Brief Intervention
for
Adolescent Alcohol and Drug Use

Manual

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SECTION I

USER INFORMATION
&
DEVELOPMENT OF BRIEF INTERVENTION

Brief Cognitive-Behavioral Intervention Overview

BCBI Module	# of Sessions	Primary Treatment Objectives
Rational-Emotive Curriculum	1	1. Identify activating events for drug use a. attending a party where most adolescents use alcohol b. using alcohol or drugs to cope with negative emotions 2. Examine irrational beliefs underlying pros and cons to activating events a. all adolescents use drugs (false perception) b. fun parties always involve drugs (false perception) 3. Develop list of alternate beliefs that promote abstinence a. many adolescents have fun at parties without using drugs b. activities can be rewarding without having alcohol/drug involvement
Problem Solving Curriculum	1	1. Discuss rationale for problem-solving skill development 2. Define problem-solving components 3. Apply problem-solving process to develop risk reduction coping skills to: a. identify high-risk situations b. resist peer pressure and handle negative emotions c. generate healthy alternatives to using drugs or alcohol 4. Apply problem-solving process to develop positive coping skills for: a. effective communication b. prosocial peer and family relationships c. academic success
Parent Training	1	1. Discuss rationale for BCBI for child 2. Develop skills to encourage effective parenting behaviors a. disciplining attitudes and behaviors b. house rules c. rewards and enforcement 3. Develop skills for supporting parenting behaviors a. family solidarity b. emotional closeness c. providing developmentally appropriate advice 4. Apply parenting skills to home situations 5. Examine personal attitudes and behaviors regarding alcohol and other drug use

BRIEF INTERVENTION OVERVIEW

The Brief Intervention approach addressed in this manual is based on five premises regarding adolescent substance abuse. First, the gap between treatment need and treatment availability appears to be significantly increasing among adolescents, particularly those who present with mild or moderate substance use behaviors. Low-end severe cases are estimated to represent about 30% of adolescents who present for a drug abuse evaluation in the Twin Cities (Winters, 1999). Second, this gap in service access is in part the result of tightening treatment eligibility criteria by cost-conscious third-party payers. Similarly, lower cost treatment options for less-severe adolescent drug abusers are potentially attractive to cost-conscious manage care systems. Fourth, with some exceptions, brief and relatively inexpensive interventions (i.e. 3 - 4 sessions) have been shown to be as effective as stand-alone therapies for *adult* substance abusers (see Bien et al., 1993; Center for Substance Abuse Treatment, 2000), and early pilot work with young adults are promising. Fifth, brief interventions are developmentally fitting given that (i) many drug-abusing youth are not "career" drug abusers and thus not amenable to disease-oriented treatment approaches, and (ii) developmentally, young people are likely to be more receptive to self-guided behavior change strategies, a cornerstone of brief interventions (Miller & Sanchez, 1994).

This manual describes a 3-session (each session lasting approximately one hour) individual therapy model for use with teenagers (12-19 years old) who are suspected of experiencing mild or moderate problems associated with alcohol or other drug use. Sessions 1 and 2 involve individual counseling with the adolescent; Session 3 involves an individual counseling session with the parent or guardian of the teenager. It is recommended that the three sessions be scheduled such that there is a 10-day interval between Sessions 1 and 2, and a 10-day interval between Sessions 2 and 3.

USERS OF BRIEF INTERVENTION

This brief intervention is designed for trained professionals, including teachers, school counselors, social workers, psychologists and other youth-serving professionals who are working with drug-abusing teenagers. The techniques presented in this manual are kept simple and concise so that teachers, school counselors, social workers, and other professionals can take advantage of these methods. It is important that the person initiating the intervention be familiar with basic counseling skills, the theories and practices involved, and a basic understanding of the etiology, course and treatment of adolescent alcohol and other drug addiction. This includes knowledge of cognitive-behavioral therapy, motivational interviewing, and the stages of change model. Preferably, users of brief intervention have a certified degree in addiction counseling or a license in a related field of behavioral science.

Knowledge about the various drugs and their effects is crucial to implementing this type of intervention. The therapist must pay attention to the physical symptoms and emotional behavioral effects of substance use and abuse. Clarification may be needed to help the adolescents recognize their possible misconceptions about using drugs and their effects. Drug education materials and resources are provided in the appendix of this manual.

CLIENTS FOR WHOM BRIEF INTERVENTION IS INTENDED

The brief intervention model has been developed for application with teenagers that display the early stages of drug use problems (see Figure 1). That is, the intervention is intended for teenagers who are exhibiting mild or moderate problems associated with alcohol or other drug use. Such early-stage users often meet formal criteria for a substance abuse disorder and show harmful or hazardous consequences of their drug use. For example, the youth may be experiencing problems at school resulting from drug use or is getting into arguments with his or her parents and friends as a result of drug use.

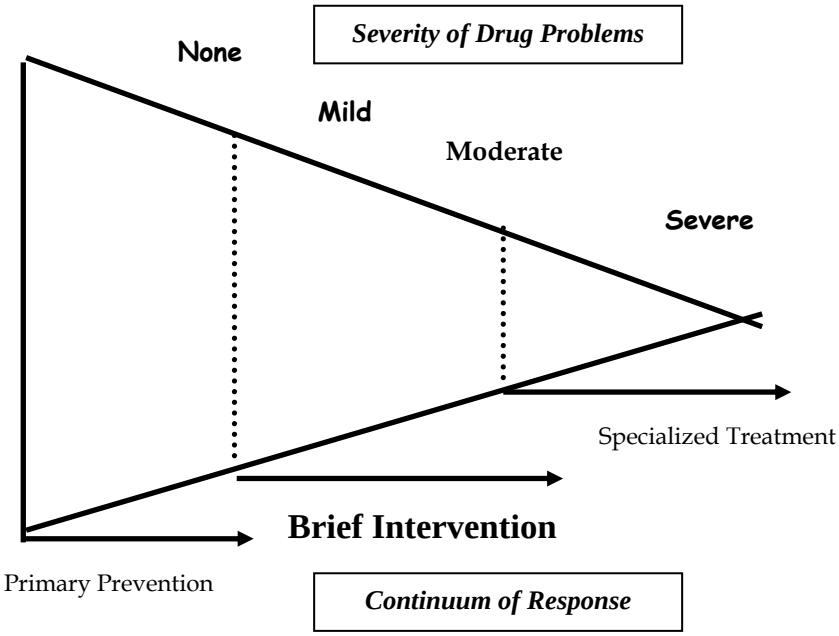
Assessments are used prior to the intervention to screen for individuals who would be better suited for other more extensive or specific treatment methods. The U.S. Department of Health and Human Services has provided some criteria for determining the appropriateness of a brief intervention (Center for Substance Abuse Treatment, 1999).

The criteria below can assist with identifying participants who are <u>not appropriate for a brief intervention</u>:

- Previous treatment failure
- Serious drug dependency
- Severe psychoses
- Hazardous intoxication
- Significant withdrawal symptoms

This brief intervention will focus on drug abusing adolescents (ages 12- to 19- years old) whose substance use ranges from mild to moderate levels. It is not intended for individuals who are in crisis, or those who require hospitalization for medical or psychiatric circumstances.

Figure 1



*** Adapted from Broadening the Base of Alcohol Treatment, Institute of Medicine, 1990**

Figure 1(above) represents a model for exploring how a continuum of care can be applied across a variety of drug use problems. The range of drug use problems is indicated on the top; responses to these problems are illustrated on the bottom. In general, specialized treatments, such as intensive outpatient and residential treatment, are appropriate referrals for youth with severe drug use problems, such as a substance dependence disorder, whereas brief interventions are viewed as an appropriate response for mild-to-moderate users, that is, youth with an substance abuse disorder.

POTENTIAL SETTING

Schools

Brief intervention is appropriate for inclusion in school-based chemical health programs that wish to add more services to supplement extant prevention and education programs. The procedures are a suitable response for students with a mild or moderate drug abuse problem. In a recent study by D'Amico and Fromme (2000), a group of high school students were given a school-based brief intervention in comparison to a group who received the traditional Drug Abuse Resistance Education (DARE) curriculum. Students who had participated in the brief intervention had considerably larger reductions in the frequency of alcohol consumption and drug use versus those who participated in only the DARE program (D'Amico & Fromme, 2000).

Juvenile Justice

Alcohol and drug abuse is a common factor among adolescent offenders and yet treatment for these problems is not widely available. Thus, a brief intervention, with its focus on reducing resistance to change and increasing participant engagement, can be a valuable

tool in this setting. Research has indicated that participants in brief intervention programs have reduced overall criminal behaviors (Hubbard, Craddock, Flynn, Anderson, & Ethridge, 1997).

Mental Health
Several adolescent studies indicate a strong co-association between psychiatric disorders and substance abuse (Clark & Bukstein, 1998). Brief interventions for substance abuse during mental health treatment are valuable because such treatments are focused and can easily be integrated into a general mental health regimen for the client.

Waiting Lists
Adolescents who are on any waiting lists for intensive treatment may be suitable candidates for brief intervention. In this light, brief intervention provides a therapeutic bridge for the client as he or she awaits more intensive treatment. The brief intervention therapist can begin the process of increasing the client's readiness to change and awareness as to benefits of reducing or stopping drug use.

WHY USE BRIEF INTERVENTION FOR DRUG ABUSING YOUTH?

The development of effective, cost-efficient, and time-efficient interventions for drug abusing adolescents is important, yet an under-studied priority in the health care delivery field. Pressures for shorter forms of drug abuse treatment are emerging from several sources (U.S. Department of Health and Human Services, 1999c). Examples of sources include: historical developments in the field that encourage the use of such approaches within a comprehensive, community-based continuum of care for a broad range of substance use problems; cost containment policies in the managed health care sector; and the expansion of community-based detection systems, such as in-school health clinics.

Research has indicated that brief interventions can be effective when treating adult alcoholics (see reviews by Bien et. al., 1993; U.S. Department of Health and Human Services, 1999a), and with young substance abusers (Breslin et al., 2002; Monti et al., 2001). Whereas brief interventions have many forms and vary in length (ranging from a one-time 10-minute session to several one-hour sessions), the approach described here is organized around a 3-session model that integrates developmentally adjusted components of motivational interviewing, cognitive-behavioral therapy and stages of change theory. Key behavior change features of the model include the adolescent taking an active role in determining therapy goals, personalizing feedback to the client in the form of identifying costs and benefits of their substance use, and establishing specific action steps that will facilitate the change process.

BACKGROUND

Why do adolescents use drugs?

The criteria for adolescent drug use are mixed. There is no easy answer. There are several factors to consider including physiological, psychological, and sociological influences. Physiological influences can be anything from a family history of alcoholism and/or substance abuse to mental health disorders. Psychological factors can include stress, inadequate social skills, negative affect, personality and self-image. Sociological influences can range from family and peer interactions to ethnic background, neighborhood, and religion. There are so many different causes that there is no distinct answer for this question. Tarter and Schneider (1976) have provided fourteen variables that affect one's decision to start, stop, and continue to use alcohol, (Lawson, Peterson, & Lawson, 1983).

Some of these variables include:

- Childhood exposure to alcohol and/or drugs
- Quantity deemed appropriate or excessive by the family
- Family drinking customs and attitude about intoxication
- Activities associated with drinking
- Social rewards and punishments for drinking, etc.

Common behavioral characteristics of adolescents under the influence may include:

- Impulsiveness
- Aggressiveness
- Gratification seeking
- Low motivation for achievement
- Psychopathology

Some additional theories regarding the causes of adolescent drug use are because they are readily available, they are a quick and inexpensive method towards feeling good, to gain acceptance from peers, or as a coping mechanism to relieve the symptoms of depression, tension, and pressure (Beschner & Friedman, 1979). Environmental factors such as a stressful event (e.g. death, illness, or injury) can also trigger this behavior. Segal, Cromer, Stevens, & Wasserman (1982) discovered three main objectives for drug use among adjudicated adolescents. These are:

1. To expand awareness
2. Drug effect (to get "high")
3. To increase activity and satisfy curiosity

In conclusion, one cannot discuss the causes of adolescent drug use without touching upon the developmental transition of adolescence in general. Puberty, cognitive development, and identity development are a few of the hurdles that adolescents must face in their path towards adulthood. An increase in health risks, including substance disorders, is a common corollary of this transitional period.

Who is at risk for developing a substance abuse problem?
Deviations of temperament in early childhood have indicated a risk for substance abuse (Galanter & Kleber, 1999). The most common characteristics associated with this deviation are: irritability, impulsive behaviors, reduced attention span, aggressive behaviors, and those who are "emotional" are all considered at risk.

Environmental factors also contribute to the development of substance abuse as well. Stressful events, lack of parental support and supervision, and deviant peer groups all play a supportive role. Social and cultural norms, socioeconomic factors, neighborhood, and lack of judicial enforcement can be included as risk factors.

Peck (1983) stated that if the adolescent has friends who use marijuana, 92% used it as well. If only a few friends were users, 66% did not use marijuana. It stands to reason that parents, teachers and other people involved with these young people need to pay close attention to daily activities and associated peers as a result of this research.

What is the difference between drug use, abuse and dependence?
In defining these terms it is important to know that, with regard to adolescents, this topic is highly controversial. Some believe that any substance use by an adolescent is abuse since alcohol is not legal for use until they have reached the legal drinking age. A traditional definition of abuse is the use of psychoactive substances to cause a boost in the person's exposure to damaging and dangerous consequences. This definition does not specifically apply to adolescents and does not permit those who merely experiment with substances and then never use again. The diagnostic manual of the American Psychiatric Association (DSM-IV; 1994) considers abuse to be a residual disorder of dependence.

Lawson and Lawson (1992) offer a list of signs to indicate drug abuse among adolescents. Some of these signs include:

- A sudden change in the child's peer group
- Experiencing significant highs and lows in their energy level and behavior
- A strong defiance towards rules and regulations
- Excessive sleeping

- Excessive excuses for misbehavior(s)
- Poor hygiene
- Self isolation
- A drastic change in weight
- Withdrawal from activities which were formerly enjoyed
- Defensiveness
- Coming home under the influence
- Short fused (lack of anger management skills)

A few of these can be viewed as typical adolescent behavior. However it is important to recognize these signs as a signal to pay closer attention to the child and the changes in their behavior.

Additional warning signs may include:

- Trouble in school (truancy, detentions, suspensions, & failing grades)
- Poor social skills
- Low self-esteem
- Low self-efficacy

For the purpose of this intervention, use is not considered abuse until it has emerged beyond the initial experimental stages, becomes more frequent, and has incurred some consequences (positive or negative).

Substance dependence is generally considered a more severe level of substance use, and it refers to an incessant need or drive to continue to seek out and use substances regardless of the harsh personal and negative consequences. Youth at this level of substance use may require a more intensive treatment program to achieve abstinence, and thus are not recommended to use this brief intervention as a sole treatment experience.

What are some protective factors to prevent substance abuse?
Protective factors are people, activities, and skills that help prevent an adolescent from using alcohol or drugs. The more protective factors a person has, the more positive their outcome will be. All people have the ability to lead a healthy life style that does not include substance abuse. Youth who have a strong sense of self, a supportive family, and non-using peers generally fare better with the risk of developing a substance abuse problem. The following list details several protective factors for adolescents.

- Parents/guardians whose parenting style represents a more authoritative approach
- A peer group or best friend who does not use
- Positive role models (i.e. coaches, teachers, clergy, extended family)
- A positive self-image and self-esteem
- An affiliation with one's school (i.e. band, team sports, clubs)
- Academic competence and success
- Having hobbies or other positive activities outside of school
- Being resilient in cases of high-risk, stress, or traumatic events

A resilient adolescent is one who can spring back in the face of adversity. Resiliency is a strength that supports the young adult in maintaining their sobriety during difficult and pressuring situations.

GOALS AND OBJECTIVES

Abstinence is usually the long-term goal of drug treatment. However, to start in motion the process of abstinence, it stands to reason that harm reduction is a logical early-stage goal of a brief intervention. Any behavior change that reduces harm is a positive result. By taking on a more flexible approach toward goal attainment, adolescent clients may be more receptive to the change process.

Harm reduction goals may include:

- A reduction in the frequency and/or intensity of the usage
- A reduction in driving under the influence
- A reduction of use before or during responsibilities (i.e. no use before or during school or work)
- Avoid use of new or unfamiliar substances

The brief intervention model also emphasizes that behavior change goals need to be individualized. This feature recognizes the heterogeneity of adolescent drug involvement. Each young person has their own reasons for substance use, and they may differ greatly in terms of willingness to change and treatment goals. By using individualized goals and

personalized feedback, the treatment can be more directly focused for each adolescent's specific needs.

A variety of techniques are integrated into the model in order to establish behavior change goals with the adolescent. One strategy is to engage the adolescent to discuss both the pros and cons of drug use. This method helps the individual recognize that while drug use may have short-term personal benefits, drug use can also affect school performance, interfere with peer and family relations, and increase many health risks.

The therapist is instructed to be non-judgmental, non-labeling, and non-confrontational. Restated, the therapist's job is to act as a teacher or coach in order to help the adolescent progress through the stages of change. The intent is to move the client from low problem recognition and little willingness to change, to the "action" stage in which specific steps of positive behavior change are identified and implemented by the youth.

To summarize, brief intervention is designed to help the client:

- Understand the purpose of brief intervention
- Learn new skills that promote healthier behaviors
- Take responsibility for self change
- Set goals to enhance success in life
- Become more aware of their drug use and its impact
- Enhance personal problem solving skills
- Generate alternatives to drug use

DESIGNING THE BRIEF INTERVENTION: A DEVELOPMENTAL APPROACH

The core components of this brief intervention – stages of change theory, motivational interviewing, and cognitive-behavioral therapy - have been age-adjusted. These adjustments include simplification of concepts, heavy emphasis on client engagement, and consideration of behavior change goals likely to be relevant to an adolescent. Provided below is a summary of these components.

Stages of Change Model

The Stages of Change Model, as described by Prochaska, DiClemente and Norcross (1992), provides a framework to understand the motivational state of a client with respect to changing health behaviors. These five stages of change can be readily adapted to apply to a young person who may be faced with examining his or her drug use behaviors. Figure 2 (below) offers a description of how the stage of change of model can be applied to a young person (U.S. Department of Health and Human Services, 1999b).

It stands to reason that many adolescents in therapy are likely in the pre-contemplation or the contemplation stage (see figure 2). The therapist should recognize that this status need not be a barrier to change. Rather the therapist should focus on ways to help the young person progress to the next stage. One should not always assume that a teenager who is in the precontemplation or contemplation stage is at a therapeutic dead end. Thus, the therapist should consider the client's ambivalence about change as normal and not necessarily stable.

Figure 2. Stages of Change Model

The Stages of Change Model		
Stage	**Example**	**Response**
Pre-contemplation. The teenager has no intention of changing their behavior anytime soon, regardless of possible negative consequences.	An alcohol-using youth who limits his or her drinking to social situations and has experienced only minimal alcohol-related consequences.	Provide information about the connection between possible problems and consequences connected with continued alcohol use. Include information about the harmful effects of alcohol on judgment, driving skills, etc.
Contemplation. The youth has begun to recognize some negative consequences related to their drug abuse. Change has not been affirmed or committed.	A teenager who has several negative consequences as a result of their use. The individual understands some of dangers of using but has not made a decision to cut-down or stop using.	Examine indecisiveness by helping the young person recognize the costs of their drug use.
Preparation. The adolescent has decided to change their drug-using behavior and has made preparations for this change.	The teenager has decided to reduce or stop using and makes a commitment to get help with this choice.	Improvement of the intentions towards change is needed. A brief intervention can be useful in providing options for change.
Action. The adolescent puts forth the effort to continue a plan for change. Some signs of progress are observed in terms of attitude and behavior.	The youth receives counseling or therapy. Thoughts of continued use may still be present so relapse prevention is important.	Develop and maintain a plan of action. Brief interventions can be used to support positive change, prevent relapse, and to connect the adolescent with recovery-supporting resources.
Maintenance. New, healthier behaviors are in place. Long-term objectives are being considered and planned.	A teenager who is receiving counseling or self-help on a regular basis, has found a sponsor, made new sober friends, and found replacement activities that revolve around sobriety.	Prevention of a relapse is the main objective. A brief intervention can be used to help provide encouragement to maintain sobriety.

Cognitive-behavioral Therapy
Cognitive-behavioral therapy (CBT) is a therapeutic technique used to change one's perceptions, thoughts, and feelings about his or her behavior and to increase a person's awareness as to how social experiences affect the way a person acts. CBT is based on the principles of the social learning theory; it focuses on the importance of overcoming skill deficits and increasing the client's existing coping skills by providing a means to obtaining social support.

The "ABC" principles of CBT are included in the brief intervention in order to facilitate the change process. The ABC model refers to an **A**ntecedent that is responded to by various **B**ehaviors or **B**eliefs, which, in turn, is followed by the **C**onsequences. By applying specific therapeutic steps outlined in the manual, such as assessing high-risk situations and identifying errors in thinking that may contribute to bad decisions, the therapist helps the young person choose attitudes and behaviors that are a healthier alternative to drug use behaviors.

Motivational Interviewing
Motivational interviewing, or motivational enhancement, is a therapeutic technique designed to enhance an individual's motivation to change a specified behavior. The curriculum for the brief intervention model has incorporated many features of motivational interviewing.

Miller and Rollnick (1991) have identified key elements that are important to the successful application of motivational interviewing. Interventions that contain even some of these elements have been proven effective in instigating change and reducing drug use (Bien et al., 1993). These elements are:

- Personalizing feedback about the client's problems and willingness to change
- Emphasizing the importance that change is the client's responsibility
- Providing specific and action-oriented recommendations on how to change, including a list of alternative behaviors
- Conducting oneself as an empathetic therapist
- Encouraging self-efficacy or optimism in the client

Each of these central elements of effective motivational interviewing is described below.

Personalized Feedback
Personalized feedback should be offered in a way that shows respect as well as cultural and individual sensitivity. The therapist who maintains a non-confrontational and non-

labeling approach will facilitate this process. Feedback is not to be used to "prove" that the adolescent has a drug use problem, rather it is to assist the young person to recognize that change is necessary. In the brief intervention model, the client completes various assessment and worksheets to encourage the feedback process.

Participant's Responsibility

The model emphasizes the importance that the adolescent is ultimately responsible for choosing what to do about his or her drug use behaviors. Thus, the therapist's goals are not forced upon the client. In this light, the therapist offers information, provides guidance and suggestions, and seeks a commitment from the client about what changes he or she will make. For example, in Section II of the manual, one of the initial statements from the therapist to the client is this: "I am not going to tell you what to do; only you can decide what you will do. But I would like to find out what you think about using drugs and/or alcohol and maybe see if together we can come up with some ways to avoid problems in the future. You are the only one who will decide what happens with your use of drugs and/or alcohol. If you choose, you can continue using the way that you have been, or you can make a change. The choice is yours."

When the client is permitted to make his or her own choices about change, several positive expectations for change are set in motion, including the client recognizing that change is primarily his or her responsibility, and if change occurs, self-efficacy is enhanced.

Recommendations and Alternatives for Change

Recommendations for change within the brief intervention model are offered as advice to the client, not as rigid prescriptions of change that reflect the therapist's philosophy. Of course, the therapist can ask the client if he of she is interested in hearing the therapist's suggestions, but such information should be communicated in a non-dogmatic manner.

A list of alternative behaviors to drug use is provided in the manual. The idea is to offer the adolescent a variety of choices that can replace former patterns of behavior in specific situations. For example, an exercise is described to help the client think of specific alternatives to using alcohol or other drugs when faced with a trigger, such as boredom or anxiety.

The decisional balance exercise is a primary technique described in the model to assist with the process of establishing specific goals. This exercise involves engaging the client to examine the pros and cons of one's substance use. It is from the con list that the therapist can begin the process of developing with the client specific action goals for change.

Therapist Empathy

Reflective listening skills are an important part of motivational interviewing. The therapist is encouraged to create a safe environment that allows the young person to feel comfortable talking about personal matters. Statements such as, "I understand what you

are saying and I am not going to judge you on this" or "What do you see as the next step for yourself?" are effective empathetic statements.

Self-efficacy Skills

Self-efficacy refers to the feeling of self-accomplishment. The change process is enhanced when clients feel that self-improvement is based on their accomplishments. The brief intervention model incorporates several features that encourage client self-efficacy, such as having the therapist acknowledging positive change – no matter how small- and reminding the client that the therapy goals are the client's responsibility.

