staple in non-beverage foods
   - O c. global energy drinks recorded $55 billion in sales in 2017
   - O d. all of the above

Recovery: One Life and One Day... – Steve Arterburn and David Stoop

8. Nowinski found these two variables most important to recovery success
   - O a. helping others and developing a personal relationship with God
   - O b. having a sponsor and developing a personal relationship with God
   - O c. carrying the message to others and having a sponsor
   - O d. a personal relationship with God and four meetings per week

Relief or Anguish? Pain Management 101 – Adam Bianchini

9. With chronic opioid use, the pain threshold
   - O a. increases with time making the pain more tolerable
   - O b. decreases with time as the brain compensates
   - O c. increases over time to aid in surviving the pain
   - O d. decreases, making the user less sensitive to pain

The Opioid Tsunami: A Growing National Crisis – Karl Benzio

10. Labeling addiction as a chronic disease
    - O a. limits our understanding of why people abuse drugs
    - O b. helps us understand and treat drug abuse
    - O c. addresses the underlying psychological causes
    - O d. is not endorsed by the Surgeon General

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2. Be able to articulate a more comprehensive understanding of this issue's core theme.
3. Be able to integrate spirituality and faith-based constructs into the delivery of care.

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« TIM CLINTON, ED.D., LPC, LMFT

Modern-day Insanity

Morning news programs have intensified recently on how the opioid addiction crisis is now believed to be far worse than most had previously estimated. This "invisible" epidemic, which offers seekers relief, pleasure and satisfaction, is taking our neighbors, colleagues, fellow church members, and loved ones hostage. It has no boundaries and shows no mercy. And no matter how it starts and runs its course, it never fulfills its promises.

In 2015 alone, this "growing national tragedy" claimed approximately 33,000 lives in America—more than 90 per day. Of the thousands of deaths that occur each year from opioid overdose, roughly half involved prescription pain medications. What is sobering to me is that despite the increased awareness of drug and other substance addiction, deaths from overdosing continue to rise. Heroin-related deaths have increased sharply, more than tripling since 2010, with 10,500 dying in 2014 from an overdose. Sadly… on any given day, 580 people try heroin for the first time.

The scary part is that there seems to be no end in sight. It could be one of the greatest, if not *the* greatest, challenges we are facing today. Years ago, Earnest Becker, Pulitzer Prize winning author and cultural anthropologist, dialed in on the trend we are seeing and said, "Modern man is drinking and drugging himself out of awareness, or he spends his time shopping, which is the same thing." But why? And why now?

As I pondered this, I was reminder once again of the words of the late Christian philosopher, Dallas Willard. "They point out that social and political revolutions have shown no tendency to transform the heart of darkness that lies deep in the breast of every human being. That is evidently true. And amid a flood of techniques for self-fulfillment there is an epidemic of depression, suicide, personal emptiness, and escapism through drugs and alcohol, cultic obsession, consumerism, and sex and violence—all combined with an inability to sustain deep and enduring personal relationships. So obviously the problem is a spiritual one. And so must be the cure."[1]

That makes sense to me. When life is not the way it is supposed to be… when our relationships with God and/or others become conflicted and confusing for whatever reason, we reach for anything to fill the brokenness or emptiness to numb the pain.

Addictions destroy individuals, families, friendships, reputations, and careers. They make people prisoners of their own desires. Despite all this, God offers hope to addicts.

Ecclesiastes 6:7 sheds some light on this I think. It says, "All a man's labor is for his mouth and yet the appetite is not satisfied."

Brokenness begs for healing. So, therefore, we reach for more, and more, and more…. It's like the old line, "The more I drink, the more I drink." A modern-day insanity.