CAUTIONS WHEN USING BRIEF INTERVENTION

As in any counseling setting with a young person, it is important that the adolescent client be fully advised of mandated reporting laws; for example, if he or she discloses being a victim of physical or sexual abuse, or reports that he or she may harm himself or herself, the therapist is required to report such information to the proper authorities.

The therapist is also advised to obtain written consent from the parent prior to implementing the brief intervention when working with teenagers younger than 18 years old. The consent form should describe the brief intervention procedures, the goals of the counseling sessions, and that the therapist is mandated to report to proper authorities any disclosure by the youth of physical or sexual abuse.

A final caution is a reminder of the limitations of brief intervention approaches. The model described in this manual is not appropriate as a stand-alone therapy for teenagers with a substance dependence disorder. Such youth are likely to require a more intensive treatment program. Also, when abstinence is the only goal of treatment, brief intervention may not be an appropriate treatment choice. This is not to say that brief intervention cannot strive for an abstinence goal. Abstinence is an ultimate goal for nearly all drug-abusing teenagers. But brief intervention is designed so that it is appropriate for short-term goals to include risk elimination, risk reduction, and pattern normalization, in the context that abstinence is a long-term goal.

SECTION II

ADOLESCENT
SESSION ONE

ADOLESCENT SESSION 1

INTRODUCTION

It is vital to the change process that the therapist establishes rapport with the participant at the outset of therapy. Rapport building can be accomplished by employing the use of reflective listening skills, being non-judgmental, and asking questions to help investigate the positive and negative consequences of the substance-abusing behavior.

The opening session should clarify the basic elements of the brief intervention. Monti and colleagues (2001) have identified the following components:

1. The overall purpose and content of the intervention.

2. The counselor's role, with an emphasis on what the counselor will and will not do in the sessions.

3. Limitations of confidentiality; that is, if the client shows a risk for harming oneself or others, or is being abuse by others (physically or sexually), it must be reported by the therapist.

4. A description of program-specific elements, such as requirements of attendance, number of sessions, etc.

The following statement illustrates how a therapist can provide these introductory elements in a non-judgmental approach:

- `What I would like to do is explore your use of alcohol and other drugs with you. We are concerned about teenage drug use, and about the kinds of things that happen when young people have been using.`

- I am not going to tell you what to do; only you can decide what you will do. But I would like to find out what you think about using drugs and/or alcohol and maybe see if together we can come up with some ways to avoid problems in the future. If you're interested, you can make a change, or you can continue using the way that you have been. The choice is yours.

- Is this okay? Can we try this out?

CLIENT ASSESSMENT

At this point, pertinent background information about the client should be collected and reviewed. As a guide, a CLIENT QUESTIONNAIRE is provided in order to structure this review.

- To help us get a better idea of how we want to proceed, I would like you take this short questionnaire. It will only take 5 minutes. After you are done, we will review the results together.

CLIENT QUESTIONNAIRE

Name:_____ Date:_____

- This questionnaire asks about you and your experiences. Some questions ask how often you have used alcohol and other drugs. Others ask how much you agree with a statement.
- Please read each question carefully. Circle the answer that is right for you.
- Please answer every question.

PART I

DURING THE PAST 12 MONTHS, HOW MANY TIMES (IF ANY)	**Never**	**1-2**	**3-5**	**6-9**	**10-19**	**20-39**	**40+**
1. Have you had alcoholic beverages (including beer, wine, and liquor) to drink?	1	2	3	4	5	6	7
2. Have you used marijuana (grass, pot) or hashish (hash, hash oil)?	1	2	3	4	5	6	7
3. Have you used drugs other than alcohol and marijuana?	1	2	3	4	5	6	7

4. If you have used other drugs, put an **X** in the space next to each drug that you have used at least **once during the past 12 months.**

_____ cocaine (coke, crack)
_____ amphetamines (such as uppers, speed, bennies)
_____ barbiturates (such as downs, goofballs, yellows, blues)
_____ heroin (smack, horse, skag)
_____ other narcotics (such as methadone, opium, morphine, codeine, Demerol)
_____ tranquilizers (such as Librium, valium)
_____ psychedelics (such as LSD, PCP)
_____ inhalants (such as glue, aerosol cans, gases, white-out)
_____ club drugs (meth, Ecstasy, MDMA, Special K, GHB, roofies)
_____ over the counter drugs (DXM, cough syrup, NoDoz)
_____ prescription drugs (not taken as prescribed)

PART II (PRQ)

The next set of questions asks whether you disagree or agree with these statements. Make a check mark in the appropriate blank.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. My use of alcohol or drugs has caused many problems in my life…….	_____	_____	_____	_____
2. I can quit using alcohol or drugs on my own…….	_____	_____	_____	_____
3. I am glad to be in this program…….….	_____	_____	_____	_____
4. My problems are caused by alcohol or drugs ……	_____	_____	_____	_____
5. I believe I have a problem with alcohol or drugs…….……	_____	_____	_____	_____
6. My use of alcohol or drugs has hurt others	_____	_____	_____	_____
7. I want to change my life and get away from alcohol and drugs……	_____	_____	_____	_____
8. I came to this program on my own……..	_____	_____	_____	_____
9. There are many good reasons for me to stop using alcohol or drugs…….	_____	_____	_____	_____
10. I am in this program because of bad luck……	_____	_____	_____	_____
11. I know why people are so upset about my alcohol or drug use……	_____	_____	_____	_____
12. I need help for my alcohol/drug problems	_____	_____	_____	_____
13. Using alcohol or drugs is a real problem in my life……..	_____	_____	_____	_____

	Strongly Disagree	Disagree	Agree	Strongly Agree
14. I can control my alcohol or drug use…	_____	_____	_____	_____
15. I have a bad alcohol or drug problem…..	_____	_____	_____	_____
16. I came to this program because of school or legal problems……	_____	_____	_____	_____
17. It will be a struggle for me to stop using alcohol or drugs……	_____	_____	_____	_____
18. People sent me to this program to get me out of the way……..	_____	_____	_____	_____
19. It's okay for me to use alcohol or drugs now and then…….	_____	_____	_____	_____
20. I need to stop using alcohol or drugs completely……	_____	_____	_____	_____
21. I have more important things to do than to be in this program……	_____	_____	_____	_____
22. I need help to stop using alcohol or drugs	_____	_____	_____	_____
23. I am willing to give up my old friends so I can stop using drugs or drinking……	_____	_____	_____	_____
24. I was forced into coming to this program	_____	_____	_____	_____
25. I think some type of help for my alcohol or drug use is a good thing for me	_____	_____	_____	_____

Scoring PART II (PRQ) of the Client Questionnaire

1. Assign these values to the response options:

Strongly Disagree	= 1
Disagree	= 2
Agree	= 3
Strongly Agree	= 4

2. Compute unweighted total score on the PRQ using these four steps:
(Note: Some items have reverse scoring and some are not scored)

Step 1	Compute:	Q1 + Q3 + Q4 + Q5 + Q6 + Q7 + Q9 + Q11 + Q12 + Q13 + Q15 + Q17 + Q20 + Q22 + Q23 + Q25 = **PRQ1**
Step 2	Note:	Reverse the scores assigned to Q2, Q14, Q19, Q21, and Q24 Such that: 1 = 4, 2 = 3, 3 = 2, 4 = 1
Step 3	Compute:	Q2 + Q14 + Q19 + Q21 + Q24 = **PRQ2**
Step 4	Compute:	**PRQ1 + PRQ2 = PRQ Score**

3. Interpretation guidelines

Low recognition of a problem:	**PRQ Score = 21 – 39**
Moderate recognition of a problem:	**PRQ Score = 40 – 59**
High recognition of a problem:	**PRQ Score = 60+**

Helpful Hints: Review Results of the CLIENT QUESTIONNAIRE

- Let's go over your answers on the 1st page of the questionnaire, regarding your drug use. Can you tell me more about your use of alcohol and other drugs? (We will review the results of the second part of the questionnaire later).
- How old were you when you started to use?
- Was there anything going on in your life when you started to increase your use?
- What kinds of trouble, if any, have you gotten into because of your use of drugs and/or alcohol?

THE DECISIONAL BALANCE EXERCISE

To move the first session from an introductory orientation to a more focused session, the decisional balance exercise is utilized. This exercise is basically an exploration and discussion regarding the positive and negative consequences of the adolescent's substance usage. The answers to the questions being asked in this exercise are to be recorded on the PROS AND CONS WORKSHEET included in this section. Summarize the answers provided by the participant, and clarify any inconsistencies.

- What do you like about using drugs and/or alcohol?

  Or

- What are the good things about using?
- What else? (Ask repeatedly until they have no more answers to provide)
- What don't you like as much about using drugs and/or alcohol?

  Or

- What are the not-so-good things about using?
- What else? (Ask repeatedly until they have no more answers to provide)
- Which effects of using drugs or alcohol matter the most to you?

If the participant has no or limited ideas of the effects of alcohol/drugs, ask:

- Can I share a few more effects of alcohol or drug use that other students have mentioned?

Discuss how the adolescent envisions the new suggestions of effects – are they pros or cons? Have these effects, or similar effects, already occurred to him/her or his/her friends?

ENVISION THE FUTURE: PROS AND CONS OF CHANGING USE PATTERNS

Asking the adolescent to think about their future can sometimes be a difficult task. The objective here is to help the young person to imagine the future if use did not continue. A change in the non-use direction may result in reduced penalties, consequences, and hassles from family and friends. The adolescent may gain back some privileges and freedoms that have been taken away as a consequence of their substance use behavior. Explain that they can shed their reputation as a "druggie," "drunk" or a "loser," and that the change will increase their self-respect.

Record the participant's answers on the lower half of the PROS AND CONS WORKSHEET.

- What do you think will happen if you continue to use the same way?
- By changing your use of drugs, you benefit from……
- What do you think would be the good things that would happen if you stopped using so much?

If the participant leaves out the major consequences if use were to continue, ask:

- May I tell you some of my own concerns as well?

If yes, discuss possible consequences that the client may face based on what you have learned from prior discussions. Consequences might be getting arrested for a DUI/DWI, losing your driver's license until age 21, or placed on probation.

If the client leaves out some major benefits associated with discontinuing or reducing use, ask:

- May I suggest one or two more?

If yes, organize your discussion around benefits that might occur based on prior discussions. For example, the benefits of discontinuing may be to regain privileges, or regain respect from his or her parents.

BRINGING FRIENDS AND FAMILY INTO THE DISCUSSION

It is recommended that the discussion of the pros and cons of use be extended to include additional questions regarding the attitudes of family and friends toward the client's drug use:

- What do your friends think about your using?
- How does this affect your decisions about using?
- What do your parents think about your using?
- How do their attitudes affect your decisions about using?

Summarize these answers on the PROS AND CONS WORKSHEET and share them with the client. Discuss answers. Clarify any inconsistencies and answers provided by the youth.

PROS AND CONS WORKSHEET

Name/ID:_____ **Date:** _____

In the space below, write down some of the positive reasons for your continued substance use. Be specific.

1. The pros of my using are:

A. _____

B. _____

C. _____

D. _____

In the space below, write down some of the negative reasons for your continued substance use.

2. The cons of my using are:

A. _____

B. _____

C. _____

D. _____

Now think of some of the positive and negative outcomes would be with changing your substance use. Write some ideas below.

3. The pros of my choice to change my using habits are:

A. _____

B. _____

C. _____

D. _____

4. The cons of my choice to change my using habits are:

A. _____

B. _____

C. _____

D. _____

My friends think: _____

My parents/guardians think: _____

My siblings/extended family think: _____

The attitudes of all these people affect my decision about using by: _____

_____

HOW TO COPE WITH CRAVINGS AND TRIGGERS

As the adolescent begins to make a change there will be difficulties along the way. These blockades to drug reduction or abstinence occur most frequently in the beginning of the stages of change. However these obstacles can last for extended periods of time over the course of time. It is important that the adolescent understand that continued feelings of craving to use drugs may be a normal part of the change process, and that there are specific strategies to cope in these situations. To begin, it is important for the young person to discover what may trigger continued drug use. Then the client is encouraged to learn skills for how to deal with these situations with non-drug use responses. The goal of this activity is to encourage the adolescent to engage in rewarding activities that do not promote or activate drug use behaviors.

Review possible drug involvement triggers with the young person. Provided below is a list of triggers often cited by young people.

Triggers can be:

- Contact with the drug
- Watching others use
- Situations where others are using, i.e. a party
- Certain emotions for example anger, frustration, boredom, and even excitement can be triggers
- Physical symptoms – not feeling well, nervous or tense

Can you think of any others? Please tell me about them.

Write his or her responses on the TRIGGERS AND CRAVINGS WORKSHEET

(Adapted from U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism, 1999a: *Cognitive-Behavioral Coping Skills Therapy Manual*.)

TRIGGERS AND CRAVINGS WORKSHEET

Name/ID_____ **Date**_____

Circle the reason or reasons for your own drug or alcohol use.

- **Boredom –** feeling that there is nothing else to do that is worthwhile. Some people use drugs or alcohol to make the boredom pass more quickly or to make boring activities seem more fun.

- **Escape –** to avoid uncomfortable situations, arguments, memories, or actual physical pain. Some people want to escape from their pain and use drugs and/or alcohol to make themselves feel numb or to forget.

- **Relaxation –** to unwind and reduce tension. Some people don't know how to relax without using drugs.

- **Socialization –** involves social settings such as a party or family gathering. Many people who are shy or uncomfortable in these situations use alcohol and drugs to help to reduce this uncomfortable feeling in themselves and to help them relax in this type of situation.

- **Improved self-image –** to make one's self look better in the eyes of others.

- **Attraction or Romance –** to invoke excitement or the feeling of being in love or having someone be attracted to one's self.

- **To hell with it –** when a person has just given up trying to reach any worthwhile goal. This is a person that feels that nothing matters and there is no reason for them to try.

- **No control –** a person who gives up trying to control his or herself. People who feel like this think that they just don't want to make any more effort to fight the urge to drink or use drugs.

Other – please describe: _____

_____

_____

Encourage the client to think carefully about the triggers of his or her drug use, and engage the adolescent in a conversation about alternative activities to assist in avoiding or dealing with triggers for use (*Things that Make You Happy* worksheet may be used here). Suggested script may include:

- It is not uncommon for people of all ages to get in the habit of doing something - whether it is work, exercise, drug use, or something else –that consumes a significant portion of their life so that it may interfere with their ability to enjoy other activities. With this in mind, can you think of other activities that you used to enjoy that you no longer do, or you engage in much less frequently, compared to when you didn't use drugs or alcohol?
- What were the pros and cons of those other activities?
- One thing we've learned through working with students is that people use alcohol/drugs because they serve a purpose - for you, this purpose might be…. (mention items from PROS list above). However, when the alcohol/drugs are significantly reduced (or are no longer present), a void remains. Filling that void with an activity or hobby that you enjoy is the key to a healthy lifestyle.
- Here is a list of some common activities from which some people find enjoyment (show list of *Things that Make you Happy*). Which activities on this list (or otherwise) are ones that you may enjoy?
- How do you think that these other activities might impact your triggers and/or cravings for drugs or alcohol?

Transcribe some alternate activities to help cope with triggers or cravings on the *What Sets Off Your Use worksheet,* and encourage the client to envision the pros and cons of the alternate activity versus the drug use.

Things that may make you happy

1. Taking a long hot bath
2. Thinking about your future and what you want to do
3. Going out with a boyfriend/girlfriend
4. Going to a movie
5. Jogging
6. Going for a walk
7. Listening to music
8. Sitting in the sun and relaxing
9. Reading a magazine or book
10. Hanging out with friends
11. Painting your nails
12. Dancing
13. Rearranging your room
14. Cooking
15. Taking your dog for a walk
16. Going swimming.
17. Drawing or doodling
18. Exercising
19. Playing sports
20. Talking with a friend or relative
21. Singing
22. Going rollerblading or rollerskating
23. Playing with a pet
24. Painting
25. Going on a bike ride
26. Doing a puzzle
27. Going shopping
28. Playing a musical instrument
29. Making a gift for someone
30. Buying CDs
31. Watching sports on TV or going to a game
32. Buying clothes
33. Going out to dinner
34. Working
35. Getting your hair done or hair cut
36. Going for coffee or tea
37. Going to hear live music
38. Going for a drive
39. Watching a favorite TV show
40. Going to a park
41. Completing a task
42. Writing in a diary or writing letters
43. Spending time with a child
44. Going on a picnic
45. Meditating
46. Playing cards
47. Seeing or showing photos
48. Doing word puzzles
49. Playing pool
50. Playing video games
51. Talking on the phone
52. Getting a massage
53. Going to the mall
54. Thinking about your good qualities
55. Going bowling
56. _____
57. _____
58. _____
59. _____
60. _____
61. _____
62. _____
63. _____
64. _____
65. _____

WHAT SETS OFF YOUR DRUG AND/OR ALCOHOL USE WORKSHEET
HOW CAN YOU RESPOND?

Name/ID: _____ Date: _____

In the first column, list the reasons/triggers of what sets off the student's use of drugs and/or alcohol. In the second column, list several alternatives to prevent or control these causes and influences.

TRIGGER	**ALTERNATIVE**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**

Assist the youth in envisioning situations in which triggers or cravings may appear, then finding alternative situations or activities to modify those triggers. Suggested scenarios are listed below.

TRIGGERS AND CRAVINGS SCENARIOS

1. You are at a party with your friends and someone passes you a joint. You don't feel like smoking it just now. What would you do? Is there another way/healthier way that you could handle this situation?

_____

_____

_____

_____

2. You have had a really hard day. You got an "F" on your test, your best friend has turned on you and you are really frustrated. How would you have handled this situation in the past? What can you do now instead of using drugs and/or alcohol?

_____

_____

_____

_____

3. You have a big presentation in front of the entire school tomorrow. You are really nervous and are having a hard time falling to sleep. What have you done in the past to relieve this anxiety? What else could you do?

_____

_____

_____

ASSESSMENT FOR CHANGE

The session has progressed to the point where now it is time to take a "temperature reading" of the client's willingness to change.

- So far, we have discussed the pros and cons of your use, consequences of your use, how your use is affected and impacted by family and friends, triggers for use, and alternative activities. Now I'm interested in finding out how you feel about making healthy changes in you drug use at this time.

- Place a mark on the READY TO CHANGE WORKSHEET that fits how the client feels right now.

READY TO CHANGE WORKSHEET I

Name/ID: _____ Date: _____

Here is a scale that will help us to determine how ready you are to change your use of alcohol and/or drugs. Place a number on the scale that indicates how you feel about this right now.

1 2 3 4 5 6 7 8 9 10

Not ready somewhat ready very ready

Please circle one of the following statements that best describes you right now.

1. I don't want to quit/reduce using drugs and/or alcohol.

2. I don't really like to use drugs and/or alcohol but I don't want to stop/reduce right now.

3. I am thinking about stopping/reducing my use of drugs and/or alcohol.

4. I have definitely decided that I want to stop/reduce using drugs and/or alcohol.

5. I have already stopped/reduced using drugs and/or alcohol.

- You have marked a _____. This means you are _____ ready to change. This number is a way of measuring how ready you are to make changes in your use. The questionnaire you filled out at the beginning of the meeting (part II) is also a way of measuring how ready you are to make positive changes….

You will now want to promptly score by hand Part II. This section produces a measure of the client's degree of willingness to change (low, medium, or high).

- The results of Part II of the questionnaire show a score that indicates *(low or moderate or high)* level of interest in making changes in your alcohol/drug use. How do you feel about this?
- (If low): What are some of the reasons why you do not want to change your drug use pattern?
- (If moderate or high): This is great. What are some of the reasons why you are thinking about changing your drug use pattern?
- Do you feel that these results from the questionnaire - Part II are consistent with the number you just provided on the 1 – 10 Ready to Change scale?

ESTABLISHING GOALS

The last significant task for Session One focuses on assisting the client to establish goals. Given the non-judgmental philosophy of the brief intervention, the counselor is encouraged to support any positive changes to which the client is willing to agree. Perhaps the goal will be as minimal as simply "to think about reducing drug use in the future." Admittedly, this goal may seem like a small gain to most, but it is important to begin the change process somewhere with a client. It comes as no surprise for professionals who have worked with many drug-abusing youth in treatment that most teenage clients do not readily choose abstinence as an immediate treatment goal. Risk reduction, use reduction, and normalization of use are meaningful improvements for the short-term. Abstinence can still be a logical long-term goal even when attaining this is preceded by non-abstinence goals.

Here is a suggested script for the process of establishing goals:

- Where does this leave us now?

OR

- What do you think has to change?
- How would you like things to be different?

Elicit what the youth would like to change about their drug using behaviors

- Reflect responses and generate clearly specified goals
- Identify people who might be helpful in this regard
- Reinforce goals with statements such as:

  - That's safe
  - That would be less risky
  - Drug and other alcohol use is not essential for fun

*Possible Goal*s - Record the goals on ESTABLISH GOALS WORKSHEET.

- Self-monitoring (for the most recalcitrant client)
- Abstinence
- Minimize usage
- Risk harm reduction
- Engaging in or improvement of other healthy behaviors, such as improved relationships, academic achievements, or job attainment.

If the participant cannot come up with any goals, try this exercise again in Session Two.

ESTABLISH GOALS WORKSHEET

Name/ID: _____ Date: _____

In the space below, write down some healthy goals that you will work on during the next week, including at least one drug or alcohol goal.

1. _____

2. _____

3. _____

4. _____

What might get in the way of trying to reach these goals?

1. _____

2. _____

3. _____

4. _____

Where does this leave us now? What can you do to prevent these obstacles?

1. _____

2. _____

3. _____

4. _____

EXPLORING BARRIERS TO CHANGE

Of course, your client is likely to face obstacles toward achieving his or her goals.

Here are scripted questions below.

- `What might get in the way of you trying to reach these goals?`

`Or`

- `What might make it hard to actually change your substance using behaviors?`

- `What do you need to do to achieve these goals?`

- `Let’s explore what kinds of feelings and situations that set-off your using drugs and/or alcohol. Can you identify three situations or feelings that seem to have led you to use?`

Support self-efficacy statements provided by the adolescent.

Transcribe the answers to the bottom half of the “ESTABLISHING GOALS” WORKSHEET. Discuss with the client how each goal may be faced with a barrier and remind them of the alternative activities that they had discussed earlier in the session. Review with the student how to respond to possible obstacles accordingly.

CONCLUSION OF SESSION ONE

Review the worksheets from this session. Place an emphasis on the ESTABLISH GOALS WORKSHEET and request that the young person work on these goals prior to Session Two, and provide a copy of the goals to the client as a reminder. Ask if the adolescent has any questions as to what action steps have been agreed upon. Set a date for Session Two. Thank the participant for his or her time.

The list below of "Advantages of Not Using Drugs" may be given to the client at the conclusion of Session One. A reproducible copy of this sheet can be found in the appendix of this manual.

- Keep your head clear
- Better relationship with family
- Feel better physically
- Save money
- Would not have to hide it anymore
- Feel better about yourself
- Think more clearly
- More time to enjoy hobbies, sports, etc.
- Better able to control moods and feelings
- Good for my weight (less calories)
- Don't have to worry about making a fool of yourself at parties
- Don't wake up wondering what happened the night before
- No more hangovers
- Self-confidence from overcoming the urge to use
- Wouldn't have a bad reputation
- Wouldn't regret things
- Health reasons
- Improved communication skills – not so snappy
- Better sleep
- Not so worried about others knowing
- Improved relationships with others, including family
- More time for yourself and your family and friends
- Able to plan for your future more clearly

SECTION III

ADOLESCENT
SESSION TWO

The second and final session with the adolescent should be used to:

1) Review progress made since the first session
2) Establish longer-term goals
3) Identify resources and support systems available.

REVISIT THE FIRST SESSION

Revisit Goals

Probe the client for any progress with the goals. Review if the client's support system was a barrier or a facilitator to the goals. Make suggestions when needed. Help the adolescent to deal with any frustrations they may have experienced in his or her effort to change their behavior. Offer support for continued application of helping techniques and strategies that were discussed in Session One, and offer new ones as appropriate. Be supportive, positive, and non-judgmental.

If the original goals appear to be too difficult or unattainable in the short run, then adjustments are in order. Also, be alert for signs of significant concern, and consider the value of referring the client to a formal mental health and/or chemical dependence evaluation.

Suggested script:

- How was your week? *(Get a general feel on how they are doing.)*
- What was it like working on your goals last week? *(Review their specific goals individually.)*

FOR EACH GOAL:

- What did you do to help achieving this goal?
- What got in the way, if anything?
- (*If goal was met*) What was this change like for you?
- We'll be setting more goals at the end of today's meeting, so let's keep in mind how your experiences with these goals went.

Revisit Pros and Cons
Discuss the pros and cons from the first session and see if the client has shifted the "weight" of the pros and cons in favor of more cons relative to pros. If the client reduced use or abstained from use during the intervening period, inquire as to pros and cons were experienced by virtue of the reduced or non-use behaviors. Reinforce desired responses; emphasis that any progress was due to the client's initiative.

Suggested script:
- What was it like for you to use less (or not at all)?
- Did you think of any more advantages of not using?
- Did you think of any more disadvantages of continued use?

PROBLEM SOLVING AND PEER PRESSURE

Personal Decision-Making Skills
To facilitate progress towards the therapy goals, the adolescent client may need help and support with their decision-making skills. One of the ways to facilitate these goals is to help him or her explore their own methods of decision and the efficacy of those methods. If the client is having difficulty thinking about decision-making in regards to drug use, you may broaden the approach to include other situations – from something as simple as which show to watch on TV to something more complex like where to apply for a job. This plan may help sharpen the client's problem-solving skills when faced with personal triggers of drug use.

Script
- Frequently when people are faced with a decision, they have a general way in which they approach their response. For example, if you were at a party and were faced with the decision to have a drink/use drugs or not, what thoughts would enter your mind to influence your decision to use or not to use?
- What are the different options you have in this situation?

Discuss alternative responses and review outcomes and consequences of each.

- Some people think through a situation before they make a decision regarding their next step, while others just do what

comes first or is easiest, regardless of the consequences (i.e. act first, think later). Others may have different decision-making styles. What kind of decision-maker are you?

- How well has this method worked for you?

Reinforce that certain decision-making styles are better able to help a person to think before acting. By teaching the adolescent to stop and think before acting, it helps reinforce that they may wish to choose a healthier behavior rather than to use drugs.

Dealing with Peer Pressure (especially useful with younger adolescents)
Though many adolescents do not recognize the social pressures associated with drug use, some acknowledge a hard time refusing social pressures to use drugs without losing "face." Talk to the client about such social peer pressures, and question students who have not recognized peer pressure in regards to witnessing peer pressure or hypothetical situations of peer pressure. Have him or her describe various situations in which they were pressured by their peers or others to use drugs or if they saw others being pressured. Discuss how effective refusal techniques can be learned. Engage the client in how they might approach these social situations.

Provided below are several alternatives to saying no to using. Discuss with him or her situations in which these statements will apply. Support him or her in trying one of these alternatives to saying "no" during the next time they feel pressured by someone to use drugs. Discuss with the youth about the feasibility of each alternatives among their groups of friends (i.e., how would your friends react if you tried this method?) Try role-playing a couple of situations.

- Do you feel that you experience peer pressure? (Not only for drugs, but also other behaviors, such as sex, delinquent behavior, etc.)

- What would your friends say or do if …...? (Provide individualized example.)

- How do you react to that? Are there other ways you could also react? *(Remind student of problem-solving skills from above, and discuss refusal techniques from handout below.)*

Make certain that the adolescent understands that they must speak assertively and make eye contact while using these techniques. Reinforce that the client need not feel guilty or weak about a decision to refuse to use drugs.

Refusal Techniques

Tell me what you think about the following ways to refuse effectively.

- "Not now, I'm not ready."
- Just say "no thank you" and leave it at that.
- Give a reason or excuse (e.g., "No thanks, I have a test/big game tomorrow").
- Broken record – keeping saying "no" over and over again.
- Walk away – ignore the person and the situation.
- Avoid the situation – if you know there will be drugs/alcohol at the party don't go.
- Change the subject – start talking about something else.
- Strength in numbers – be with friends that you can trust.
- Use humor – make a joke of the situation.
- Use your health as an excuse – (e.g., "I'm allergic to smoke").
- Reverse the pressure - (e.g., "If you want a beer so badly get one yourself").
- Be honest- tell them you are not into it (e.g., "It's just not my thing").
- Suggest an alternative – try something else to do.

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

SUPPORT NETWORK

It is important for the adolescent to know that there are people in his or her life that will support his or her healthy lifestyle, including the choice to reduce or eliminate drug use. You can help the adolescent recognize the supportive people in his or her environment. Have the client answer the following questions. Then follow by having him or her complete the SOCIAL SUPPORT WORKSHEET.

- Who among the people you know – friends, family, other adults, - is there to support you? Who really cares about your health and well-being?
- Which of these people would support your choice to reduce/quit using drugs or alcohol?
- What type of support would be most helpful for you?

Share the examples below with the participant.

Is there someone you know that….

- is good at coming up with ideas and alternatives that are healthier choices (Problem-solver)?
- who listens, is supportive, and understanding (Moral supporter)?
- can help take-off some of the pressure (Load sharer)?
- can answer questions and help to find other resources and information (Information provider)?
- if all else fails, this is the person you call for help (Emergency back-up)?

SOCIAL SUPPORT WORKSHEET

Name/ID: _____ Date: _____

Answer the following questions to the best of your ability

1. Who do you think may be able to offer you support?

_____

_____

_____

Suggestions:

- Think of people who have been helpful to you in the past such as friends, family members or other people that you know.
- Find people who are not biased. Those who will not pick sides.
- If you can't think of people who can be of help to you now, think of those who may be helpful later on.

2. Think of ways that these supportive people can help you. List at least three.

_____

_____

_____

3. Name someone to whom you are supportive? Tell how you support them.

_____

_____

(Adapted from Sampl, S. and Kadden, R. (2001). Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.)

PRESENT RECENT RESOURCES MATERIALS/EDUCATIONAL TOLS

Based on the information the client provides during the first session, it can be very helpful for the therapist to integrate individualized resources during this session. These resources should focus on the facts of drugs use and generally concentrate on drugs the client is using or plans to use, but can also address other concerns of the client, such as drugs a friend/family member is using or any general health concerns the youth presents, including sexual health, mental heath, academic concerns, or employment. The therapist should highlight some of the main points from each resource, and provide copies of the resources for the client to read on his or her own time *(several resources and educational tools are included in the appendix, or add your own resources/tools here).*

Suggested script:

- Based on our conversation last week, I thought I'd bring in some more information for you to review and think about. I can go through them with you now, and then you can take them and read them on your own more thoroughly or keep them for reference later. Does that sound OK?

REVISIT READY TO CHANGE

Have the client complete the READY TO CHANGE scale again. Compare the recorded score with the one from Session One. If there is a higher score chosen this time, reinforce this good news. Draw a connection between the improved readiness to change and progress that was made with the personal goals.

If there is no score change - or a drop in score - provide support that drug use habits can be difficult to tackle and that it is okay if it takes some time.

READY TO CHANGE WORKSHEET - II

Name/ID: _____ Date: _____

1. Are you seriously thinking about changing your drug and/or alcohol use within ***the next six months***?
   YES MAYBE NO

2. Are you seriously thinking about changing your drug and/or alcohol use within ***the next month***?
   YES MAYBE NO

Here is the same scale that you have seen before. This will help us to determine how ready you are now to change your use of drugs and/or alcohol. Place a number on the scale that indicates how you feel about this today.

1 2 3 4 5 6 7 8 9 10

Not ready Somewhat ready Very ready

Please circle one of the following statements that best describes you right now.

1. I don't want to quit/reduce using drugs and/or alcohol.

2. I don't really like to use drugs and/or alcohol but I don't want to stop/ cut down right now.

3. I am thinking about stopping/reducing my use of drugs and/or alcohol.

4. I have definitely decided that I want to stop/reduce using drugs and/or alcohol.

5. I have already stopped/reduced using drugs and/or alcohol.

FUTURE GOALS

Complete the "future goals" worksheet with student. Revisit goal sheet from Session 1 with the student and create revised goals that could be attainable. Discuss with the student goals for the immediate future, up to next major holiday, event, etc. (Christmas, spring break, end of school year, etc.) Also discuss goals for the longer term, 1 year from now. Write these goals out on the bottom of the "alternative to saying no" handout so the student can take them with her/him.

CLOSURE

Summarize both sessions, emphasizing the details of the client's goals for change. Review strategies to overcome barriers and encourage use of supports. Make sure to answer any questions. Congratulate the youth for maintaining commitment to the intervention. And of course, thank the client for their respectful participation.

Also, some clients will benefit from referral information. This could be in the form of instructions to call the counselor in case of concerns, or the client could be given specific contact information of an appropriate program, school counselor, or your business card for further reference.

CHAPTER IV

PARENT OR GUARDIAN SESSION

INTRODUCTION

Parents may exert an enormous influence – both positive and negative - on their child's efforts to change drug use behavior patterns. Research from both the family therapy and drug prevention fields offer a set of basic principles that serve to facilitate or encourage healthy behaviors. These principles include adequate monitoring of the whereabouts of the child, consistent disciplining, fostering a supportive interpersonal relationship with the child, and exhibiting personal behavior that communicates a healthy relationship with legal substances.

This chapter describes a separate therapy session for use with the parent(s) or guardian(s) of the adolescent client who is receiving the brief intervention. The session focuses on teaching and encouraging parent behaviors that promote healthy change in their child. It is recommended that this session be conducted after the two client sessions.

BREAKING THE ICE

Begin with some casual conversation. Review the events that led their son or daughter to the brief intervention. Discuss their view of what happened and how they feel about him or her receiving therapy. Ask open-ended questions rather than yes/no or close-ended questions.

- Thanks for coming here today and being a part of this program. One of our goals is, with parent assistance, to help adolescents make healthy choices, including the reduction of alcohol and drug use.

- Before we get started, I would like to talk for a moment about confidentiality. I want to reiterate that things you and I discuss today will not be shared with your son/daughter, their school, or anyone else.

- Likewise, I do not specifically share information that your on/daughter has shared with me.

- To start, it is my understanding that (child's name) was referred to this program because of… (*Let parent discuss their understanding of the situation.)*

- What do you hope you and your child will gain from this brief intervention?

Next, give the parent/guardian an overview of the brief intervention. Explain the goals and methods of treatment. Summarize the main ideas. Answer any questions and address any concerns they may have. Be reassuring and empathetic in your answers.

- I would like to review the goals and purpose of the brief intervention for your child. Please feel free to ask any questions or concerns you may have.

- The idea of the therapy is to collect personal information and then to use that information to help an adolescent reduce or stop their use of alcohol and other drugs. By learning about the history of drug use, it can help to individually focus the sessions.

- Each person has their own reason for using alcohol and other drugs. The brief intervention has been designed to meet these specific needs.

- Although abstinence is what we strive to attain with students, experience and research have shown that smaller, more attainable goals are more effective. Our aim is to assist your child in achieving a healthy balance interpersonally as well as throughout other aspects of life including school, family, and work.

- Do you have any questions or concerns?

- Now there are a few specific questions that I would like to ask. These will help us discuss how you can help facilitate your son/daughter's goals.

PARENT/GUARDIAN WORKSHEET

Name/ID: _____ Date: _____

I would like to start by asking a few questions about (child's name) experiences and relationships that might help us get a better feel for what we can focus on to help her/him make healthy choices. Feel free to ask any questions that you may have as we go along.

1. Can you tell me a little about your son/daughter's interests/hobbies? What are his/her strengths? What are things that are difficult for her/him. (Try to find out level of activity.) Is he/she in groups, clubs, etc.?

_____

_____

_____

2. How is (child's name) connection with school? How is his/her school performance? Have there been changes with his/her performance/connection to school? How do you feel about the friends he/she hangs out with?

_____

_____

3. Understanding that adolescence is a time of building independence from parents, does (child's name) participate in activities with the family? How would you describe the relationship you (or other members of the family) have with him/her? How satisfied are you with these relationships?

_____

_____

_____

4. Regarding (child's name) use of alcohol or other drug, what do you think has contributed to his or her use? [*Discuss factors that contribute to drug use among teens (e.g., poor school connection, friends that use, lack of involvement with activities, etc.) Use this as a segue to discuss family factors that contribute including genetic and environmental factors. Inquire about individuals in the home who may have difficulties with drug use.] If others have a history of use*, what has your child's reaction to their use been?

_____

_____

_____

5. Have you discussed with any friends or other family members about what to do about your son/daughter's using? Has there been anyone who has been supportive and/or helpful in this journey to help your child?

6. What steps, if any, have you taken already to try to prevent or reduce your son/daughter's use? In what ways have you shown support? (*Reinforce positive steps. Give examples if needed, "do special activities together, earn privileges, etc."*)

7. In what ways have you tried control or discipline to prevent or reduce your son/daughter's use? (Probe for skills related to monitoring and supervision. *Offer some other suggestions if needed.*

FAMILY RULES

Complete the FAMILY RULES worksheet with the parent.

- The next thing I would like to talk about pertains to the attitudes or rules in your household regarding alcohol and drugs.

Discuss the answers. Support responses that indicate healthy attitudes and behaviors in the family. Probe for details when the answer is vague. Coach the parent to offer healthier alternative, if necessary.

Family Rules about Alcohol and Other Drug Use

Name/ID: _____ Date: _____

1. Studies have shown that it can helpful to include your child or children in creating your household rules or expectations about alcohol or drug. Do you have rules about this in your household? If so, would you be willing to share them with me?

_____

_____

_____

2. Sometimes these rules are assumed or unsaid among family members. How have these rules been communicated to your child/ren?

_____

_____

_____

3. I recognize that adolescence can be stressful time for parents especially when alcohol/drug use is involved. With this in mind, do you have people close to you that you can turn to for support?

If Yes, how are they supportive?
If No, what types of resources are (can) you using (use) to assist you in dealing with this problem?

_____

_____

_____

_____

(Adapted from Walking the Talk: A Program for Parents about Alcohol, Tobacco and Other Drug Use and Nonuse - A Participant Workbook. Developed by The Center for Substance Abuse Prevention, Rockville, MD, 2001).

PARENT READINESS TO HELP THEIR CHILD CHANGE

- Next, could you take a moment to complete this questionnaire. It asks you about your attitude and expectations regarding your son/daughter. We can discuss your answers when you are done.

Give the parent the PARENT (Guardian) QUESTIONNAIRE. This questionnaire should be administered as a self-report form.

Hint: Spend time reviewing the answers to these critical items: **5, 7** and **10**.

Parent (Guardian) Questionnaire

Name/ID:_____ **Date:**_____

Please answer whether you disagree or agree with these statements about your child by making a check in the appropriate blank. Your answers will be kept confidential.

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1. As a parent/guardian, I have great concerns about my child's use of alcohol and/or drugs…..	_____	_____	_____	_____
2. I want my child to receive help for his/her alcohol and/or drug use…….	_____	_____	_____	_____
3. I want my child to quit using alcohol and/or drugs……..……	_____	_____	_____	_____
4. I want my child to reduce their usage of alcohol and/or drugs……..	_____	_____	_____	_____
5. As a parent/guardian, I am willing to do whatever is takes to stop my child from using…..	_____	_____	_____	_____
6. I believe that my child has a problem with alcohol and/or drugs……..	_____	_____	_____	_____
7. My child's use of alcohol and/or drugs is just "typical teenage behavior"…….	_____	_____	_____	_____
8. I think it's okay for my child to use alcohol and/or drugs every now and then……...	_____	_____	_____	_____
9. My alcohol and/or drug use is not a concern…	_____	_____	_____	_____
10. I tried to help my child to change his or her alcohol and/or drug use but it didn't work out….....	_____	_____	_____	_____
11. I believe my child can change his or her alcohol and/or drug use without help…….	_____	_____	_____	_____
12. I will make time to help my child with his or her alcohol and/or drug use problems……	_____	_____	_____	_____

BRAIN DEVELOPMENT

Parents/guardians have found it informative to discuss the biological impact of adolescent alcohol and drug use. Present the resources and discuss key points. Topics to discuss include:

1. The adolescent brain and the pruning process
2. Brain is not mature until age 24
3. Alcohol/drugs have a greater physiological impact on teens than on adults
4. How teens can get "hooked" quicker that adults
5. Gender differences regarding the impact of alcohol

INCREASE/DECREASE RISK FOR ALCOHOL OR DRUG PROBLEM

Show parent/guardian the Increase/Decrease Risk handout and review. If desired, place check marks next to those that apply to their family to identify level of severity. Utilize both the risk and protective items when establishing goals in the next section. For example, items parents indicate that they would like to enhance could be incorporated into a goal.

RISK AND PROTECTIVE FACTORS

What can **Increase the Risk** of an adolescent developing a drug or alcohol problem?

- **Early age of first use (age 13 or younger)**
- **Poor social coping skills (depression, anxiety, aggression, impulsivity)**
- **Feeling unloved by family; low mutual attachment with parents**
- **Ineffective parenting (supervision, monitoring, consequences, modeling)**
- **Perceived external approval of drug use (peers, family, community)**
- **Affiliation with deviant peers**
- **Having easy access to money from a job or above average disposable income**
- **Chaotic home environment**
- **Past or current drug or alcohol problems within the family**
- **Past or current family emotional, physical, or sexual abuse or neglect (especially depression)**
- **_____Other - Specific to adolescent**

What can **Reduce the Risk** of an adolescent development a drug or alcohol problem?

- **Feeling connected with and valued by family and other significant adults**
- **Parental supervision**
- **Child involvement in activities that provide joy, enhance self-esteem, prevent idol time**
- **Parent involvement with child's activities**
- **High educational aspirations of parents and child**
- **Academic success**
- **Feeling connected with school and valuing academic achievement**
- **Strong bonds w/ social institutions (school, community, extra-curr. activ., church)**
- **Personal disapproval of drug and alcohol use**
- **Personal belief that drug and alcohol use is dangerous and harmful**
- **Parents who verbalize expectations/consequences for using alcohol or drugs**
- **Follow through on consequences**

Adapted from: Falkowski, Carol (2002). ***Dangerous Drug: An Easy–to-Use Reference for Parents and Professions.*** **Hazelden, Center City, MN.**

Signs of Concern and Ideas to Address Them

Discuss signs of problematic drug use that parents/guardians should be aware of in the future. Show them the *What a Drug Problem May Look Like* sheet. This list is intended to help parents identify specific problematic behavior across multiple domains that may be correlated with a drug use problem. Note that there is no specific number of items that needs to be endorsed (i.e., this is not a diagnostic tool) and some items indicate severity more than others. The sheet is intended to give an overall picture or to show change over time. Make sure the parent/guardian knows how to access resources in their community if needed or that they can call you in the future for referral purposes.

What a Drug Problem May Look Like

FAMILY

- ❑ **Arguments**
- ❑ **Withdrawal from family**
- ❑ **Fighting**
- ❑ **Irresponsibility**
- ❑ **Coming in late or not at all**
- ❑ **Scapegoat behavior**
- ❑ **Physically/verbally abusive**
- ❑ **Dishonesty, sneakiness**
- ❑ **Defiant, hostile**
- ❑ **Secretive, silent**
- ❑ **Destructive**
- ❑ **Money or articles missing**
- ❑ **Finding drugs or paraphernalia**

SCHOOL

- ❑ **Skipping school regularly**
- ❑ **Chronic tardiness**
- ❑ **A drop in grades**
- ❑ **Getting caught using in/before school**
- ❑ **Change in attitude & behavior**
- ❑ **Conflict with school staff or students**
- ❑ **School staff concerned**
- ❑ **Suspension, detention**

JOB

- ❑ **Chronic late arrival**
- ❑ **Inability to get along with others**
- ❑ **Irresponsibility**
- ❑ **Missing work repeatedly**
- ❑ **Accidents on the job**
- ❑ **Working below potential**
- ❑ **Fired**

SEXUAL

- ❑ **Negative change in sexual values**
- ❑ **Promiscuity**
- ❑ **Seductive dress/talk/behavior**
- ❑ **STDs**

SPIRITUAL

- ❑ **Hopelessness**
- ❑ **Extreme self-centeredness**
- ❑ **"I don't care" attitude**
- ❑ **Negative changes in values**
- ❑ **Drops interests, activities that used to be important**
- ❑ **Creative activities (i.e. art, music) accompanied by drug use**

PHYSICAL

- ❑ **Lazy, lethargic**
- ❑ **Change in appearance**
- ❑ **Regularly tired**
- ❑ **Hangovers, "sick"**
- ❑ **Broken bones**
- ❑ **Car accidents**
- ❑ **Red eyes/using Visine**
- ❑ **Blackouts, passing out**
- ❑ **Weight loss/gain**
- ❑ **Getting in fights, beat up**
- ❑ **Suicide talk or behavior**
- ❑ **Overdosing**
- ❑ **Caught high/drunk**

EMOTIONAL

- ❑ **Mood swings**
- ❑ **Flat affect**
- ❑ **Out of touch with feelings**
- ❑ **Extreme anger, depression**
- ❑ **Irritability**
- ❑ **Hopeless, "who cares" attitude**
- ❑ **Defensive**
- ❑ **Non-communicative**

LEGAL

- ❑ **Minor consumption**
- ❑ **Possession charges**
- ❑ **Shoplifting**
- ❑ **Stealing**
- ❑ **Vandalism**

MENTAL

- ❑ **Poor concentration**
- ❑ **Distracted**
- ❑ **Memory loss**
- ❑ **Lower attention span**
- ❑ **Lack of motivation**

SOCIAL

- ❑ **Negative change in friends**
- ❑ **Secretive about friends**
- ❑ **Social activities increasingly drug-oriented**
- ❑ **Dropping activities not associated with drug use**
- ❑ **Unexplained coming/going, phone calls, etc**

HOW TO TALK TO KIDS ABOUT DRUGS AND ALCOHOL USE

For many parents, this topic is a very difficult one. Some parents choose do nothing; others become upset by accidentally discovering some drug paraphernalia and then end up lecturing or berating their child about the dangers of drugs. Research has shown that one of most powerful influences that can be exerted by parents in an effort to reduce the likelihood that their child will use drugs is to communicate to him or her that you disapprove of drug use and would be very upset if use occurred.

- Let's spend some time on the topic of how to talk to your son/daughter about drug use, especially if he or she returns to using.

- One effective and straightforward approach is to make sure that you tell your child that you care about their well-being and that you are concerned that they not use drugs.
-
- This approach was been created around a six-step process that attempts to reduce defensiveness and open the lines of communication. Here are the six steps. Let's review each of these steps.

Give the parent/guardian a copy of the SIX-STEPS HANDOUT and review each step with them. Answer any questions and address any concerns they may have.

Six Steps: Talking to kids about alcohol and other drugs

Step One – "I care"
Tell your child that you care about him or her. Attempt to build upon your relationship to help to reduce the potential defensiveness in your child. An example of this approach is, "I care about you and I don't want you to get hurt."

Step Two – "I see"
In this step, you need to tell your child what they have done that has caused you concern. Just give the facts, not your opinion, based upon what you have seen or found. An example of this is, "when you came in last night you were three hours late and smelled like alcohol."

Step three – "I feel"
This is where you tell your child about how this behavior or discovery has made you feel. Be sure to take away any blame from this step. For example, "I am really worried that you might get hurt or killed."

Step four – "Listen"
This has to be one of the most important steps. You will need to listen to what the adolescent has to say about their drug use or drinking behaviors. Some may not say anything at all at this point but it is useful to allow this opportunity for the young person to tell their side. It is possible that your child is not ready to talk. You can tell them that you are available to listen to what they have to say at another time.

Step five – "I want"
After hearing your child's side you need to tell them what you want to happen next and what you want them to do. For example, "I don't want you to use drugs at all." Reinforce that you "want" him or her to continue seeing the therapist if the problem does not get better.

Step six – "I will"
This final step is where you tell your child what you will and will not do in order to help them with this problem. Some may choose to be available to just listen when the young person chooses to discuss the issue. Other parents may choose to make an appointment with a chemical health counselor. The best time to talk is when you have calmed down from the initial shock of learning about your child's use of alcohol or other drugs. You will need to find a place to talk where you cannot be interrupted. The time to talk is not while your child is still under the influence of drinking or using other drugs. If the problem persists, encourage your child to make an appointment with the therapist.