The Silence is Deafening

The real tragedy here is that the Church is basically silent. How did we get to this point of darkness? Where did we go wrong? What can we do about the opioid crisis, the heroin epidemic, and other vicious drug addictions? Is it hopeless or can we fight back against the danger that is seemingly taking over? As we ponder these questions, I hope you will hold on to five important truths:

1. Treatment is rarely "once and done." Sometimes addicts will return to their addictions several times before making an ultimate decision to retain long-term sobriety. Relapse can be devastating for individuals and their families who thought the problem had been resolved. However, there is no "quick fix" in addiction treatment. It can be a long and difficult process to break free from the chains of addiction, especially if the roots go deep. Research suggests that 40-60% of alcohol or drug users will relapse at least once in the first year of their journeys toward recovery.[2]

2. Ultimately, you cannot choose sobriety for another individual. In some cases, like suicidal behavior or psychosis, you can force treatment upon people… other times, you cannot. As heartbreaking as this reality is, you can never make *the choice to get well* for another person. It must be an internal decision from the addict. Recovery is more than a change of behavior; it is a change in thinking, attitude, heart, and lifestyle. You can do everything in your power to help a loved one struggling with addiction but, ultimately, the choice to break free belongs to him or her.

3. Addicts are often skillful at being deceptive, even to themselves. We all have this uncanny ability to lie to ourselves… and let's be honest; we do it all the time. However, when it comes to an addiction, this tendency is on steroids! People live in denial and often say things like, "I'm not addicted; are you kidding me? Come on. Stop saying that to me. I'm not addicted." In order to recover from addiction, we must first recognize and admit that we have a problem—and that's something most people do not like to do.

4. It's about the brain. The bad news is addiction is deeply rooted in the brain… and once it takes hold, the body and brain will crave the forbidden substance that they now depend on to function. However, there's good news, too! The brain has a quality known as *plasticity*, which means it is not unalterable—it can change.[3] The brain can be rewired and break free of addiction's stronghold. It will take work. It will take focus. It will take determination, courage, and tenacity. You may think the addiction has taken hold of your brain so deeply that you can never change; but be encouraged… change is possible!

5. It is never hopeless. Addictions destroy individuals, families, friendships, reputations, and careers. They make people prisoners of their own desires. Despite all this, God offers hope to addicts. God wants to free His people from anything that takes His rightful place in their lives. He wants to show them that He can meet all their needs. With God's help and the compassionate accountability of other believers, addicts can be set free… bought back. Jesus has already paid the price.

It is time for the Church to awaken to this issue and begin to educate and mobilize a front line defense and helping and healing ministry. Who better than the Church to fill the void with the hope we have in Christ? It takes prayer, persistence, and a lot of courage to step out in faith. I love this verse, Galatians 5:1, which says, "It is for freedom that Christ has set us free. Stand firm, then, and do not let yourselves be burdened again by a yoke of slavery." It is all about a dynamic relationship with Jesus Christ… and when you make that connection, it ultimately satisfies the soul. ✠

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Endnotes

1 Willard, D. (1999). *The spirit of the disciplines* (New York, NY: Harper Collins). Preface.

2 http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.462.8284&rep=rep1&type=pdf.

3 Clinton, T, & Laaser, M. (2015). *The fight of your life* (Shippensburg, PA: Destiny Image, Publishers). chapter 4.

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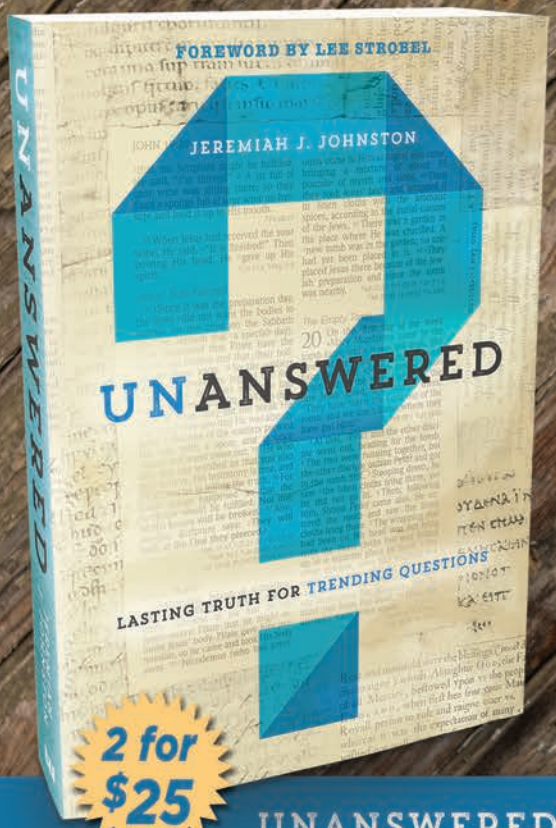

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