(Adapted from Walking the Talk: A Program for Parents about Alcohol, Tobacco and Other Drug Use and Nonuse - A Participant Workbook . Developed by The Center for Substance Abuse Prevention, Rockville, MD, 2001).

PRESENT RESOURCE MATERIALS/ EDUCATIONAL TOOLS

Throughout the session it is important for the therapist to be cognizant of various issues/topics that arise whereby the parent may benefit from obtaining additional information (e.g., info on specific drugs, healthy eating, mental health issues, etc.) Offer the parent/guardian supplemental information on these topics (see Appendix for examples). This information can be distributed via handouts, e-mail, web site info, etc. It is recommended that the therapist bring an array of handouts to the session pertaining to a variety of topics. Therapists can build their own resource handout portfolio utilizing information obtained via reliable web sites or agencies (e.g., SAMHSA, NIDA, CDC, WHO). Parents have found these supplemental resources to be quite beneficial.

SUMMARY/REVIEW OF SESSION

Review the intervention techniques discussed in this session.

- Parental discipline – what has discipline been like, how would you like to change discipline behaviors, who can support you in discipline matters with your child?
- Positive and supportive behaviors –doing things with child such as shopping coffee, lunch, hugs, small talk, prosocial modeling of behavior, other social interactions not necessarily revolved around substances
- Attitudes and behaviors regarding their own use drugs
- Encouraging child to get involved with activities at school, community, etc.

Reinforce what behaviors and attitudes the parent needs to display more frequently (that is, the positive actions) and needs to display less frequently (that is, the negative actions). Review the parent's answers from the FAMILY RULES and PARENT QUESTIONNAIRE

SET GOALS

Complete the Goals Worksheet with the parent. Create concrete goals that could be attainable. Discuss with the parent goals for the near future (up to next major holiday, event, etc. such as Christmas, spring break, end of school year, etc.). Also discuss goals for the longer term, 1 year from now. Write these goals out on the bottom of the Resources handout so the parent can take them with her/him.

HELPFUL RESOURCES FOR PARENTS

Partnership for a Drug Free America
http://www.drugfree.org/parent

Parents The Anti-Drug
http://www.theantidrug.com

4parents
http://www.4parents.gov/

Family Guide
http://www.family.samhsa.gov

Immediate Goals up to _____(list event, holiday, etc.)

1. _____
2. _____
3. _____
4. _____

Goals 1 YEAR from now

5. _____
6. _____
7. _____
1. _____

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Appendix A

SUBSTANCE SPECIFIC INFORMATION

(Please refer to individual articles/resources for appropriate citation)

Tobacco

Common names: Cigarettes, smokes, sticks, butts, Bogarts, bogies, chew, snuff etc.

What is it?

Tobacco comes from the dried and crushed leaves of the tobacco plant. It is the second most popular drug in the world next to alcohol. The drug nicotine in tobacco is responsible for the short-term effects from smoking and the addiction it causes. Tobacco can be smoked in pipes or cigarettes, chewed, or snorted in powder form. All of these forms are just as addictive.

Short-term effects

Short-term effects of using tobacco can include an increase in pulse and blood pressure. Stomach acids increase and the person's skin may become cooler. Urine production is reduced. The amount of activity in a person's brain and nervous system will first increase and then slow back down. Appetite is decreased and the person will be less able to perform energetic and physical activities.

Long-term effects

The long-term effects from using tobacco are very grim. The blood vessels in the person's heart and brain will narrow or darken. This will cause the person to become short of breath and cough frequently. Pneumonia, bronchitis, emphysema and other lung infections are common. Cancer of many different forms as well as stomach ulcers may develop. The person's skin becomes rough, wrinkled, and dry and it ages prematurely. A pregnant woman who smokes can cause the baby to be born prematurely or to have low birth weight. A woman who smokes and takes birth control pills has the increased risk of developing blood clots, a heart attack, and/or a stroke.

Signs of usage

Frequent cough, smoke smell on clothing and hair, yellowish stain of fingers and teeth, possession of a lighter or other tobacco products, decreased appetite, etc.

Legal status

The sale of tobacco products is illegal to minors in the United States under the age of 18.

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

Information About Smoking:
A Guide for Teens

Do you smoke? Have you ever stopped to think about how smoking is affecting your body and your life? Most teens are aware that people who have smoked for awhile can get lung cancer and emphysema and eventually die, but many don't know about all of the bad things that smoking can to them right now. If you smoke, you owe it to yourself to find out about the effects of smoking on your life now. This guide provides some information about what smoking is doing to your body and some of the common reasons why people keep smoking even though they know it's bad for them. These are important things to think about to help you decide if you should continue smoking.

Why is cigarette smoking bad for me?

Everyone knows that smoking can cause cancer when you get older, but did you know that it also has bad effects on your body right now? A cigarette contains about 4000 chemicals, many of which are poisonous. Some of the worst ones are:

- Nicotine: a deadly poison
- Arsenic: used in rat poison
- Methane: a component of rocket fuel
- Ammonia: found in floor cleaner
- Cadmium: used in batteries
- Carbon Monoxide: part of car exhaust
- Formaldehyde: used to preserve body tissue
- Butane: lighter fluid
- Hydrogen Cyanide: the poison used in gas chambers

Every time you inhale smoke from a cigarette, small amounts of these chemicals get into your blood through your lungs. They travel to all the parts of your body and cause harm.

What do all these chemicals do to my body?

As you might imagine, even small amounts of the poisonous chemicals in cigarettes can do bad things to your body. **Here are some facts about what smoking cigarettes does to you**:

- Smoking makes you smell bad, gives you wrinkles, stains your teeth, and gives you bad breath.
- Smokers get 3 times more cavities than non-smokers.
- Smoking lowers your hormone levels.
- When smokers catch a cold, they are more likely than non-smokers to have a cough that lasts a long time. They are also more likely than non-smokers to get bronchitis and pneumonia.
- Teen smokers have smaller lungs and a weaker heart than teen non-smokers. They also get sick more often than teens who don't smoke.

What happens to my lungs when I smoke?

Every time you inhale smoke from a cigarette, you kill some of the air sacks in your lungs, called alveoli. These air sacks are where the oxygen that you breathe in is transferred into your blood. Alveoli don't grow back, so when you destroy them, you have permanently destroyed part of your lungs. This means that you won't do as well in activities where breathing is important, like sports, dancing, or singing.

Smoking paralyzes the cilia that line your lungs. Cilia are little hairlike structures that move back and forth to sweep particles out of your lungs. When you smoke, the cilia can't move and can't do their job. So dust, pollen, and other things that you inhale sit in your lungs and build up. Also, there are a lot of particles in smoke that get into your lungs. Since your cilia are paralyzed because of the smoke and can't clean them out, the particles sit in your lungs and form tar.

I know smoking is bad for me, but I really like it.

Many teens like the feeling that smoking gives them. This good feeling is from the nicotine in the cigarettes. Some teens think smoking will help them lose weight or stay thin. Many teens also feel like smoking gives them a sense of freedom and independence, and some smoke to feel more comfortable in social situations. If this sounds like you, **you should stop and think about whether the things you like about smoking are really worth the risks**.

- Nicotine can make you feel good, but is feeling good (a feeling you can also get from healthy activities like playing sports) really worth all the bad things cigarettes do to you? If you smoke, you'll get sick more often. You also have the chance of getting lung cancer or emphysema, which will make you really sick for a long time before you die. If you are very sick, that good feeling from nicotine won't seem so important anymore.
- Smoking doesn't really help people lose weight. If that were true, every smoker would be thin.
- Smoking lowers your hormone levels.

Do you think that smoking is a sign that you can do what you want? That you are in control of your life?

Think about it this way: When you decide to start smoking, you are doing exactly what tobacco companies want you to do. They spend millions of dollars every year on advertising to try to get new people, especially teens, to smoke. Once they have you hooked, THEY are controlling YOU. You are forced to buy their products in order to support your addiction. Do you really want a big corporation controlling your life and telling you how to spend your money?

Why should I stop smoking if I'm not addicted?

Many people don't realize they are addicted to smoking. They think they can easily quit any time they want. But when they try, they forget it is extremely difficult. Unfortunately, it is very easy to get addicted. Cigarettes are just as addictive as cocaine or heroin. Even

if you only smoke one or two cigarettes a day and even if you've never bought a pack of cigarettes yourself, you are at risk. Stressful situations or hanging out with friends who smoke might cause you to smoke more and become addicted. Try going a whole week without smoking at all. If you find this difficult, you are probably addicted to cigarettes.

If I quit smoking, won't I gain weight?

Many people are afraid to quit smoking because they think they will gain weight. In reality, many do gain a little but not enough to change how they look. People don't gain weight because they stop smoking. They gain weight because they start eating more. Often, people confuse the feeling of craving nicotine with hunger and eat to try to make this uncomfortable feeling go away. Smokers are also used to having something in their hands and in their mouth, so they may pick up food to replace holding a cigarette. To keep from gaining weight, try these things:

- Drink sips of water instead of eating when you feel uncomfortable.
- Eat carrot or celery sticks or other healthy, low calorie foods.
- Exercise. This will also help take your mind off smoking and make you healthier.
- Keep busy. You will be less likely to eat when you're not really hungry if you are doing other things.

I'll quit in a year or two when I'm ready.

A lot of people put off quitting smoking, thinking that they'll do it when the time is right. Only 5% of teens think they will still be smoking in 5 years. Actually, about 75% of them are still smoking more than five years later. If you smoke, it will never seem like the right time to quit and quitting will never be easy. The longer you smoke, the harder it will be to stop and the more damage you will do to your body. **Here are some reasons to quit sooner rather than later**:

- Most teens would rather date a non-smoker.

- You'll save money if you quit smoking. A pack of cigarettes costs about $5.00. Even if you only smoke a couple packs a week, you're spending about $40 per month and $480 per year on smoking. Think of all the other things you could use that money for.
- You only have one pair of lungs. Any damage you do to them now will be with you for the rest of your life.
- The longer you smoke, the better your chances are of dying from it. One out of 3 smokers die from smoking and many more become very sick. Think about your friends who smoke. 1/3 of them will die from smoking if none of you quit.

Smoking can have serious effects on your life. The longer you smoke, the more damage you do to your body and your health. Most people who begin smoking as teens say that they wish they had never started. The decision to start or continue smoking is all up to you and no one can make you stop, but you should think really hard about whether it is the best thing for your body and your life.

Updated: 3/12/06

NIDA NOTES

Research Findings

Volume 16, Number 1 (March, 2001)

Smoking May Lead to Anxiety Disorders in Adolescents and Young Adults

Using a wealth of data obtained through a 25-year longitudinal study, NIDA-funded researcher Dr. Judith Brook of the Mount Sinai School of Medicine in New York, Dr. Patricia Cohen of Columbia University in New York, and their colleagues have documented adverse effects of smoking in several critical areas of functioning during young adulthood. Most recently, the team has reported a connection between tobacco use by adolescents and young adults and the likelihood that they will develop agoraphobia (fear of leaving home or of the outdoors), generalized anxiety disorder, or panic disorder. Analyzing data from their Children in the Community study, funded by NIDA and the National Institute of Mental Health, the researchers were able to separate the effects of smoking from the effects of age, gender, childhood temperament, alcohol and other drug abuse, and depression among the adolescents, as well as parents' smoking, education, and behavioral and/or mental health problems.

The researchers interviewed 688 youths and their mothers in 1983, between 1985 and 1986, and again between 1991 and 1993. A total of 69 of the youths smoked heavily - at least 20 cigarettes every day - and experienced an anxiety disorder during adolescence, early adulthood, or both. Of these 69 youths, 29 (42 percent) began smoking before they were diagnosed with an anxiety disorder. The remaining 40 youths were split between those who were diagnosed with anxiety disorders before they reported heavy smoking (13, or 19 percent) and those who reported smoking and were diagnosed with anxiety disorders at the same interview session (27, or 39 percent).

Adolescents who smoked heavily were 6.8 times more likely to develop agoraphobia, 5.5 times more likely to develop generalized anxiety disorder, and 15.6 times more likely to

develop a panic disorder as young adults than were their counterparts who smoked fewer than 20 cigarettes a day or not at all. The investigators speculate that impaired respiration and the potentially damaging effects of nicotine on blood vessels to the brain may help explain why the adolescents who smoked heavily were at increased risk of developing anxiety disorders.

The long-held notion that depression causes some adolescents to smoke may be true. But Dr. Brook's study suggests the opposite may also be true - that smoking increases the risk of depression in this population. Dr. Brook and her team recommend that future research examine further the possible relationships between various anxiety disorders and smoking.

Source

Johnson, J.G.; Cohen, P.; Pine, D.S.; Klein, D.F.; Kasen, S.; and Brook, J.S. The association between cigarette smoking and anxiety disorders during adolescence and early adulthood. *Journal of the American Medical Association* 284(18):2348-2351, 2000.

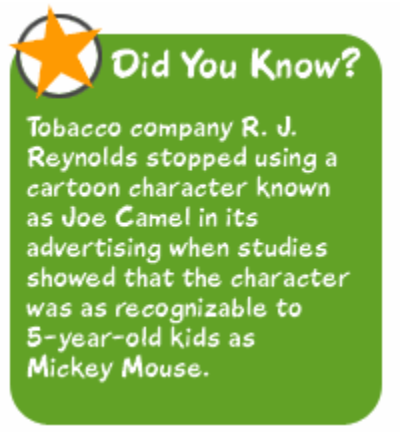
When your parents were young, people could buy cigarettes and smoke pretty much anywhere - even in hospitals! Ads for cigarettes were all over the place. Today we're more aware about how bad smoking is for our health. Smoking is restricted or banned in almost all public places and cigarette companies are no longer allowed to advertise on buses or trains, billboards, TV, and in many magazines.

Almost everyone knows that smoking causes cancer, emphysema, and heart disease; that it can shorten your life by 14 years or more; and that the habit can cost a smoker thousands of dollars a year. So how come people are still lighting up? The answer, in a word, is addiction.

Once You Start, It's Hard to Stop

Smoking's a hard habit to break because tobacco contains nicotine, which is highly addictive. Like heroin or other addictive drugs, the body and mind quickly become so used to the nicotine in cigarettes that a person needs to have it just to feel normal.

Almost no smoker begins as an adult. Statistics show that about nine out of 10 tobacco users start before they're 18 years old. Some teens who smoke say they start because they think it helps them look older (it does - if yellow teeth and wrinkles are the look you want). Others smoke because they think it helps them relax (it doesn't - the heart actually beats faster while a person's smoking). Some light up as a way to feel rebellious or to set themselves apart (which works if you want your friends to hang out someplace else while you're puffing away). Some start because their friends smoke - or just because it gives them something to do.



Some people, especially girls, start smoking because they think it may help keep their weight down. The illnesses that smoking can cause, like lung diseases or cancer, do cause weight loss - but that's not a very good way for people to fit into their clothes!

Another reason people start smoking is because their family members do. Most adults who started smoking in their teens never expected to become addicted. That's why people say it's just so much easier to not start smoking at all.

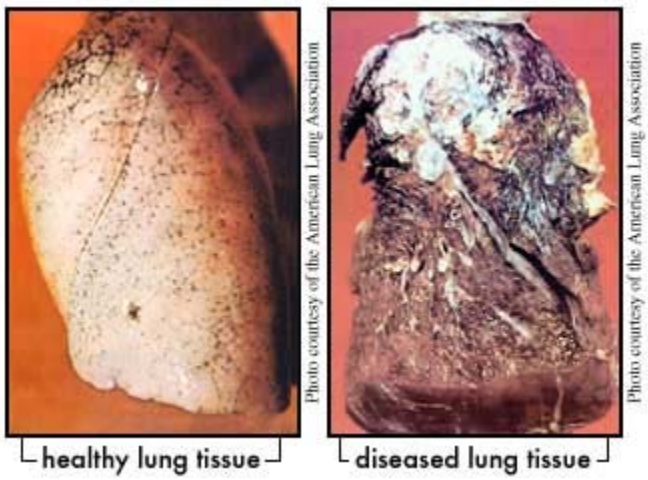
The cigarette ads from when your parents were young convinced many of them that the habit was glamorous, powerful, or exciting - even though it's essentially a turnoff: smelly, expensive, and unhealthy. Cigarette ads from the 1940s even showed doctors recommending cigarettes as a way to relax!

Cigarette ads still show smokers as attractive and hip, sophisticated and elegant, or rebellious and cool. The good news is that these ads aren't as visible and are less effective today than they used to be: Just as doctors are more savvy about smoking today than they were a generation ago, teens are more aware of how manipulative advertising can be. The government has also passed laws limiting where and how tobacco companies are allowed to advertise to help prevent young kids from getting hooked on smoking.

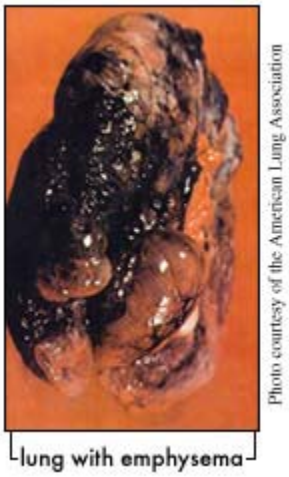
How Smoking Affects Your Health

There are no physical reasons to *start* smoking - the body doesn't need tobacco the way it needs food, water, sleep, and exercise. In fact, many of the chemicals in cigarettes, like nicotine and cyanide, are actually poisons that can kill in high enough doses. The body's smart and it goes on the defense when it's being poisoned. For this reason, many people find it takes several tries to get started smoking:

First-time smokers often feel pain or burning in the throat and lungs, and some people feel sick or even throw up the first few times they try tobacco.



The consequences of this poisoning happen gradually. Over the long term, smoking leads people to develop health problems like cancer, emphysema (breakdown of lung tissue), organ damage, and heart disease. These diseases limit a person's ability to be normally active - and can be fatal. Each time a smoker lights up, that single cigarette takes about 5 to 20 minutes off the person's life.



Smokers not only develop wrinkles and yellow teeth, they also lose bone density, which increases their risk of **osteoporosis** (pronounced: ahs-tee-o-puh-**row**-sus, a condition that causes older people to become bent over and their bones to break more easily). Smokers also tend to be less active than

nonsmokers because smoking affects lung power. Smoking can also cause fertility problems in both men and women and can impact sexual health in males.

The consequences of smoking may seem very far off to many teens, but long-term health problems aren't the only hazard of smoking. Nicotine and the other toxins in cigarettes, cigars, and pipes can affect a person's body quickly, which means that teen smokers experience many of these problems:

- **Bad skin.** Because smoking restricts blood vessels, it can prevent oxygen and nutrients from getting to the skin - which is why smokers often appear pale and unhealthy. An Italian study also linked smoking to an increased risk of getting a type of skin rash called psoriasis.

- **Bad breath.** All those cigarettes leave smokers with a condition called halitosis, or persistent bad breath.

- **Bad-smelling clothes and hair.** The smell of stale smoke tends to linger - not just on people's clothing, but on their hair, furniture, and cars. And it's often hard to get the smell of smoke out.

- **Reduced athletic performance.** People who smoke usually can't compete with nonsmoking peers because the physical effects of smoking - like rapid heartbeat, decreased circulation, and shortness of breath - impair sports performance.

- **Greater risk of injury and slower healing time.** Smoking affects the body's ability to produce collagen, so common sports injuries, such as damage to tendons and ligaments, will heal more slowly in smokers than nonsmokers.

- **Increased risk of illness.** Studies show that smokers get more colds, flu, bronchitis, and pneumonia than nonsmokers. And people with certain health conditions, like asthma, become more sick if they smoke (and often if they're just around people who smoke). Because teens who smoke as a way to manage weight often light up instead of eating, their bodies lack the nutrients they need to grow, develop, and fight off illness properly.

Smoking Is Expensive

Not only does smoking damage health, it costs an arm and a leg. Depending on where you live, smoking a pack of cigarettes a day can cost about $1,800 dollars a year. That adds up. It's money you could save or spend on something for yourself.

Kicking Butt and Staying Smoke Free

All forms of tobacco - cigarettes, pipes, cigars, and smokeless tobacco - are hazardous. It doesn't help to substitute products that seem like they're better for you than regular cigarettes - such as filter or low-tar cigarettes.

The only thing that really helps a person avoid the problems associated with smoking is staying smoke free. This isn't always easy, especially if everyone around you is smoking and offering you cigarettes. It may help to have your reasons for not smoking ready for times you may feel the pressure, such as "I just don't like it" or "I want to stay in shape for soccer" (or football, basketball, or other sport).

The good news for people who don't smoke or who want to quit is that studies show that the number of teens who smoke is dropping dramatically. Today, only about 22% of high school students smoke, down from 36% just 7 years ago.

If you do smoke and want to quit, there's more information and support out there than ever. Different approaches work for different people - for some, quitting cold turkey is best, whereas others find that a slower approach is the way to go. Some people find that it helps to go to a support group especially for teens; these are sometimes sponsored by local hospitals or organizations like the American Cancer Society. And the Internet offers a number of good resources. Check out some of these by clicking on the Resources tab to the right of this article. When quitting, it can be helpful to realize that the first few days are the hardest, and it's normal to have a few relapses before you manage to quit for good.

Staying smoke free will give you a whole lot more of everything - more energy, better performance, better looks, more money in your pocket, and, in the long run, more life to live!

Alcohol

Common names: Beer, wine, brew, booze, hooch, moonshine, vino, sauce, etc.

What is it?

Alcohol is a depressant that reduces the activities of the central nervous system. Alcohol is created by the fermentation of grains, vegetables, and/or fruits.

Short-term effects

The short-term effects of using alcohol cause the person to feel relaxed and less inhibited. People abuse alcohol to become more relaxed, sociable, and as a inexpensive way to get "high." While under the influence of alcohol, thinking becomes distorted as well as judgmental capabilities, reaction time and the decision-making processes. Working or performing other physical and/or mental coordinated tasks will become difficult under the influence of alcohol abuse. Mood may be affected in addition to the ability to control one's temper and actions. Risk taking has been associated with alcohol use. When a person consumes a large amount of alcohol, it is called, "binge drinking." The effects of alcohol can be increased if combined with other drugs. A "hangover" occurs when the person consumes a large amount of alcohol and feels ill the next day.

Long-term effects

Long-term effects of using alcohol have been proven to be very damaging overall. A person who consumes alcohol heavily on a regular basis may suffer from; an inflamed stomach or pancreas, cirrhosis of the liver, cancers of the gastrointestinal tract, heart disease, high blood pressure, brain and nerve damage. In pregnant women, the prenatal exposure to alcohol can cause Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE). These include facial abnormalities, growth deficiencies, and damage to the central nervous system that can result in developmental delays, learning disabilities, hyperactivity, memory deficits, and behavioral disorders. Excessive use of alcohol can cause psychotic behavior and/or death.

Signs of usage

Talkative, boastful, slurred speech, giddiness, a loss of coordination, alcohol smell on one's breath, staggering, nausea, vomiting, delayed reaction time, etc.
Symptoms of a hangover include; headache, stomach ache, low blood sugar, dehydration and possibly an irritation of the lining of the digestive system, an alcohol smell on the person's breath or clothing indicates usage, etc.

Legal status

Alcohol is legal to consume in the United States provided the individual is of drinking age. In most states, this is 21-years-old.

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

Alcohol

What is alcohol?

Alcohol is a general term for a class of chemical compounds. When referring to alcohol as a drink, it means a liquid made by fermenting sugar and plant materials to form an intoxicating drink.

It belongs to the group of drugs called 'depressants'. Depressant drugs do not necessarily make you feel 'depressed'. Rather, they slow down the activity of the central nervous system. They slow down the messages going to and from the brain and the body.

What is a standard drink?

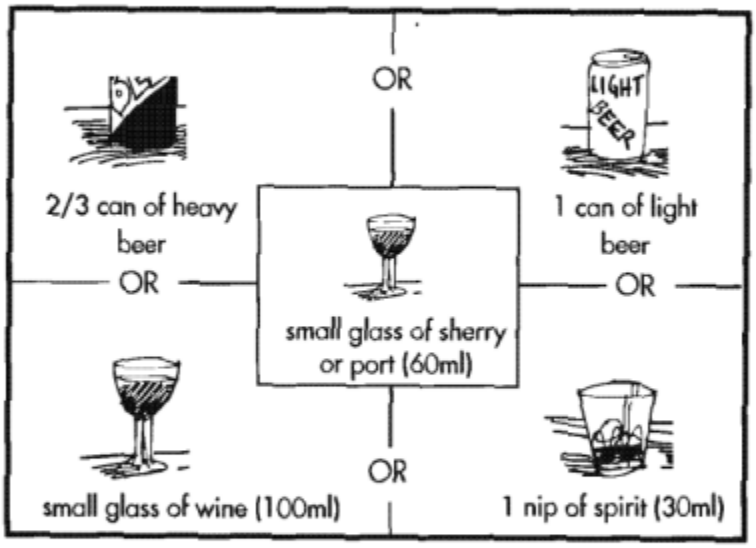
A standard drink contains 10 grams of alcohol and takes a healthy liver one hour to remove from the body. See the following diagram:

What is a standard drink?

Some types of alcohol are stronger than others.

A standard drink contains about 10 grams of pure alcohol.

1 standard drink =



These packages contain . . .

up to 2 standard drinks | up to 40 standard drinks | 36 standard drinks

The following table gives a guideline for drinking alcohol.

	Men (Standard drinks a day)#	**Women (Standard drinks a day) #**
Responsible *	0-4	0-2
Hazardous	4-6	2-4
Harmful	more than 6	more than 4

Effects of alcohol

Short-term effects

Depending on how much you drink, your experience with alcohol and the environment in which you are drinking, alcohol can cause:

- relaxation, feeling of well-being
- loss of inhibitions
- dizziness, unclear judgment
- uncoordinated movements, slow reactions
- blurred vision, slurred speech
- unconsciousness
- death

Effects of long-term use and misuse

See the following diagram for effects of long-term use and misuse of alcohol.

The Long Term Health Effects Of Alcohol

Central Nervous System (brain and spinal cord)

- impaired senses
  —vision, hearing, dulled smell and taste, decreased pain perception
- altered sense of time and space
- impaired motor skills, slow reaction
- impaired judgment, confusion
- hallucinations
- fits, blackouts
- tingling and loss of sensation in hands and feet
- early onset dementia (alcohol related brain damage)
- Wernicke's Syndrome and psychosis (delirium)
- mood and personality changes
- feeling anxious or worried

Circulatory System

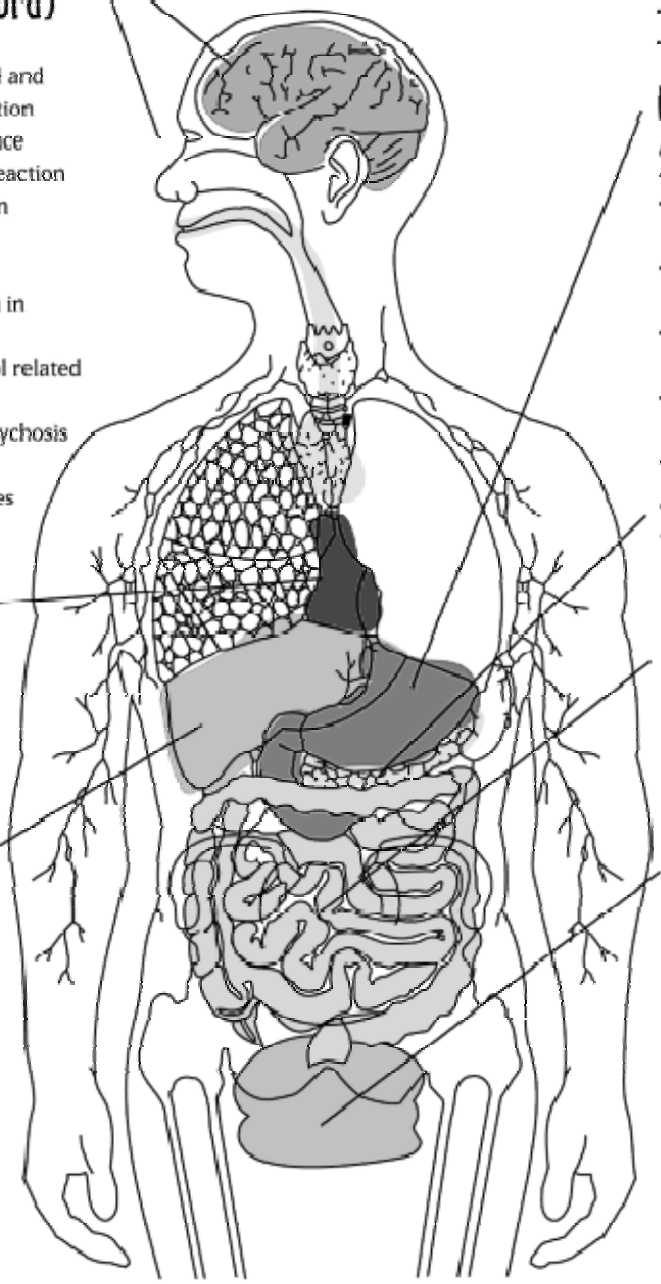
- high blood pressure
- irregular heart beat
- damage to the heart muscle
- increased risk of heart attack and stroke

Liver

- swollen, painful inflamed
- cirrhosis
- cancer
- fluid build up (oedema)
- increased risk of haemorrhage
- liver failure, coma and death

Pregnancy and Babies

- fetal alcohol syndrome/fetal alcohol effects
  —small head, possible brain damage, retarded growth and development



General Body

- weight gain
- headaches
- muscle weakness

Gastrointestinal System

- stomach lining inflamed and irritated
- ulcers of the stomach or duodenum
- inflammation or varicose veins of the oesophagus
- loss of appetite, nausea, diarrhoea and vomiting
- cancer

Pancreas

- painful, inflamed, bleeding.

Intestines

- irritation of the lining
- inflammation and ulcers
- cancer of intestines and colon

Reproductive System Male and Female

- reduced fertility
- impaired sexual performance
- impotence
- decreased sperm count and movement
- increased risk of breast cancer in females
- early onset of menopause
- irregular menstrual cycle

Alcohol and pregnancy

Alcohol crosses the placental barrier. Alcohol intake by the mother at critical times in fetal development can cause 'Fetal Alcohol Syndrome'. The baby may suffer from deformities and learning and behavioral problems. It is strongly recommended that women wanting to get pregnant or who are pregnant do not drink alcohol. There is also evidence that alcohol misuse can affect sperm production. It is recommended that men wanting to father a child reduce alcohol intake to low risk levels.

Withdrawal

If a person has been a heavy drinker and suddenly stops, he or she will experience withdrawal to some degree. Withdrawal symptoms can be severe and life threatening.

adapted from www.nt.gov.au

Teens' brains may pay price for drinking

- Alarming evidence indicates drinking alcohol at a young age causes neurological damage and opens a door for alcoholism.

By KATY BUTLER • New York Times

Teenagers have been drinking alcohol for centuries. In pre-Revolutionary America, young apprentices were handed buckets of ale. In the 1890s, at age 15, writer Jack London regularly drank grown sailors under the table.

For almost as long, concerned adults have tried to limit teenage alcohol consumption.

But what was once a social and moral debate may soon become a neurobiological one.

The costs of early heavy drinking, experts say, appear to extend far beyond the time away from doing homework, dating, acquiring social skills and the related tasks of growing up.

Mounting research suggests that alcohol causes more damage to the developing brains of teenagers than was previously thought, injuring them significantly more than it does adult brains. The findings, though preliminary, have demolished the assumption that people can drink heavily for years before causing themselves significant neurological injury. And the research even suggests that early heavy drinking may undermine the precise neurological capacities needed to protect a person from alcoholism.

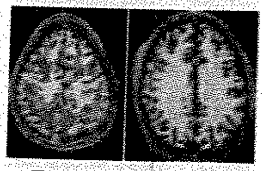
The findings may help explain why people who begin drinking at an early age face enormous risks of becoming alcoholics. According to the results of a national survey of 43,093 adults, published on Monday in Archives of Pediatrics & Adolescent Medicine, 47 percent of those who begin drinking alcohol before age 14 become alcohol dependent at some time in their lives, compared with 9 percent of those who wait at least until age 21. The correlation holds even when genetic risks for alcoholism are taken into account.

The most alarming evidence of physical damage comes from federally financed laboratory experiments on the brains of adolescent rats subjected to binge doses of alcohol.

"There is no doubt about it now: There are long-term cognitive consequences to excessive drinking of alcohol in adolescence," said Aaron White, an assistant professor at Duke University and co-author of a recent study of college drinking.

"We definitely didn't know five or 10 years ago that alcohol affected the teen brain differently," White said. "Now there's a sense of urgency. It's the same place we were in when everyone realized what a bad thing it was for pregnant women to drink alcohol."

Mounting research suggests that alcohol causes more damage to the developing brains of teenagers than was previously thought. Early heavy drinking may also undermine the brain's ability to protect a person from alcoholism. **A4**



Two scans show the brain activity of a 15-year-old nondrinker, left, and a drinker, right.

Taken From Minneapolis Star Tribune newspaper, July 2, 2006

Binge drinking affects more than the abuser

Connie Midey
The Arizona Republic
Feb. 21, 2006 12:00 AM

The first time Jay Hitchcock drank alcohol, he downed two six-packs of beer, threw up and blacked out.

He was 15 years old, and he thought it was so cool to drink that he continued doing it off and on for years, even when it became anything but cool.

"It was absolute hell," says Hitchcock, 44, of Phoenix, who's in recovery now.

Heavy episodic drinking, the more precise term for the binge drinking he engaged in, has repercussions beyond physical health. Hitchcock experienced many of them, from elevated liver enzymes to two failed marriages.

"I don't have cirrhosis of the liver," he says, "but I'd be a fool to think the drinking didn't do a lot of damage to me physically, psychologically and spiritually. It shipwrecks you on all sides."

Often associated with young adults, binge drinking can occur at any age.

It's defined for men as consuming five or more alcoholic drinks in one sitting, says Karen Moses, director of wellness and health promotions at Arizona State University. (One drink is 12 ounces of beer or 5 ounces of wine or 1 ounce of 80-proof distilled spirits.)

For women, four or more drinks in one sitting is considered binge drinking.

Moses says one-third of ASU students, about the same percentage as at colleges nationwide, report drinking at binge levels, especially in the first six to 12 months after leaving home.

"One of our concerns in terms of long-term health and personal consequences is for those who don't return to normal (drinking behavior)," Moses says.

Educational presentations, counseling, support groups and other programs at ASU aim to intervene before the drinkers - and their dorm- and classmates who drink moderately or not at all - are adversely affected.

Among college students alone, alcohol-related incidents cause 1,400 to 1,700 deaths every year in the United States, says Henry Wechsler, director of college alcohol studies at Harvard University's School of Public Health.

More than 500,000 college students a year receive accidental injuries because of their drinking, and more than 600,000 are assaulted by students who drink, he says.

"The binge drinker is much more likely to miss classes and get behind in schoolwork, have breakdowns in interpersonal relations, get into fights and become injured, and get into trouble with authorities," he says.

Binge drinking also is associated with changes in brain function, poor nutrition, rapes and risky sexual behavior.

With effort, much of the damage can be repaired, and the rewards include "being able to participate fully in life," Moses says.

Wechsler recommends starting by finding friends for whom drinking is not the main activity and cutting back on drinking.

For people like Hitchcock, however, moderate drinking is impossible.

"I didn't drink all the time," he says, "but once I started, I couldn't put it down. The weekend would roll around, I'd get paid and I'd go out, start drinking and not come home until all the money was gone."

The smoking that went hand-in-hand with his drinking left him with respiratory problems. He has facial scars and nerve damage from barroom brawls and the seven car accidents he was in.

Now Hitchcock works daily on his recovery program, reads self-help books and spends time with non-drinkers. And he remembers the pain drinking caused him and his loved ones.

"You think, 'This time I'll manage the drinking and have a good time,' but there's zero chance of that," he says. "You just keep doing the same damn, stupid thing."

Binge Drinking in Adolescents and College Students

Despite laws in every State that make it illegal for anyone under the age of 21 to purchase or possess alcohol, young people report that alcohol is easy to obtain and that many high school and college students drink with one goal – to get drunk.[1] Binge drinking is defined as consuming five or more drinks in a row for boys and four or more in a row for girls.[2]

Prevalence of Binge Drinking

- Binge drinking, often beginning around age 13, tends to increase during adolescence, peak in young adulthood (ages 18 to 22), then gradually decrease.[3]
- Binge drinking during the past 30 days was reported by 8 percent of youth ages 12 to 17 and 30 percent of those ages 18 to 20.[4]
- Among persons under the legal drinking age (12 to 20), 15 percent were binge drinkers and 7 percent were heavy drinkers.[5]

Highlights of SAMHSA's 1998 National Household Survey on Drug Abuse[6] include:

- About 10.4 million adolescents ages 12 to 20 reported using alcohol. Of those, 5.1 million were binge drinkers and included 2.3 million heavy drinkers who binged at least five times a month.
- Nearly 9 percent of boys and 7 percent of girls ages 12 to 17 reported binge drinking in the previous month.
- White non-Hispanic youth ages 12 to 17 reported the highest frequency of binge drinking (9 percent) as compared with 6 percent of Hispanic and 3 percent of black non-Hispanic youth.
- Binge drinking among youth ages 12 to 17 appears to occur most frequently in the North Central region of the United States and in metropolitan areas.

DID YOU KNOW?

** Frequent binge drinkers were eight times more likely than non-binge drinkers to miss a class, fall behind in schoolwork, get hurt or injured, and damage property.[13]

** Nearly one out of every five teenagers (16 percent) has experienced "black out" spells where they could not remember what happened the previous evening because of heavy binge drinking.[14] ** More than 60 percent of college men and almost 50 percent of college women who are frequent binge drinkers report that they drink and drive.[15]

** Binge drinking during high school, especially among males, is strongly predictive of binge drinking in college.[16]

** Binge drinking during college may be associated with mental health disorders such as compulsiveness, depression or anxiety, or early deviant behavior.[17]

** In a national study, 91 percent of women and 78 percent of the men who were frequent binge drinkers considered themselves to be moderate or light drinkers.[18]

Binge Drinking on College Campuses

- According to a 1997 national study conducted by the Harvard School of Public Health, nearly half of all college students surveyed drank four or five drinks in one sitting within the previous 2 weeks.[7]
- Students who live in a fraternity or sorority house are the heaviest drinkers – 86 percent of fraternity residents and 80 percent of sorority residents report binge drinking.[8]
- In a recent study, 39 percent of college women binge drank within a 2-week period compared with 50 percent of college men.[9]
- Colleges with high binge drinking rates were also much more likely to attract students who were binge drinkers in high school.[10]
- In one multicampus survey, white non-Hispanic students reported the highest percentage of binge drinking in a 2-week period (43.8 percent), followed by Native American (40.6 percent), Hispanic (31.3 percent), Asian (22.7 percent), and black non-Hispanic (22.5 percent) students. This pattern of binge drinking differences among ethnic groups is also seen in high school students.[11]

Consequences of Binge Drinking[12]

Alcohol poisoning – a severe and potentially fatal physical reaction to an alcohol overdose – is the most serious consequence of binge drinking. When excessive amounts of alcohol are consumed, the brain is deprived of oxygen. The struggle to deal with an overdose of alcohol and lack of oxygen will eventually cause the brain to shut down the voluntary functions that regulate breathing and heart rate.

If a person is known to have consumed large quantities of alcohol in a short period of time, symptoms of alcohol poisoning include:

- Vomiting
- Unconsciousness
- Cold, clammy, pale, or bluish skin
- Slow or irregular breathing (less than 8 breaths a minute or 10 or more seconds between breaths).

Secondary Effects of Binge Drinking

- In schools with high binge drinking rates, 34 percent of non-binge drinkers reported being insulted or humiliated by binge drinkers; 13 percent reported being pushed, hit, or assaulted; 54 percent reported having to take care of a drunken student; 68 percent were interrupted while studying; and 26 percent of women experienced an unwanted sexual advance.[19]

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SAMHSA, a public health agency in the Department of Health and Human Services, is the Federal Government's lead agency for improving the quality and availability of substance abuse prevention, addiction treatment, and mental health services in the United States. Further information about SAMHSA is available on the Internet at www.samhsa.gov.

Caffeine

What is it?

The drug caffeine is derived from a variety of plants including coffee, tea, cocoa, and some nuts. It is the most widely used drug in the world because caffeine is found in coffee, tea, soft drinks, and chocolate.

Short-term effects

The short-term effects associated with caffeine intake are initially an elevation in one's mood. It reduces drowsiness and fatigue while larger doses can cause irritability, restlessness, nervousness, and insomnia. Caffeine constricts the blood vessels and increases one's heart rate, blood pressure, and over-production of gastric juices, urine output and birth defects in pregnant women.

Long-term effects

The long-term effects associated with large doses may cause irritability, restlessness, nervousness, muscle twitches, rapid and/or irregular heartbeat, inexhaustibility, agitation and insomnia. Caffeine has been proven to be a highly addictive substance.

Signs of usage

Jittery, hyperactive, talkative, anxiety, withdrawal symptoms, etc.

Legal status

Caffeine is not a restricted drug. It is legal to purchase and consume with the exception of certain athletic events including the Olympics (where it is considered a performance-enhancing drug).

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

Cannabis

Common names : Marijuana, dope, THC, pot, hemp, weed, ganja, grass, reefer, Mary Jane, hashish, hash, hash oil, chronic, gangster, boom, nugs, etc.

What is it?

The drug comes from the cannabis plant. It appears as green, brown, or gray mixtures of dried, shredded leaves, stems, and seeds. The usual method of consumption is to smoke it in a pipe, water pipe ("bong"), or rolled up in cigarette or cigar papers, called "joints," or "blunts." Hashish (or hash) is a derivative of the plant material and is typically more potent and concentrated than marijuana. Hash is a resinous substance that presents itself as hard or soft slabs that are broken up and smoked in a pipe, sometimes with added tobacco. These slabs can range in color from light brown to black and appear either hard to sticky to the touch. The active drug of these substances is THC (delta-9-tetrahydrocannabinol).

Short-term effects

The short-term effects of using marijuana are a feeling of elation and relaxation. The person might be more talkative. An increase in pulse rate and heartbeat as well as a rise in the individual's blood pressure is possible. Using marijuana has been known to cause short-term memory problems, difficulties with concentration, relaxed inhibitions, disorientated behavior, and the ability to think clearly. It can cause confusion, restlessness, excitement, and even hallucinations.

Long-term effects

The long-term effects of using marijuana may cause the person to become dependent on the drug. A loss of interest in formerly enjoyed activities, as well as the ability to learn new things may be harmed. There has been a link established with the chronic use of marijuana and a weakened immune system. The user may acquire chronic bronchitis, various forms of cancer, heart attack, stroke, and/or blood pressure difficulties. Recent studies have indicated that marijuana use in pregnancy causes ADHD, memory and concentration problems in the developing child.

Signs of usage

Excessive thirst or hunger (called, "the munchies"), red or bloodshot eyes, trouble with thinking, memory, and learning, loss of motor coordination, silliness or giddiness for no reason, sleepiness, dizziness, anxiety, talkativeness, etc.

Legal status

Purchasing, selling or possessing cannabis is illegal in the United States, with very few exceptions. The only legal use of marijuana is for treating patients who suffer from cancer, Glaucoma, and/or AIDS.

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

The Effects of Marijuana on the Lungs

Researchers at the UCLA Pulmonary Research Laboratory studied the effects of marijuana smoking in 75 young men. The men consumed an average of five marijuana cigarettes a day for two months. The study showed that the **lung damage caused by four marijuana cigarettes were equal to the damage caused by 112 tobacco cigarettes.**

Gabriel Nahas, a leading researcher and anesthesiologist at Columbia University, wrote in the Journal of American Medical Association:
"Cannabis use interfered with cell division...harmed lung tissue significantly, with the damage persisting long after cessation of smoking...lowered the lungs' defenses against bacteria 'substantially more' than does tobacco...reduced sperm counts and decreased testosterone levels (although these effects were reversible after the users stopped smoking marijuana)...caused birth defects...hindered brain function...impaired judgment while driving...and perhaps (this point was not considered proven) triggered epileptic seizures."
Although many studies have come to the same conclusions about marijuana smoking and its effects on the respiratory system, some studies have shown otherwise.

Marijuana may be greater cancer risk than tobacco, research suggests

June 21, 2000
Web posted at: 3:19 p.m. EDT (1919 GMT)

From staff reports

(CNN) -- Smoking marijuana may be a greater cancer danger than smoking tobacco, a new study from the University of California at Los Angeles suggests.

The research, conducted on mice, was published in the July issue of the Journal of Immunology. The UCLA researchers studied the effect of tetrahydrocannabinol, or THC, the major euphoriant in marijuana.

They found that THC can promote tumor growth in mice by impairing the body's anti-tumor immunity system. Mice with normal immune systems had significant tumor growth when injected with both lung cancer cells and THC. However, the compound appeared to have no effect on mice whose immune systems were already compromised.

While previous research had shown that THC can lower resistance to both bacterial and viral infections, this is the first time that THC's possible tumor-promoting activity has been reported, according to the National Institute on Drug Abuse, a part of the National Institutes of Health.

The UCLA scientists also found that the tar in marijuana smoke contains higher concentrations of substances called hydrocarbons than tar from tobacco smoke does. These hydrocarbons are a key factor in promoting human lung cancer.

Because marijuana smoke deposits four times as much tar in the respiratory tract as a comparable amount of tobacco, the exposure to carcinogens is increased, the researchers wrote.

"What we already know about marijuana smoke, coupled with our new finding that THC may encourage tumor growth, suggests that regular use of marijuana may increase the risk of respiratory-tract cancer and further studies will be needed to evaluate this possibility," Dr. Steven M. Dubinett, head of the research team that conducted the study, said in a statement.

Smoking marijuana is illegal in the United States, though several states have laws allowing its use for medicinal purposes. A federal advisory panel last year acknowledged that marijuana can fight pain and nausea, and the drug is thought to ease symptoms of the eye disease glaucoma.

What is marijuana?

Marijuana - often called ***pot, grass, reefer, weed, herb, mary jane, or mj*** - is a greenish-gray mixture of the dried, shredded leaves, stems, seeds, and flowers of ***Cannabis sativa***, the hemp plant. Most users smoke marijuana in hand-rolled cigarettes called ***joints***, among other names; some use pipes or water pipes called ***bongs***. Marijuana cigars called ***blunts*** have also become popular. To make blunts, users slice open cigars and replace the tobacco with marijuana, often combined with another drug, such as crack cocaine.[21] Marijuana also is used to brew tea and is sometimes mixed into foods.

The major active chemical in marijuana is delta-9-tetrahydrocannabinol (THC), which causes the mind-altering effects of marijuana intoxication. The amount of THC (which is also the psychoactive ingredient in hashish) determines the potency and, therefore, the effects of marijuana. Between 1980 and 1997, the amount of THC in marijuana available in the United States rose dramatically.[22]

What is the scope of marijuana use in the United States?

Marijuana is the Nation's most commonly used illicit drug. More than 94 million Americans (40 percent) age 12 and older have tried marijuana at least once, according to the 2003 National Survey on Drug Use and Health (NSDUH).[23]

Marijuana use is widespread among adolescents and young adults. The percentage of middle-school students who reported using marijuana increased throughout the early 1990s.[24] In the past few years, according to the 2004 Monitoring the Future Survey, an annual survey of drug use among the Nation's middle and high school students, illicit drug use by 8th-, 10th-, and 12th-graders has leveled off.[24] Still, in 2004, 16 percent of 8th-graders reported that they had tried marijuana, and 6 percent were current users (defined as having used the drug in the 30 days preceding the survey).[24] Among 10th-graders, 35 percent had tried marijuana sometime in their lives, and 16 percent were current users.[24] As would be expected, rates of use among 12th-graders were higher still. Forty-six percent had tried marijuana at some time, and 20 percent were current users.[24]

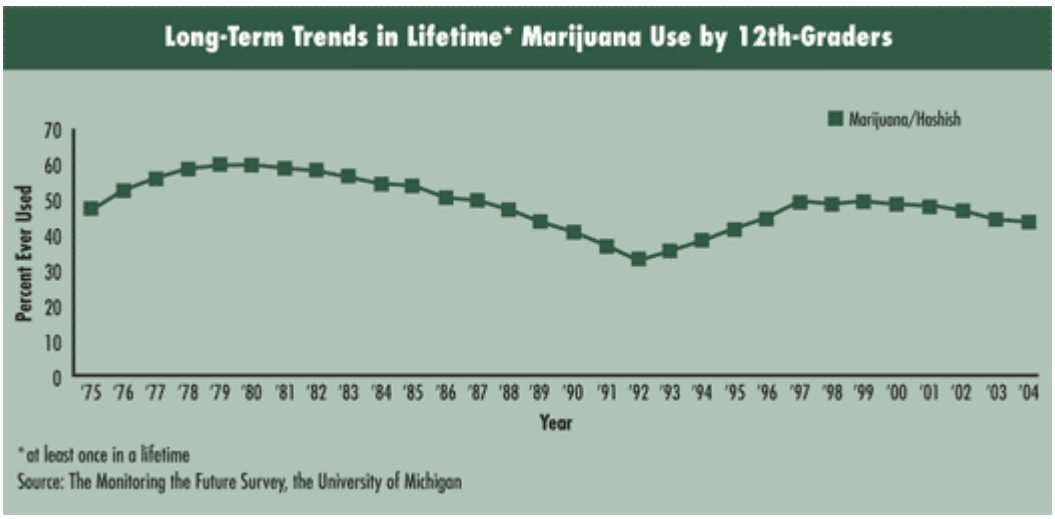
The Drug Abuse Warning Network (DAWN), a system for monitoring the health impact of drugs, estimated that, in 2002, marijuana was a contributing factor in over 119,000 emergency department (ED) visits in the United States, with about 15 percent of the patients between the ages of 12 and 17, and almost two-thirds male.[25]

In 2002, the National Institute of Justice's Arrestee Drug Abuse Monitoring (ADAM) Program, which collects data on the number of adult arrestees testing positive for various drugs, found that, on average, 41 percent of adult male arrestees and 27 percent of adult female arrestees tested positive for marijuana.[26] On average, 57 percent of juvenile male and 32 percent of juvenile female arrestees tested positive for marijuana.

NIDA's Community Epidemiology Work Group (CEWG), a network of researchers that tracks trends in the nature and patterns of drug use in major U.S. cities, consistently reports that marijuana frequently is combined with other drugs, such as crack cocaine, PCP, formaldehyde, and codeine cough syrup, sometimes without the user being aware of it.[21] Thus, the risks associated with marijuana use may be compounded by the risks of added drugs, as well.

How does marijuana affect the brain?

Scientists have learned a great deal about how THC acts in the brain to produce its many effects. When someone smokes marijuana, THC rapidly passes from the lungs into the bloodstream, which carries the chemical to organs throughout the body, including the brain. In the brain, THC connects to specific sites called *cannabinoid receptors* on nerve cells and thereby influences the activity of those cells. Some brain areas have many cannabinoid receptors; others have few or none. Many cannabinoid receptors are found in the parts of the brain that influence pleasure, memory, thought, concentration, sensory and time perception, and coordinated movement.[27]



What are the acute effects of marijuana use?

When marijuana is smoked, its effects begin immediately after the drug enters the brain and last from 1 to 3 hours. If marijuana is consumed in food or drink, the short-term effects begin more slowly, usually in 1/2 to 1 hour, and last longer, for as long as 4 hours. Smoking marijuana deposits several times more THC into the blood than does eating or drinking the drug.[28]

Within a few minutes after inhaling marijuana smoke, an individual's heart begins beating more rapidly, the bronchial passages relax and become enlarged, and blood vessels in the eyes expand, making the eyes look red. The heart rate, normally 70 to 80 beats per minute, may increase by 20 to 50 beats per minute or, in some cases, even double.[15] This effect can be greater if other drugs are taken with marijuana.[29]

As THC enters the brain, it causes a user to feel euphoric - or "high" - by acting in the brain's reward system, areas of the brain that respond to stimuli such as food and drink as well as most drugs of abuse. THC activates the reward system in the same way that nearly all drugs of abuse do, by stimulating brain cells to release the chemical dopamine.[30,31,32]

A marijuana user may experience pleasant sensations, colors and sounds may seem more intense, and time appears to pass very slowly. The user's mouth feels dry, and he or she may suddenly become very hungry and thirsty. His or her hands may tremble and grow cold. The euphoria passes after awhile, and then the user may feel sleepy or depressed. Occasionally, marijuana use produces anxiety, fear, distrust, or panic.

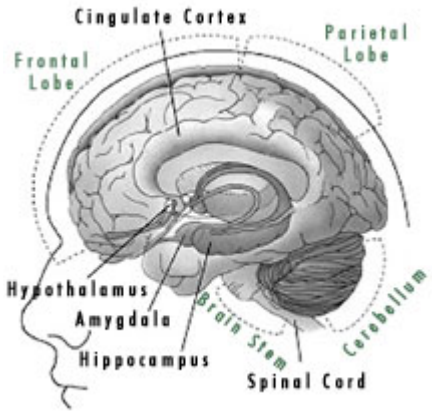
Heavy marijuana use impairs a person's ability to form memories, recall events (see Marijuana, Memory, and the Hippocampus), and shift attention from one thing to another.[8,33] THC also disrupts coordination and balance by binding to receptors in the cerebellum and basal ganglia, parts of the brain

that regulate balance, posture, coordination of movement, and reaction time.[11] Through its effects on the brain and body, marijuana intoxication can cause accidents. Studies show that approximately 6 to 11 percent of fatal accident victims test positive for THC. In many of these cases, alcohol is detected as well.[34, 35, 36]

In a study conducted by the National Highway Traffic Safety Administration, a moderate dose of marijuana alone was shown to impair driving performance; however, the effects of even a low dose of marijuana combined with alcohol were markedly greater than for either drug alone[37]. Driving indices measured included reaction time, visual search frequency (driver checking side streets), and the ability to perceive and/or respond to changes in the relative velocity of other vehicles.

Marijuana users who have taken high doses of the drug may experience acute toxic psychosis, which includes hallucinations, delusions, and depersonalization - a loss of the sense of personal identity, or self-recognition.[10,15] Although the specific causes of these symptoms remain unknown, they appear to occur more frequently when a high dose of cannabis is consumed in food or drink rather than smoked.

Marijuana's Effects on the Brain



When marijuana is smoked, its active ingredient, THC, travels throughout the body, including the brain, to produce its many effects. THC attaches to sites called cannabinoid receptors on nerve cells in the brain, affecting the way those cells work. Cannabinoid receptors are abundant in parts of the brain that regulate movement, coordination, learning and memory, higher cognitive functions such as judgment, and pleasure.

Brain Region	Functions Associated With Region
Brain regions in which cannabinoid receptors are abundant	
Cerebellum	Body movement coordination
Hippocampus	Learning and memory
Cerebral cortex, especially cingulate, frontal, and parietal regions	Higher cognitive functions
Nucleus accumbens	Reward
Basal ganglia • Substantia nigra pars reticulata • Entopeduncular nucleus • Globus pallidus • Putamen	Movement control
Brain regions in which cannabinoid receptors are moderately concentrated	
Hypothalamus	Body housekeeping functions (body temperature regulation, salt and water balance, reproductive function)
Amygdala	Emotional response, fear
Spinal cord	Peripheral sensation, including pain
Brain stem	Sleep and arousal, temperature regulation, motor control
Central gray	Analgesia
Nucleus of the solitary	Visceral sensation,

How does marijuana use affect physical health?

Marijuana use has been shown to increase users' difficulty in trying to quit smoking tobacco.[38] This was reported in a study comparing smoking cessation in adults who smoked both marijuana and tobacco with those who smoked only tobacco. The relationship between marijuana use and continued smoking was particularly strong in those who smoked marijuana daily at the time of the initial interview, 13 years prior to the followup interview.

A study of 450 individuals found that people who smoke marijuana frequently but do not smoke tobacco have more health problems and miss more days of work than nonsmokers do.[39] Many of the extra sick days used by the marijuana smokers in the study were for respiratory illnesses.

Even infrequent marijuana use can cause burning and stinging of the mouth and throat, often accompanied by a heavy cough. Someone who smokes marijuana regularly may have many of the same respiratory problems that tobacco smokers do, such as daily cough and phlegm production, more frequent acute chest illnesses, a heightened risk of lung infections, and a greater tendency toward obstructed airways.[4]

Cancer of the respiratory tract and lungs may also be promoted by marijuana smoke.[4] A study comparing 173 cancer patients and 176 healthy individuals produced strong evidence that smoking marijuana increases the likelihood of developing cancer of the head or neck, and that the more marijuana smoked, the greater the increase.[17] A statistical analysis of the data suggested that marijuana smoking doubled or tripled the risk of these cancers.

Marijuana has the potential to promote cancer of the lungs and other parts of the respiratory tract because it contains irritants and carcinogens.[40] In fact, marijuana smoke contains 50 percent to 70 percent more carcinogenic hydrocarbons than does tobacco smoke.[41] It also produces high levels of an enzyme that converts certain hydrocarbons into their carcinogenic form, levels that may accelerate the changes that ultimately produce malignant cells.[42] Marijuana users usually inhale more deeply and hold their breath longer than tobacco smokers do, which increases the lungs' exposure to carcinogenic smoke. These facts suggest that, puff for puff, smoking marijuana may increase the risk of cancer more than smoking tobacco does.

Some adverse health effects caused by marijuana may occur because THC impairs the immune system's ability to fight off infectious diseases and cancer. In laboratory experiments that exposed animal and human cells to THC or other marijuana ingredients, the normal disease-preventing reactions of many of the key types of immune cells were inhibited.[16] In other studies, mice exposed to THC or related substances were more likely than unexposed mice to develop bacterial infections and tumors.[14,43]

One study has indicated that a person's risk of heart attack during the first hour after smoking marijuana is four times his or her usual risk.[44] The researchers suggest that a heart attack might occur, in part, because marijuana raises blood pressure and heart rate and reduces the oxygen-carrying capacity of blood.

Marijuana, Memory, and the Hippocampus

Marijuana's damage to short-term memory seems to occur because THC alters the way in which information is processed by the hippocampus, a brain area responsible for memory formation. Laboratory rats treated with THC displayed the same reduced ability to perform tasks requiring short-term memory as other rats showed after nerve cells in their hippocampus were destroyed.[66] In addition, the THC-treated rats had the greatest difficulty with the tasks precisely during the time when the drug was interfering most with the normal functioning of cells in the hippocampus.

As people age, they normally lose neurons in the hippocampus, which decreases their ability to remember events. Chronic THC exposure may hasten the age-related loss of hippocampal neurons. In one series of studies, rats exposed to THC every day for 8 months (approximately 30 percent of their lifespan), when examined at 11 to 12 months of age, showed nerve cell loss equivalent to that of unexposed animals twice their age.[67, 68, 69]

Health Consequences of Marijuana Abuse

Acute (present during intoxication)

- Impairs short-term memory
- Impairs attention, judgment, and other cognitive functions
- Impairs coordination and balance
- Increases heart rate

Persistent (lasting longer than intoxication, but may not be permanent)

- Impairs memory and learning skills

Long-term (cumulative, potentially permanent effects of chronic abuse)

- Can lead to addiction
- Increases risk of chronic cough, bronchitis, and emphysema
- Increases risk of cancer of the head, neck, and lungs

The Science of Medical Marijuana

THC, the main active ingredient in marijuana, produces effects that potentially can be useful for treating a variety of medical conditions. It is the main ingredient in an oral medication that is currently used to treat nausea in cancer chemotherapy patients and to stimulate appetite in patients with wasting due to AIDS. Scientists are continuing to investigate other potential medical uses for cannabinoids.[74]

Research is underway to examine the effects of smoked marijuana and extracts of marijuana on appetite stimulation, certain types of pain, and spasticity due to multiple sclerosis. However, the inconsistency of THC dosage in different marijuana samples poses a major hindrance to valid trials and to the safe and effective use of the drug. Moreover, the adverse effects of marijuana smoke on the respiratory system [4, 5, 6] will offset the helpfulness of smoked marijuana for some patients. Finally, little is known about the many chemicals besides THC that are in marijuana, or their possible deleterious impact on patients with medical conditions.

How does marijuana use affect school, work, and social life?

Students who smoke marijuana get lower grades and are less likely to graduate from high school, compared with their nonsmoking peers.[20,45,46,47]

Workers who smoke marijuana are more likely than their coworkers to have problems on the job. Several studies have associated workers' marijuana smoking with increased absences, tardiness, accidents, workers' compensation claims, and job turnover. A study among postal workers found that employees who tested positive for marijuana on a pre-employment urine drug test had 55 percent more industrial accidents, 85 percent more injuries, and a 75 percent increase in absenteeism compared with those who tested negative for marijuana use.[48]

Depression[18], anxiety[18], and personality disturbances[50] are all associated with marijuana use. Research clearly demonstrates that marijuana use has the potential to cause problems in daily life or make a person's existing problems worse. Because marijuana compromises the ability to learn and remember information, the more a person uses marijuana the more he or she is likely to fall behind in accumulating intellectual, job, or social skills. In one study of cognition, adults were matched on the basis of their performance in the 4th grade on the Iowa Test of Basic Skills. They were evaluated on a number of cognitive measures including the 12th-grade version of the Iowa Test. Those who were heavy marijuana smokers scored significantly lower on mathematical skills and verbal expression than nonsmokers.[9]

Moreover, research has shown that marijuana's adverse impact on memory and learning can last for days or weeks after the acute effects of the drug wear off.[9,51] For example, a study of 129 college students found that among heavy users of marijuana - those who smoked the drug at least 27 of the preceding 30 days - critical skills related to attention, memory, and learning were significantly impaired, even after they had not used the drug for at least 24 hours.[33] The heavy marijuana users in the study had more trouble sustaining and shifting their attention and in registering, organizing, and using information than did the study participants who had used marijuana no more than 3 of the previous 30 days. As a result, someone who smokes marijuana once daily may be functioning at a reduced intellectual level all of the time. More recently, the same researchers showed that a group of long-term heavy marijuana users' ability to recall words from a list was impaired 1 week following cessation of marijuana use, but returned to normal by 4 weeks.[51] An implication of this finding is that even after long-term heavy marijuana use, if an individual quits marijuana use, some cognitive abilities may be recovered.

Another study produced additional evidence that marijuana's effects on the brain can cause cumulative deterioration of critical life skills in the long run. Researchers gave students a battery of tests measuring problem-solving and emotional skills in 8th grade and again in 12th grade.[52] The results showed that the students who were already drinking alcohol plus smoking marijuana in 8th grade started off slightly behind their peers, but that the distance separating these two groups grew significantly by their senior year in high school. The analysis linked marijuana use, independently of alcohol use, to reduced capacity for self-reinforcement, a group of psychological skills that enable individuals to maintain confidence and persevere in the pursuit of goals.

Marijuana users themselves report poor outcomes on a variety of measures of life satisfaction and achievement. A recent study compared current and former long-term heavy users of marijuana with a control group who reported smoking cannabis at least once in their lives, but not more than 50 times. Despite similar education and incomes in their families of origin, significant differences were found on educational attainment and income between heavy users and the control group: fewer of the cannabis users completed college and more had household incomes of less than $30,000. When asked how marijuana affected their cognitive abilities, career achievements, social lives, and physical and mental health, the overwhelming majority of heavy cannabis users reported the drug's deleterious effect on all of these measures.[53]

The Body's Natural THC-Like Chemicals

THC owes many of its effects to its similarity to a family of chemicals called the *endogenous cannabinoids*, which are natural *Cannabis*-like chemicals. Because a THC molecule is shaped like these endogenous cannabinoids, it interacts with the same receptors on nerve cells, the cannabinoid receptors, that endogenous cannabinoids do, and it influences many of the same processes. Research has shown that the endogenous cannabinoids help control a wide array of mental and physical processes in the brain and throughout the body, including memory and perception, fine motor coordination, pain sensations,[70] immunity to disease, and reproduction.[71]

When someone smokes marijuana, THC overstimulates the cannabinoid receptors, leading to a disruption of the endogenous cannabinoids' normal function. This overstimulation produces the intoxication experienced by marijuana smokers. Over time, it may alter the function of cannabinoid receptors, which, along with other changes in the brain, can lead to withdrawal symptoms and addiction.[60,72,73]

Can marijuana use during pregnancy harm the baby?

Research has shown that some babies born to women who used marijuana during their pregnancies display altered responses to visual stimuli, increased tremulousness, and a high-pitched cry, which may indicate problems with neurological development.[54, 75] During the preschool years, marijuana-exposed children have been observed to perform tasks involving sustained attention and memory more poorly than nonexposed children do.[55,56] In the school years, these children are more likely to exhibit deficits in problem-solving skills, memory, and the ability to remain attentive.[55,56]

Is marijuana use addictive?

Long-term marijuana use can lead to addiction for some people; that is, they use the drug compulsively even though it often interferes with family, school, work, and recreational activities. According to the 2003 National Survey on Drug Use and Health (NSDUH), an estimated 21.6 million Americans aged 12 or older were classified with substance dependence or abuse (9.1 percent of

the total population). Of the estimated 6.9 million Americans classified with dependence on or abuse of illicit drugs, 4.2 million were dependent on or abused marijuana.[57] In 2002, 15 percent of people entering drug abuse treatment programs reported that marijuana was their primary drug of abuse.[58]

Along with craving, withdrawal symptoms can make it hard for long-term marijuana smokers to stop using the drug.[49] People trying to quit report irritability, difficulty sleeping, and anxiety.[59,60] They also display increased aggression on psychological tests, peaking approximately 1 week after they last used the drug.[61]

In addition to its addictive liability, research indicates that early exposure to marijuana can increase the likelihood of a lifetime of subsequent drug problems. A recent study of over 300 fraternal and identical twin pairs, who differed on whether or not they used marijuana before the age of 17, found that those who had used marijuana early had elevated rates of other drug use and drug problems later on, compared with their twins, who did not use marijuana before age 17. This study re-emphasizes the importance of primary prevention by showing that early drug initiation is associated with increased risk of later drug problems, and it provides more evidence for why preventing marijuana experimentation during adolescence could have an impact on preventing addiction.[62]

Solvents and Aerosols/Inhalants

Common names: Gas, glue, sniff, etc. - the process of inhaling them is called, "huffing"

What is it?

Solvents and inhalants are found in many household products such as gas in aerosol cans, correction fluid, spray paint, air freshener, various types of glue, marking pens, etc. These substances were not designed to be used recreationally or to become intoxicated. They are dangerous chemicals that are used in products such as gasoline and model airplane glue.

Short-term effects

The short-term effects from inhaling these chemicals produce lightheadedness, euphoria, and sometimes a fantasy-like state. Nausea is common and drooling can occur by the individual while under the influence of these chemicals. Sneezing and coughing can happen. A loss of muscular coordination as well as the reduction of reflex speed has been indicated. Permanent brain damage and death can occur from only one usage.

Long-term effects

Long-term effects such as weight loss, nose bleeds, bloodshot eyes, and sores on the nose and mouth are common. An interference with the growth of blood cells has found to be connected with inhaling these chemicals. Suffocation and heart failure can cause permanent brain damage or death. Fatigue, mental confusion, depression, irritability, hostility, and paranoia may occur. Tremors may develop from the lack of coordination as well as neurological damage.

Signs of usage

The user may become sensitive to light, have slurred speech, drowsiness or loss of consciousness, runny nose and/or watery eyes, a loss of muscle control, paint on the face and hands, and sores on the nose and mouth are common, etc.

Legal status

Possessing these types of solvents, aerosols and inhalants is legal in the United States. However, a person must be 18-years-old to purchase them in many states (i.e. airplane glue).

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

Ecstasy (MDMA, methylenedioxymethamphetamine)

Common names: E, X, XTC, Adam, the love drug, designer drug, also called, "a club drug," because of the usage by those who attend nightclubs or parties called "raves," etc.

What is it?

Ecstasy or methylenedioxymethamphetamine (MDMA) is a psychoactive drug with hallucinogenic and amphetamine-like effects. There is no approved medical usage for this drug at this time. Generally it is taken orally in the form of a tablet or gelatin capsule. The powder form of ecstasy can be snorted as well.

Short-term effects

The short-term effects in the low to moderate doses produce a mild intoxication, euphoria, and a sense of pleasure. People who have used the drug report to feel more connected with others as well as the lack of inhibition. Large doses of this drug increase the negative effects and may cause alterations in one's perceptions, thinking processes, and/or memory. The agony of ecstasy is the severe risk of dehydration and hypothermia. Deaths have been caused by the hazardous increase of the victims' body temperatures. This happens more often at raves as users over-exert themselves while dancing. These drugs combined with other drugs and/or with alcohol, increase the dangerous effects. Psychiatric problems may develop that can last from days to weeks, and in extreme cases, years.

Long-term effects

Long-term effects of using Ecstasy cause severe depression and concentration difficulties. Damage to the nerves and brain chemicals that cause permanent memory and learning disabilities have been documented. People who have used this drug frequently have noted weight loss, confusion, irritability, depression, paranoia, psychosis, and fatigue. Some reactions in certain people may be more severe than others and unpredictable from only one usage.

Signs of usage

Users may experience sweating, increased heart rate and blood pressure, increased sensitivity to touch, nausea, anxiety, panic attacks, blurred vision, jaw pain (from grinding teeth), insomnia, vomiting, paranoia and convulsions.

Legal status

At this time, Ecstasy is illegal to purchase, sell, or consume in the United States.

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

NIDA InfoFacts: MDMA (Ecstasy)

MDMA (3,4 methylenedioxymethamphetamine) is a synthetic, psychoactive drug chemically similar to the stimulant methamphetamine and the hallucinogen mescaline. Street names for MDMA include Ecstasy, Adam, XTC, hug, beans, and love drug. MDMA is an illegal drug that acts as both a stimulant and psychedelic, producing an energizing effect, as well as distortions in time and perception and enhanced enjoyment from tactile experiences.

MDMA exerts its primary effects in the brain on neurons that use the chemical serotonin to communicate with other neurons. The serotonin system plays an important role in regulating mood, aggression, sexual activity, sleep, and sensitivity to pain.

Research in animals indicates that MDMA is neurotoxic; whether or not this is also true in humans is currently an area of intense investigation. MDMA can also be dangerous to health and, on rare occasions, lethal.

Health Hazards

For some people, MDMA can be addictive. A survey of young adult and adolescent MDMA users found that 43 percent of those who reported ecstasy use met the accepted diagnostic criteria for dependence, as evidenced by continued use despite knowledge of physical or psychological harm, withdrawal effects, and tolerance (or diminished response), and 34 percent met the criteria for drug abuse. Almost 60 percent of people who use MDMA report withdrawal symptoms, including fatigue, loss of appetite, depressed feelings, and trouble concentrating.

Cognitive Effects

Chronic users of MDMA perform more poorly than nonusers on certain types of cognitive or memory tasks. Some of these effects may be due to the use of other drugs in combination with MDMA, among other factors.

Physical Effects

In high doses, MDMA can interfere with the body's ability to regulate temperature. On rare but unpredictable occasions, this can lead to a sharp increase in body temperature (hyperthermia), resulting in liver, kidney, and cardiovascular system failure, and death.

Because MDMA can interfere with its own metabolism (breakdown within the body), potentially harmful levels can be reached by repeated drug use within short intervals.

Users of MDMA face many of the same risks as users of other stimulants such as cocaine and amphetamines. These include increases in heart rate and blood pressure, a special risk for people with circulatory problems or heart disease, and other symptoms such as muscle tension, involuntary teeth clenching, nausea, blurred vision, faintness, and chills or sweating.

Psychological Effects

These can include confusion, depression, sleep problems, drug craving, and severe anxiety. These problems can occur during and sometimes days or weeks after taking MDMA.

Neurotoxicity

Research in animals links MDMA exposure to long-term damage to neurons that are involved in mood, thinking, and judgment. A study in nonhuman primates showed that exposure to MDMA for only 4 days caused damage to serotonin nerve terminals that was evident 6 to 7 years later. While similar neurotoxicity has not been definitively shown in humans, the wealth of animal research indicating MDMA's damaging properties suggests that MDMA is not a safe drug for human consumption.

Hidden Risk: Drug Purity

Other drugs chemically similar to MDMA, such as MDA (methylenedioxyamphetamine, the parent drug of MDMA) and PMA (paramethoxyamphetamine, associated with fatalities in the U.S. and Australia) are sometimes sold as ecstasy. These drugs can be neurotoxic or create additional health risks to the user. Also, ecstasy tablets may contain other substances in addition to MDMA, such as ephedrine (a stimulant); dextromethorphan (DXM, a cough suppressant that has PCP-like effects at high doses); ketamine (an anesthetic used mostly by veterinarians that also has PCP-like effects); caffeine; cocaine; and methamphetamine. While the combination of MDMA with one or more of these drugs may be inherently dangerous, users might also combine them with substances such as marijuana and alcohol, putting themselves at further physical risk.

Extent of Use

National Survey on Drug Use and Health (NSDUH)*

In 2004, an estimated 450,000 people in the U.S. age 12 and older used MDMA in the past 30 days. Ecstasy use dropped significantly among persons 18 to 25—from 14.8 percent in 2003 to 13.8 percent in 2004 for lifetime use, and from 3.7 percent to 3.1 percent for past year use. Other 2004 NSDUH results show significant reductions in lifetime and past year use among 18- to 20-year-olds, reductions in past month use for 14- or 15-year-olds, and past year and past month reductions in use among females.

Community Epidemiology Work Group (CEWG)**

In many of the areas monitored by CEWG members, MDMA, once used primarily at dance clubs, raves, and college scenes, is being used in a number of other social settings. In addition, some members reported increased use of MDMA among African-American and Hispanic populations.

Monitoring the Future (MTF) Survey ***

Lifetime**** use dropped significantly among 12th-graders in 2005, from 7.5 percent in 2004 to 5.4 percent. The perceived risk in occasional MDMA use declined significantly among 8th-graders in 2005, and perceived availability decreased among 12th-graders.

Lifetime Prevalence of MDMA Use by Students
Monitoring the Future Survey, 2003–2005

	2003	2004	2005
8th-Graders	3.2%	2.8%	2.8%
10th-Graders	5.4	4.3	4.0
12th-Graders	8.3	7.5	5.4

For more information, please visit www.ClubDrugs.org and www.Teens.drugabuse.gov.

** NSDUH (formerly known as the National Household Survey on Drug Abuse) is an annual survey of Americans age 12 and older conducted by the Substance Abuse and Mental Health Services Administration. Copies of the latest survey are available at www.samhsa.gov and from the National Clearinghouse for Alcohol and Drug Information at 800-729-6686*

*** CEWG is a NIDA-sponsored network of researchers from 21 major U.S. metropolitan areas and selected foreign countries who meet semiannually to discuss the current epidemiology of drug abuse. CEWG's most recent reports are available at www.drugabuse.gov/about/organization/cewg/pubs.html*

**** These data are from the 2005 Monitoring the Future Survey, funded by the National Institute on Drug Abuse, National Institutes of Health, DHHS, and conducted annually by the University of Michigan's Institute for Social Research. The survey has tracked 12th-graders' illicit drug use and related attitudes since 1975; in 1991, 8th- and 10th-graders were added to the study. The latest data are online at www.drugabuse.gov.*

***** "Lifetime" refers to use at least once during a respondent's lifetime. "Annual" refers to use at least once during the year preceding an individual's response to the survey. "30-day" refers to use at least once during the 30 days preceding an individual's response to the survey.*

What Is It?

Ecstasy is a slang term for an illegal drug that has effects similar to those of hallucinogens and stimulants. Ecstasy's scientific name is "MDMA," short for 3,4-methylenedioxymethamphetamine, a name that's nearly as long as the all-night dance club "raves" or "trances" where ecstasy is often used. That's why MDMA is called a "club drug."

MDMA is synthetic—it doesn't come from a plant like marijuana does. MDMA users often make the drug in secret "labs"—in trailers, basements, and even kitchens—hidden around the country. Other chemicals or substances are often added to, or substituted for, MDMA in ecstasy tablets, such as caffeine, dextromethorphan (in some cough syrups), amphetamines, or cocaine. Makers of ecstasy can add anything they want to the drug. So the purity of ecstasy is always in question. [1]

What Are the Common Street Names?

Slang words for MDMA are ecstasy, E, XTC, X, Adam, hug, beans, clarity, lover's speed, and love drug. [1][2]

How Is It Used?

MDMA is usually taken by mouth in a pill, tablet, or capsule. These pills can be different colors, and sometimes the pills have cartoon-like images on them. Some MDMA users take more than one pill at a time, called "bumping." [1][2][3]

How Many Teens Use It?

According to a 2005 NIDA-funded study, many smart teens are turning their backs on MDMA. Since 2001, the percentage of 8th-graders who have ever tried MDMA has dropped from 5.2% in 2001 to 2.8% in 2005. The drop for 10th-graders was from 8.0% in 2001 to 4.0% in 2005, and 12th-graders have had the greatest decrease, from 11.7% in 2001 to 5.4% in 2005. According to 12th-graders, MDMA also seemed to be less available in 2005, which is good; but fewer 8th-graders saw “great risk” in occasionally using MDMA, and that’s not so good. It means that 8th-graders may not understand the health risks of using MDMA as well as they should. [4]

Is MDMA Addictive?

Like other stimulant drugs, MDMA appears to have the ability to cause addiction. That is, people continue to take the drug despite experiencing unpleasant physical side effects and other social, behavioral, and health consequences.

No one knows how many times a person can use a drug before becoming addicted or who’s most vulnerable to addiction. Genetic makeup, living environment, and other factors probably play a role in a person’s susceptibility to addiction

What Are the Common Effects?

In general, NIDA-supported research shows that abuse of any club drugs can cause serious health problems and, in rare instances, even death. Many drug abusers take combinations of drugs, including alcohol, which may further increase their danger.

For most abusers, a "hit" of ecstasy lasts for 3 to 6 hours. Once the pill is swallowed, it takes only about 15 minutes for MDMA to enter the bloodstream and reach the brain. About 45 minutes later, a user experiences MDMA's peak level (high). It's downhill from there, unless the user "bumps" and takes more MDMA. But even if a person takes only one pill, the side effects of MDMA—including feelings of sadness, anxiety, depression, and memory difficulties—can last for several days to a week (or longer in regular MDMA users). [1][2][3]

Initial Effects

MDMA abusers might feel very alert or "hyper" at first. At raves, they can keep on dancing for hours at a time. They may also experience distortions in time and other changes in perception, such as an enhanced sense of touch. Some, however, can become anxious and agitated. Sweating or chills may occur, and MDMA abusers may feel faint or dizzy. [3]

MDMA abusers can also become dehydrated through vigorous activity in a hot environment. MDMA can interfere with the body's ability to regulate its temperature, which can cause dangerous overheating (hyperthermia.) This, in turn, can lead to serious heart, kidney, or liver problems—or, rarely, death. MDMA can be extremely dangerous in high doses, or when multiple small doses are taken within a short time period to maintain the high. Blood levels of the drug can reach very high levels, increasing the risk of hyperthermia and other health risks of MDMA. [2]

Other Effects On the Body

MDMA can also cause muscle tension, clenching of teeth, nausea, blurred vision, fainting, and chills or sweating. It increases heart rate and blood pressure.

Effects On the Mind

MDMA can cause confusion, depression, sleep problems, intense fear, and anxiety. In regular abusers, some of these side effects can last for days or weeks after taking MDMA.

Dangers

MDMA can be dangerous in high doses. It can cause a noticeable increase in body temperature (hyperthermia), which also has been associated with dehydration. Hyperthermia can lead to cardiovascular problems, seizures, liver failure, and muscle breakdown that can cause kidney failure. These have been reported in some fatal cases at raves. [1]

MDMA has been shown to be neurotoxic (damage nerve tissue) in studies using animals. It's not yet known whether this drug is neurotoxic in humans. However, regular users of MDMA have demonstrated memory loss, and this may reflect damage to the neurons that release serotonin, which affects the ability to sleep and helps to regulate mood.

Long-term Effects

Although it is not yet known whether MDMA causes long-term brain damage in humans, or whether the effects are reversible when someone stops using the drug, a study of non-human primates showed that exposure to high doses of MDMA for 4 days produced brain damage that was evident 6 to 7 years later. The study researchers found that some of the damaged nerve fibers grew back, but not necessarily in the same parts of the brain. It's like cutting off a branch of a fruit tree: The tree is still alive and can sprout a new limb somewhere else, but it may not bear as much fruit as the old one.

Risks to the Brain

Brain imaging research in humans indicates that MDMA may affect neurons that use serotonin to communicate with other neurons. The serotonin system plays a direct role in regulating mood, aggression, sexual activity, sleep, and sensitivity to pain. [5, 6]

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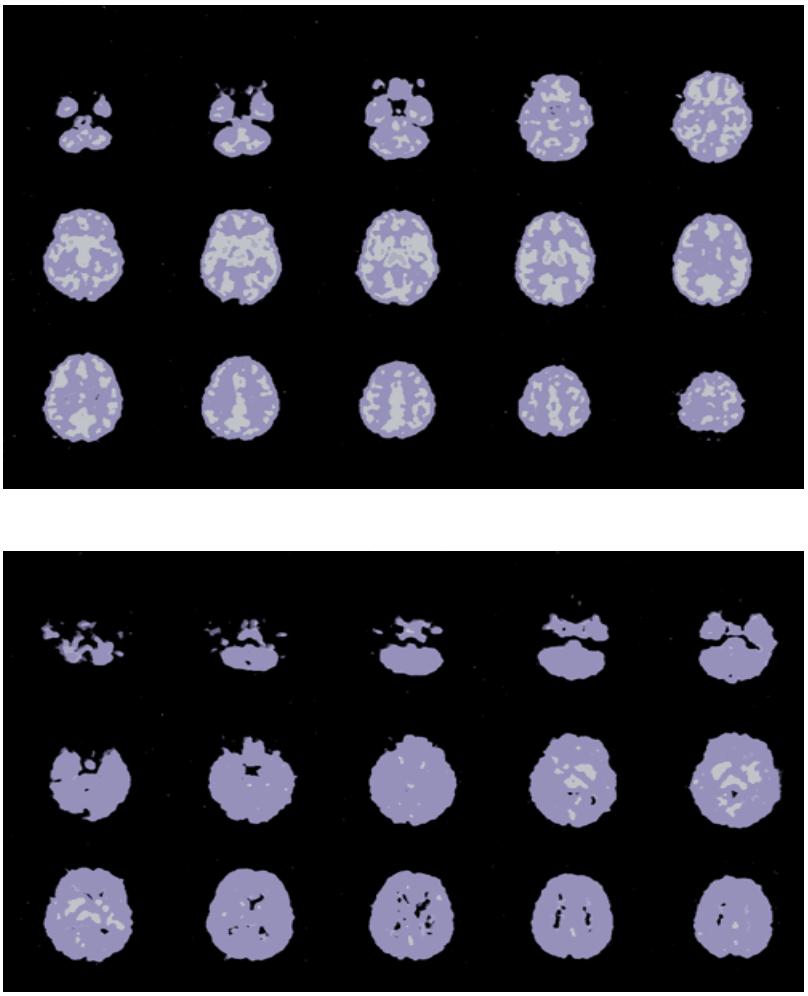
"Ecstasy" Damages the Brain and Impairs Memory in Humans

By Robert Mathias, NIDA NOTES Staff Writer

A NIDA-supported study has provided the first direct evidence that chronic use of MDMA, popularly known as "ecstasy," causes brain damage in people. Using advanced brain imaging techniques, the study found that MDMA harms neurons that release serotonin, a brain chemical thought to play an important role in regulating memory and other functions. In a related study, researchers found that heavy MDMA users have memory problems that persist for at least 2 weeks after they have stopped using the drug. Both studies suggest that the extent of damage is directly correlated with the amount of MDMA use.

"The message from these studies is that MDMA does change the brain and it looks like there are functional consequences to these changes," says Dr. Joseph Frascella of NIDA's Division of Treatment Research and Development. That message is particularly significant for young people who participate in large, all-night dance parties known as "raves," which are popular in many cities around the Nation. NIDA's epidemiologic studies indicate that MDMA (3,4-methylenedioxymethamphetamine) use has escalated in recent years among college students and young adults who attend these social gatherings.

In the brain imaging study, researchers used positron emission tomography (PET) to take brain scans of 14 MDMA users who had not used any psychoactive drug, including MDMA, for at least 3 weeks. Brain images also were taken of 15 people who had never used MDMA. Both groups were similar in age and level of education and had comparable numbers of men and women.



These brain scans show the amount of serotonin activity over a 40-minute period in a non-MDMA user (top) and an MDMA user (bottom). Dark areas in the MDMA user's brain show damage due to chronic MDMA use.

In people who had used MDMA, the PET images showed significant reductions in the number of serotonin transporters, the sites on neuron surfaces that reabsorb serotonin from the space between cells after it has completed its work. The lasting reduction of serotonin transporters occurred throughout the brain, and people who had used MDMA more often lost more serotonin transporters than those who had used the drug less.

Previous PET studies with baboons also produced images indicating MDMA had induced long-term reductions in the number of serotonin transporters. Examinations of brain tissue from the animals provided further confirmation that the decrease in serotonin transporters seen in the PET images corresponded to actual loss of serotonin nerve endings containing transporters in the baboons' brains. "Based on what we found

with our animal studies, we maintain that the changes revealed by PET imaging are probably related to damage of serotonin nerve endings in humans who had used MDMA," says Dr. George Ricaurte of The Johns Hopkins Medical Institutions in Baltimore. Dr. Ricaurte is the principal investigator for both studies, which are part of a clinical research project that is assessing the long-term effects of MDMA.

"The real question in all imaging studies is what these changes mean when it comes to functional consequences," says NIDA's Dr. Frascella. To help answer that question, a team of researchers, which included scientists from Johns Hopkins and the National Institute of Mental Health who had worked on the imaging study, attempted to assess the effects of chronic MDMA use on memory. In this study, researchers administered several standardized memory tests to 24 MDMA users who had not used the drug for at least 2 weeks and 24 people who had never used the drug. Both groups were matched for age, gender, education, and vocabulary scores.

The study found that, compared to the nonusers, heavy MDMA users had significant impairments in visual and verbal memory. As had been found in the brain imaging study, MDMA's harmful effects were dose-relatedÑthe more MDMA people used, the greater difficulty they had in recalling what they had seen and heard during testing.

The memory impairments found in MDMA users are among the first functional consequences of MDMA-induced damage of serotonin neurons to emerge. Recent studies conducted in the United Kingdom also have reported memory problems in MDMA users assessed within a few days of their last drug use. "Our study extends the MDMA-induced memory impairment to at least 2 weeks since last drug use and thus shows that MDMA's effects on memory cannot be attributed to withdrawal or residual drug effects," says Dr. Karen Bolla of Johns Hopkins, who helped conduct the study.

The Johns Hopkins/NIMH researchers also were able to link poorer memory performance by MDMA users to loss of brain serotonin function by measuring the levels of a serotonin metabolite in study participants' spinal fluid. These measurements showed that MDMA users had lower levels of the metabolite than people who had not used the drug; that the more MDMA they reported using, the lower the level of the metabolite; and that the people with the lowest levels of the metabolite had the poorest memory performance. Taken together, these findings support the conclusion that MDMA-induced brain serotonin neurotoxicity may account for the persistent memory impairment found in MDMA users, Dr. Bolla says.

Research on the functional consequences of MDMA-induced damage of serotonin-producing neurons in humans is at an early stage, and the scientists who conducted the studies cannot say definitively that the harm to brain serotonin neurons shown in the imaging study accounts for the memory impairments found among chronic users of the drug. However, "that's the concern, and it's certainly the most obvious basis for the memory problems that some MDMA users have developed," Dr. Ricaurte says.

Findings from another Johns Hopkins/NIMH study now suggest that MDMA use may lead to impairments in other cognitive functions besides memory, such as the ability to reason verbally or sustain attention. Researchers are continuing to examine the effects of chronic MDMA use on memory and other functions in which serotonin has been implicated, such as mood, impulse control, and sleep cycles. How long MDMA-induced brain damage persists and the long-term consequences of that damage are other questions researchers are trying to answer. Animal studies, which first documented the neurotoxic effects of the drug, suggest that the loss of serotonin neurons in humans may last for many years and possibly be permanent. "We now know that brain damage is still present in monkeys 7 years after discontinuing the drug," Dr. Ricaurte says. "We don't know just yet if we're dealing with such a long-lasting effect in people."

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GHB (Gamma Hydroxy Butyrate)

Common names: The "date-rape" drug, grievous bodily harm, liquid ecstasy, liquid X, easy lay, "G," etc.

What is it?
GHB is created naturally in the human body in small quantities. When larger amounts are ingested (and combined with other drugs and/or alcohol) it is very dangerous. In the liquid form, GHB looks and smells like water with a salty taste. GHB can also be in white power or capsule form. GHB has been used to increase one's sensuality and physical responsiveness. It acts by depressing the central nervous system.

Short-term effects
The short-term effects of using GHB can slow down one's breathing and heart rate and in some cases stops these functions altogether. Maintaining the dosage is difficult and it is very easy to overdose. Large quantities of GHB can cause nausea, vomiting, dizziness, amnesia and vertigo. Higher doses can place a person in a coma-like state. The heavy user is at risk for vomiting while sleeping and choking to death.

Long-term effects
Long-term effects of using GHB are unknown at this time. It has been noted to be an addictive substance that can cause physical dependence. Quitting suddenly can cause anxiety, insomnia, paranoia, and hallucinations. GHB overdoses can cause a reduced heart rate and the ability to breathe, a loss of consciousness, seizures, coma and death.

Signs of usage
Sleepiness, nausea, vomiting, dizziness, amnesia, vertigo, sensitivity to touch, etc.

Legal status
GHB is not legal to purchase, sell, or consume in the United States. For more information see the Section VII for additional resources.

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

Rohypnol

Common names: A "date-rape" drug, roofies, roachies, La Rocha, ruffies, ropes, pappas, ro-shays, robinal, the forget pill, pastaa, peanuts, etc.

What is it?

Rohypnol is the name brand for flunitrazepam. It is a benzodiazepine medicine that has sedative effects. Recently it has been discovered that it is given secretly to make a person unable to defend himself or herself from a sexual assault. The tablet form is common. Since 1999, these tablets have been adjusted to dissolve slower, make clear beverages blue, and make dark beverages murky so it is easier to detect. Some may use these drugs to increase sensuality and one's physical responses. When Rohypnol is combined with alcohol and/or other drugs the increased effects can cause death.

Short-term effects

The short-term effects of using Rohypnol may cause a person to feel drowsy, relaxed, dizzy, confused, and uncoordinated. It may also cause a person to become unconscious or to blackout anywhere from eight to twenty-four hours. Users may appear to be intoxicated or "drunk." A reduction in one's inhibitions and judgment has been indicated. The effects of the drug usually are felt within the first thirty minutes. The peak is after about two hours and typically lasts for around eight hours in duration.

Long-term effects

The long-term effects of using Rohypnol can cause physical dependency.

Signs of usage

Slurred speech, physical weakness, severe drowsiness, and difficulties in walking, drowsiness, dizziness, confusion, lack of coordination, etc.

Legal status

Rohypnol is not legal to purchase, sell, or consume in the United States.

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

Ketamine

Common names
A "date-rape" drug, drug special, K, special K, vitamin K, baby food, kit kat, ketalar, ketaset, bump, cat Valium, jet, honey oil, super acid, purple, special la coke, green, etc.

What is it?
Ketamine is an anesthetic and a painkiller that is fast acting. It was designed for use in veterinary medicine and in other special medical procedures. This drug has been used like GHB to render an individual unable to fend off a sexual assault. Generally Ketamine is found in the liquid form but can also be in the form of a white pill or powder. The powder has been used to slip into one's drink, is injected, smoked, and/or snorted.

Short-term effects
The short-term effects of Ketamine are experienced within ten minutes of ingesting the drug. The effects vary with the quantity ingested. The prevention of pain and vomiting typically occurs. When the user eats or drinks prior to taking Ketamine, it increases the change of choking on one's own vomit. Higher doses cause lack of coordination, babbling, temporary amnesia, and a reduction of the heartbeat. What this indicates is that less oxygen is getting to the brain and muscles in the person's body. Unconsciousness and death are possible from only one use. Tolerance can be developed with repeated usage.

Long-term effects
The long-term effects of Ketamine are unknown at this time.

Signs of usage
Feelings of being withdrawn, sleepiness, distraction and confusion are common symptoms. A person may have perceptual distortions with regard to time and their body.

Legal status
Ketamine is only legal for veterinarians and doctor's medical use. Purchasing, selling, or using this drug, without the consent of a physician, is illegal in the United States.

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

Opiates (Opioids, Narcotics)

Common names: Heroin = junk, horse, smack, H, skag, shit, mud, black tar, dope, mojo, brown, etc. Morphine = M, morph, Miss Emma, etc.
Methadone = Meth, etc.

What is it?

The family of drugs derived from the opium poppy is commonly referred to as narcotics. Opiates are natural substances that come from the opium poppy flower and also synthetic drugs such as meperidine (Demerol®), codeine and methadone. Doctors prescribe these drugs to help people who need relief from pain.

Short-term effects

The short-term effect of using opiates causes stimulation in the brain while the central nervous system is depressed. Initially there is a pleasurable feeling or rush, which is followed by one's thinking and reaction time to be slowed down considerably. Outcomes of using opiates include restlessness, nausea, vomiting, dry mouth, warm feelings in the body, heavy feelings of extremities, lack of consciousness, slower breath rate, constricted pupils, depression, cold skin that is moist and blue in color, coma, convulsions, and death. The potential to overdose is very high.

Long-term effects

The long-term effects from using opiates can cause infections, dependency, a reduction in respiration, and overdose. Using dirty needles causes some infections, which can lead to contracting HIV, AIDS, and other serious illnesses. Drug dependency and severe withdrawal symptoms are common. Slow, shallow breathing, clammy skin, convulsions, coma, and/or death can be caused by an overdose of these types of drugs.

Signs of usage

Scars (called "tracks") from injections, constricted pupils, loss of appetite, sniffles, watery eyes, cough, nausea, drowsiness, restlessness, etc.

Legal status

Doctors can prescribe opiates for specific medical conditions. However the use, purchase, or sale of these drugs is illegal without a prescription in the United States.

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

Opium is the crudest form and also the least potent of the Opiates. Opium is the milky latex fluid contained in the un-ripened seed pod of the opium poppy. As the fluid is exposed to air, it hardens and turns black in color. This dried form is typically smoked, but can also be eaten. Opium is grown mainly in Myanmar (formerly Burma) and Afghanistan.

Today opium is sold on the street as a powder or dark brown solid and is smoked, eaten, or injected.

Opium addiction

The powerful prescription pain reliever has become a hot new street drug that has resulted in more than 120 deaths nationwide. It will give you a high much like HIGH GRADE heroin but with worse consequences. 5mg of OXY has has as much active ingredient (oxycodone) as one Percocet. So chewing/snorting a 40mg OXY is like taking 8 Percocet at once or a 80mg Oxy is like taking 16 Percocet all at once.

Opium should be used to fight extreme pain. Doctors commonly prescribe it to cancer patients as an alternative to morphine. The drug is addictive, expensive, and when misused, it can be lethal. Opium abuse is becoming an epidemic in several rural states.

Physical dependence, which is sometimes unavoidable, develops when an individual is exposed to a drug at a high enough dose for long enough that the body adapts and develops a tolerance for the drug. This means that higher doses are needed to achieve a drug's original effects. If the patient stops taking the drug, withdrawal will occur. Just like heroin it is almost impossible to do alone as the withdrawal symptoms of Opium are worse than heroin and last longer. Professional help from a heroin detox center is the best and safest way to do this but there is NO painless way.

Drug craving is the result of the drug's imprinting in the memory of a pleasant association of euphoria with the drug. The subconscious memory then motivates the individual to seek this drug because of the false imprint. The brain, in effect, has been trained that using the drug is the fastest way to feel good. This learning process then produces a new appetite or drive to seek the drug which we call craving. This craving is most often activated by, a) memory of pleasure, b) when we feel bad and have a habit of using the drug to rapidly feel good, c) when we are in a situation with people, places and activities in which a previous habit pattern of drug use has been established.

Prescription drugs, like other addictive drugs, are able to short-circuit your survival system by artificially stimulating the reward center, or pleasure areas in your brain, without anything beneficial happening to your body. As this happens, it leads to increased confidence in the drug, and less confidence in the normal rewards of life. This first happens on a physical level. Then, it affects you psychologically. The big drug lie results in decreased interest in other aspects of life, as you increase your reliance and interest in the drug. People, places and activities involved with using drugs become more important. People, places and activities or lifestyles that worked through your normal reward system, before using the drug, become less important to you. After a while, a heavy drug user will actually resent people, places, and activities that do not fit in with that drug use.

Addictive drugs mimic the action of chemicals your brain produces to send messages of pleasure to your brain's reward center. They produce an artificial feeling of pleasure. Most addictive drugs are able to produce pleasurable effects by chemically acting like certain normal brain messenger chemicals, which produce positive feelings in response to signals from the brain.

The result is a dependence on the immediate, fast, predictable drug which, at the same time, short circuits interests in and the motivation to make life's normal rewards work. More and more confidence is placed in the drug while other survival feelings are ignored and bypassed. The result of this addiction cycle is a lack of concern for, and confidence in, other areas of life.

Opium abuse

The power painkiller Opium is being abused by more and more people across the nation. The heroin-like effects of the drug attract both legitimate and illegitimate users.

Opium abuse is spreading for a variety of reasons. First, the elevated opiate dosage makes it highly addictive. Second, in contrast to drugs such as cocaine or heroin that can be laced with other substances, with Opium you know how much of the drug you are getting; the dosage is consistent, so it is a dependable high. Finally, Opium is covered by most health insurance plans, so it is significantly cheaper than street drugs. (Opium has been referred to as "hillbilly heroin" or "the poor man's heroin.")

Common signs and side effects of opium use

Being of similar structure, the opiate molecules occupy many of the same nerve-receptor sites and bring on the same analgesic effect as the body's natural painkillers. Opiates first produce a feeling of pleasure and euphoria, but with their continued use the body demands larger amounts to reach the same sense of well-being.

Some of the illnesses associated with addiction are:

- malnutrition
- respiratory complications
- low blood pressure

Common symptoms of opium withdrawal and overdose

Withdrawal is extremely uncomfortable, and addicts typically continue taking the drug to avoid pain rather than to attain the initial state of euphoria.

Overdose symptoms include:

- slow breathing
- seizures
- dizziness
- weakness
- loss of consciousness
- coma
- confusion
- tiredness
- cold and clammy skin
- small pupils

Opium addiction

Opium is highly addictive. Tolerance (the need for higher and higher doses to maintain the same effect) and physical and psychological dependence develop quickly. Withdrawal from opium causes nausea, tearing, yawning, chills, and sweating.

As long ago as 100 AD, opium had been used as a folk medicine, taken with a beverage or swallowed as a solid. Only toward the middle of the 17th century, when opium smoking was introduced into China, did any serious addiction problems arise. In the 18th century opium addiction was so serious there that the Chinese made many attempts to prohibit opium cultivation and opium trade with Western countries. At the same time opium made its way to Europe and North America, where addiction grew out of its prevalent use as a painkiller.

Cocaine

Common names: Crack, C, coke, flake, dust, blow, nose candy, rock, white lines, etc.

What is it?

Cocaine is a fine white powder that is processed from the leaves of the coca plant. Typically it is snorted but can also be injected. Crack is a derivative of cocaine that is made by mixing cocaine with baking powder, soda and water to form a cake-like substance. This cake is broken down or cracked into small crystals about the size of a peanut. These small crystals are then smoked (also called freebasing) typically in a glass pipe. Cocaine is a forceful drug that arouses the central nervous system. A cocaine "high" usually last for only five to twenty minutes long, and each time the user needs more to obtain the "high."

Short-term effects

The short-term effects of cocaine cause a burst of energy and decrease in one's appetite. The user may feel more alert but this is just an effect of the drug and not a reality. There is a risk of stroke caused by an increase in one's heart rate and blood pressure. Strange behavior and violent acts have been connected with cocaine usage. Paranoid psychosis is possible as well as seizures and/or convulsions. Crack cocaine has been found to be instantly addictive. One use of cocaine and/or crack cocaine can cause a fatal heart attack. The risk of overdose is extremely high.

Long-term effects

The long-term effects from using cocaine may cause the individual's nose tissues to deteriorate (from repeated snorting of the drug). Tolerance and dependency develop quickly as well as the risk of overdosing. Users who inject the drug may contract AIDS, HIV, or other serious medical conditions. A paranoid psychosis may develop that can be irreversible and permanent.

Signs of usage

A person's pupils may appear larger than normal, mood swings and irritability, carefree attitude, talkativeness, euphoria, etc.

Legal status

The legal use of cocaine in the United States is for medical application only. Some medical procedures such as nasal surgeries use the drug to help reduce the pain of surgery. Possessing, purchasing, using, selling, etc. is illegal.

(Adapted from A Parent & Community Handbook, 4th Edition, Parents Against Drugs (PAD) Toronto, Canada, 1999).

NIDA InfoFacts: Crack and Cocaine

Cocaine is a powerfully addictive stimulant drug. The powdered, hydrochloride salt form of cocaine can be snorted or dissolved in water and injected. Crack is cocaine that has not been neutralized by an acid to make the hydrochloride salt. This form of cocaine comes in a rock crystal that can be heated and its vapors smoked. The term "crack" refers to the crackling sound heard when it is heated.*

Regardless of how cocaine is used or how frequently, a user can experience acute cardiovascular or cerebrovascular emergencies, such as a heart attack or stroke, which could result in sudden death. Cocaine-related deaths are often a result of cardiac arrest or seizure followed by respiratory arrest.

Health Hazards

Cocaine is a strong central nervous system stimulant that interferes with the reabsorption process of dopamine, a chemical messenger associated with pleasure and movement. The buildup of dopamine causes continuous stimulation of receiving neurons, which is associated with the euphoria commonly reported by cocaine abusers.

Physical effects of cocaine use include constricted blood vessels, dilated pupils, and increased temperature, heart rate, and blood pressure. The duration of cocaine's immediate euphoric effects, which include hyperstimulation, reduced fatigue, and mental alertness, depends on the route of administration. The faster the absorption, the more intense the high. On the other hand, the faster the absorption, the shorter the duration of action. The high from snorting may last 15 to 30 minutes, while that from smoking may last 5 to 10 minutes. Increased use can reduce the period of time a user feels high and increases the risk of addiction.

Some users of cocaine report feelings of restlessness, irritability, and anxiety. A tolerance to the "high" may develop—many addicts report that they seek but fail to achieve as much pleasure as they did from their first exposure. Some users will increase their doses to intensify and prolong the euphoric effects. While tolerance to the high can occur, users can also become more sensitive to cocaine's anesthetic and convulsant effects without increasing the dose taken. This increased sensitivity may explain some deaths occurring after apparently low doses of cocaine.

Use of cocaine in a binge, during which the drug is taken repeatedly and at increasingly high doses, may lead to a state of increasing irritability, restlessness, and paranoia. This can result in a period of full-blown paranoid psychosis, in which the user loses touch with reality and experiences auditory hallucinations.

Other complications associated with cocaine use include disturbances in heart rhythm and heart attacks, chest pain and respiratory failure, strokes, seizures and headaches, and gastrointestinal complications such as abdominal pain and nausea. Because cocaine has a tendency to decrease appetite, many chronic users can become malnourished.

Different means of taking cocaine can produce different adverse effects. Regularly snorting cocaine, for example, can lead to loss of the sense of smell, nosebleeds, problems with swallowing, hoarseness, and a chronically runny nose. Ingesting cocaine can cause severe bowel gangrene due to reduced blood flow. People who inject cocaine can experience severe allergic reactions and, as with all injecting drug users, are at increased risk for contracting HIV and other blood-borne diseases.

Added Danger: Cocaethylene

When people mix cocaine and alcohol consumption, they are compounding the danger each drug poses and unknowingly forming a complex chemical experiment within their bodies. NIDA-funded researchers have found that the human liver combines cocaine and alcohol and manufactures a third substance, cocaethylene, that intensifies cocaine's euphoric effects, while potentially increasing the risk of sudden death.

Treatment

The widespread abuse of cocaine has stimulated extensive efforts to develop treatment programs for this type of drug abuse.

One of NIDA's top research priorities is to find a medication to block or greatly reduce the effects of cocaine, to be used as one part of a comprehensive treatment program. NIDA-funded researchers are also looking at medications that help alleviate the severe craving that people in treatment for cocaine addiction often experience. Several medications are currently being investigated for their safety and efficacy in treating cocaine addiction.

In addition to treatment medications, behavioral interventions—particularly cognitive behavioral therapy—can be effective in decreasing drug use by patients in treatment for cocaine abuse. Providing the optimal combination of treatment and services for each individual is critical to successful outcomes.

Extent of Use

Monitoring the Future (MTF) Survey **

Lifetime,*** annual, and 30-day cocaine use remained stable among all three grades in 2005. Perceived harmfulness of occasional use also remained stable in 2005, measuring at 65.3 percent among 8th-graders, 72.4 percent among 10th-

graders, and 60.8 percent among 12th-graders.

Use of Cocaine in *Any Form* by Students, 2005: Monitoring the Future Survey

	8th-Graders	10th-Graders	12th-Graders
Lifetime	3.7%	5.2%	8.0%
Annual	2.2	3.5	5.1
30-Day	1.0	1.5	2.3

Crack Cocaine Use by Students, 2005: Monitoring the Future Survey

	8th-Graders	10th-Graders	12th-Graders
Lifetime	2.4%	2.5%	3.5%
Annual	1.4	1.7	1.9
30-Day	0.6	0.7	1.0

Community Epidemiology Work Group (CEWG)****

Cocaine-related death mentions in 2003 were particularly high in New York City/Newark, Detroit, Boston, and Baltimore, as measured by one Federal data source. Reports from local medical examiner data named Texas and Philadelphia as sites with the highest rates of cocaine-related deaths from 2003 through 2004.

Primary cocaine treatment admissions in 2004 accounted for 52.5 percent of treatment admissions, excluding alcohol, in Atlanta, 38.9 percent in New Orleans, and approximately 36 percent in Texas and Detroit.

National Survey on Drug Use and Health (NSDUH)*****

In 2004, 34.2 million Americans aged 12 and over reported lifetime use of cocaine, and 7.8 million reported using crack. About 5.6 million reported annual use of cocaine, and 1.3 million reported using crack. An estimated 2 million Americans reported current use of cocaine, 467,000 of whom reported using crack. There were an estimated 1 million new users of cocaine in 2004 (approximately 2,700 per day), and most were aged 18 or older although the average age of first use was 20.0 years.

The percentage of youth ages 12 to 17 reporting lifetime use of cocaine was 2.4 percent in 2004. Among young adults aged 18 to 25, the rate was 15.2 percent, showing no significant difference from the previous year. However, there was a statistically significant decrease in perceived risk of using cocaine once a month among Americans in the 12 to 17 age bracket in 2004.

Past month crack use was down for 16- or 17-year-olds but up for 21- to 25-year-olds; 21-year-olds also showed increases in past year use of both crack and cocaine.

Past month use of cocaine was down among females aged 12–17 and Asians 12 or older, but up among Blacks aged 18 to 25. There was a decrease in past year cocaine use measured among Asians aged 18 to 25.

Following a decline between 2002 and 2003, NSDUH data show an increase in the number of people receiving treatment for a cocaine use problem during their most recent treatment at a specialty facility, from 276,000 in 2003 to 466,000 in 2004.

** Snorting is the process of inhaling cocaine powder through the nose, where it is absorbed into the bloodstream through the nasal tissues. Injecting is the use of a needle to release the drug directly into the bloodstream; any needle use increases a user's risk of contracting HIV and other blood-borne infections. Smoking involves inhaling cocaine vapor or smoke into the lungs, where absorption into the bloodstream is as rapid as by injection.*

*** These data are from the 2005 Monitoring the Future survey, funded by the National Institute on Drug Abuse, National Institutes of Health, DHHS, and conducted annually by the University of Michigan's Institute for Social Research. The survey has tracked 12th-graders' illicit drug use and related attitudes since 1975; in 1991, 8th- and 10th-graders were added to the study. The latest data are online at www.drugabuse.gov.*

**** "Lifetime" refers to use at least once during a respondent's lifetime. "Annual" refers to use at least once during the year preceding an individual's response to the survey. "30-day" refers to use at least once during the 30 days preceding an individual's response to the survey*

***** CEWG is a NIDA-sponsored network of researchers from 21 major U.S. metropolitan areas and selected foreign countries who meet semiannually to discuss the current epidemiology of drug abuse. CEWG's most recent reports are available at http://www.drugabuse.gov/about/organization/cewg/pubs.html.*

****** NSDUH (formerly known as the National Household Survey on Drug Abuse) is an annual survey of Americans age 12 and older conducted by the Substance Abuse and Mental Health Services Administration. Copies of the latest survey are available at www.samhsa.gov and from the National Clearinghouse for Alcohol and Drug Information at 800-729-6686*

LSD (lysergic acid diethyl amide)

Common names: Acid, sid, yellow sunshine, California sunshine, blotter, dots, microdots, window pane, sugar cubes, trips – the effect of using the drug is called "tripping"

What is it?

LSD is an odorless, clear or white water-soluble material that has been synthesized from lysergic acid (found in rye fungus). Effects of this drug can last for hours. LSD starts out as a crystal-like substance that can be crushed into powder. In most cases, this powder is dissolved and diluted and then transferred to sheets of perforated paper (like quarter-inch postage stamps).

Short-term effects

The short-term effects of taking LSD begin within thirty to ninety minutes. Most of these trips can include both positive and negative experiences due to the intense hallucinations. The effects are highly unpredictable and may cause alterations in one's personality, mood, expectations, and surroundings. Users have experienced an increase in blood pressure, heart rate, dizziness, and loss of appetite, dry mouth, sweating, nausea, numbness, and tremors. The most notable effects are on a person's emotions and sensory perceptions. Many users have experienced "bad trips," a nightmare-like state of anxiety, paranoia and fear of insanity and/or death.

Long-term effects

Some people have reported psychosis and other psychological effects that can last long after the trip has ended. This can produce a long-lasting psychotic-like state that may include manic-depressive symptoms and/or episodes. These effects can last for years in those who have no other psychological predispositions. Some long-term users of LSD have reported "flashbacks." Physicians have labeled these flashbacks as Hallucinogen Persisting Perception Disorder, which are continuous and reoccurring sensory distortions and hallucinations. At this time, there is no treatment available to assist with this problem, however some medications can help to reduce the symptoms.

Signs of usage

Some users may appear to be experiencing several emotions simultaneously. A person's senses may become distorted and highly sensitive to colors, smells, lights, and sounds. Pupils are dilated and the person may be giddy, jittery, nauseous, numbness of the face and lips, changes in coordination, have chills, or laugh for no reason.

Legal status

Possessing, purchasing, using, selling, LSD is illegal in the United States.

(Adapted from *Hallucinogens and Dissociative Drugs: Including LSD, PCP, Ketamine, Dextromethorphan*, Research Report Series, National Institute on Drug Abuse, U.S. Department of Health and Human Services, National Institute of Health, NIH Publication Number 01-4209, March 2001).

PCP

Common names: Angel, angel dust, boat, dummy dust, love boat, peace, supergrass, zombie, etc.

What is it?

PCP is classified as a dissociative anesthetic. It is a sedative that was available in pill form in the 1960s. Today it is primarily found in powder form that is often sprinkled on marijuana cigarettes, tobacco, or other herbs and then smoked. It can also be snorted. It is also available in a rock-like form. PCP alters the neurotransmitters in the brain causing a feeling of euphoria.

Short-term effects

The short-term effects of PCP are a feeling of having an "out-of-body" experience. PCP can cause shallow, rapid breathing, an increase in heart rate, blood pressure and body temperature. The user may feel dizzy, nauseous, uncoordinated, and have blurred vision and/or hallucinations. The person can experience severe muscle contractions that can cause a bone fracture, kidney damage or kidney failure. Higher doses can cause convulsions, coma, hypothermia, violent episodes, and death.

Long-term effects

The long-term usage of PCP can cause addiction and withdrawal syndrome. Using this drug long-term can cause memory loss, depression, disorientation, and suicidal tendencies.

Signs of usage

Multiple and dramatic behavioral changes, acting drunk, euphoria, dissociative state (out of touch with reality), lack of coordination and reflexes, dizziness, nausea, etc.

Legal status

Possessing, purchasing, using, selling, PCP is illegal in the United States. Penalties are severe.

(Adapted from *Hallucinogens and Dissociative Drugs: Including LSD, PCP, Ketamine, Dextromethorphan*, Research Report Series, National Institute on Drug Abuse, U.S. Department of Health and Human Services, National Institute of Health, NIH Publication Number 01-4209, March 2001).

Methamphetamines

Common names: Meth, speed, crank, crystal, tweak, ice, glass, uppers, etc.

What is it?

Methamphetamines are drugs that are used to increase alertness, relieve fatigue, etc. In most cases, it is found in the form of a pill or powder. The powder will appear coarse and has a yellowish tint. The user may snort, smoke, take orally, or inject the drug. Due to the ignitable, corrosive, and toxic nature of the chemicals used to make this drug, there is a high risk of fires, toxic fumes, and environmental damage from the process.

Short-term effects

Much like cocaine, using methamphetamines will give an instant feeling of euphoria or "rush." It arouses the central nervous system by creating a false sense of energy. The user will have an increase in heart rate, blood pressure, energy, blurred vision, restlessness, delusions, loss of coordination, risk of stroke, and experience mind and mood changes such as anxiety and depression, etc. The initial euphoric state is typically followed by a severe "crash" once the effects wear off. From one usage, death can result from a stroke, and physical and psychological addiction may develop. There is a high risk of overdose.

Long-term effects

The long-term effects from using any type of amphetamines can include chronic fatigue, paranoia or delusional thoughts/thinking, and permanent psychological damage. These drugs have been found to be as addictive and more powerful than crack cocaine. Liver, kidney, brain, and lung damage has been found to be associated with methamphetamine usage. Withdrawal syndrome is common with apathy, long periods of sleep, irritability, and/or depression. Users can have irreversible damage to blood vessels in the brain and risk a heart attack and/or stroke.

Signs of usage

Restlessness, nervousness, irritability, dizziness, confusion, lack of appetite and/or anorexia, increased sensitivity to sounds, paranoia, argumentativeness, dilated pupils, increase in blood pressure and pulse rate, long periods without sleeping or eating, etc.

Legal status

Methamphetamines are illegal in the United States.

(Adapted from *Tips for Teens: The Truth about Methamphetamine*. SAMHSA's National Clearinghouse for Alcohol and Drug Information, United States Department of Health and Human Services, 2000).

Meth devastates the user's health in a short time.

Meth:

Speeding toward death

Speed, chalk, crank, glass, ice, sketch, lemon drop, crystal – If you don't recognize these common names for methamphetamine (meth), you might not recognize the makeshift "lab" manufacturing it next door to you. After a friend or relative uses meth, you might not recognize them either.

Watch for Meth Use

Symptoms of meth use include...
- inability to sleep
- heightened sensitivity to noise, scratching
- anorexia
- tremors or convulsions
- rapid eye movement

Parents should seek help if they notice these symptoms in their children. Meth is too addictive for kids to "grow out of."

If you can't avoid a person who seems to be on meth, move slowly, speak softly and slowly, keep your hands visible and use extreme caution.

What is meth?

A homemade, highly addictive, extremely damaging drug, methamphetamine (meth) can come in powder form or be crystalline like rock candy. It may be inhaled, smoked, swallowed or injected.

Meth is made from a cooked slurry of ingredients that might include cold medicine, battery acid, brake cleaner, anhydrous ammonia, drain cleaner, or other caustic and hazardous materials. So it's no surprise that it can devastate the health of someone who uses it, the people who make it, and the children who live and play nearby.

Why do people try it?

Some people, especially young women, first take meth thinking it will help them overcome shyness or lose weight. Because it is quickly addicting, experimentation can have disastrous results.

The rush-high-crash cycle

Taking methamphetamine (meth) can put even the first-time user into a rush-high-crash cycle.

1. The drug very quickly produces an intense, euphoric **rush**.
2. A **high** – a feeling of energy, alertness and well-being –may last up to 12 hours or more.
3. The high is followed by a **crash** of intense agitation, depression, paranoia or anxiety, and consequently a craving for more of the drug.

This cycle makes people spiral into heavy usage, during which they may not eat or sleep for days at a time.

Photo courtesy of Wright County Sheriff's Office

Children live in more than half of homes where meth labs are found.

Highly addictive

It's not unusual for people to become addicted to methamphetamine (meth) the first time they use it.

"Unlike heroin and many other drugs, there are no medications known to help people stop craving meth," says Tracy Powell, MD, emergency physician at Buffalo Hospital.

The effects linger in the body for a long time, exceeding the length of many treatment plans. Addicts are often so violent, exhausted and ill when they start treatment, they aren't able to stay awake, much less participate in therapy.

Ruins the user's health

Meth users may experience convulsions, high body temperature, stroke, shaking, stomach cramps, heart damage, blood vessel damage and more.

Long-term users may have auditory hallucinations, paranoia, and violent rages. They may feel like bugs are crawling under their skin and scratch at them. Permanent brain damage, extreme anorexia, skin abscesses, tooth and bone loss, suicidal tendencies and violent behavior are common effects of meth.

Generates violent crime

Meth users are often very violent as a result of the drug and their hallucinations. They often steal materials to make meth, or to buy meth. Domestic abuse is common in homes where meth is used.

A big problem, growing fast

Meth-related adult court case filings in Minnesota rose 736 percent between 1999 and 2004. Treatment admissions for meth rose 292 percent between

Neighborhood Safety

Report suspicious sites to police. Clues include...

- secretive or unfriendly occupants
- frequent visitors, especially at unusual times
- chemical smells
- trash including chemical containers, coffee filters, cold medicine packaging, duct tape rolls, and red-stained cloth
- blacked out windows

Do not enter or approach any suspicious site yourself, touch any suspicious materials or interact with anyone there.

ercent of all crime is meth-related.

n in the back of a car, so it's difficult for
ıeth labs," says Gary Miller, Wright County

issioner, adds, "In the past 10 years, more
Wright County, costing taxpayers nearly a
clean-up efforts on top of the personal toll

this drug takes on its users and their families."

Damaging the environment, families

The process of cooking flammable, caustic chemicals not only makes toxic vapors, but can start fires or cause explosions. In fact, 15 percent of meth labs are discovered because of a fire or explosion.

Making one pound of meth produces about five pounds of toxic waste, most of which are illegally and irresponsibly disposed of.

Children live in more than half of homes where meth labs are found. Besides being taken from their homes, these kids (as well as adults) must be decontaminated – all traces of chemical residue washed off – and given clean clothes before they can be treated.

What's being done?

To reduce access to methamphetamine (meth) ingredients, many pharmacies and retailers, including Allina Community Pharmacies, are placing pseudoephedrine and ephedrine products behind counters. Legislation has been proposed to more tightly control those medicines.

Community efforts like Wright County's MEADA (Methamphetamine Education and Drug Awareness) Coalition educate and involve citizens in the fight against meth. For more information, visit www.meada.org or call 763-682-7713.

Buffalo Hospital, Healthy Communities Magazine, volume 11, number 3, fall 2005; MEADA Coalition

normal prescribed use. However, people discovered methamphetamines made them feel relaxed and began using the drugs recreationally. Abusers grind pills into powder, which they then snort like cocaine, or they dissolve it into a liquid and inject it.

Hall and colleagues also support investigating whether certain prescription drugs might be used to treat meth abuse.

SOURCE: **University of Iowa Health Science Relations New Release**

Meth Treatment Takes More Time

Methamphetamine Effects Linger Longer After Abstinence

Methamphetamine abusers do not necessarily need specialized treatment but do need more time in intensive outpatient or residential drug treatment programs than they normally receive under current practices.

University of Iowa researchers made the recommendation for longer treatment times for meth abusers and identified areas of research that could help improve treatment, including retention and new drug therapies.

"In reviewing studies we found that treatment does work if you can give people sufficient access to treatment," said James Hall, Ph.D., UI associate professor of pediatrics, social work, public health and nursing and one of the review authors. "We were worried that you need a special care ward or other special setting, but at least based on the data we reviewed, that doesn't seem to be the case."

The Time Factor

"What seems to make a difference is time. Meth effects can last up to six months for just one use, and the drug can do greater damage to a person's physical, behavioral and thinking functions than many other illicit drugs or alcohol," Hall wrote. "For this reason, it takes much longer to treat a person with a meth addiction than it does to treat someone with a cocaine or heroin problem. This time factor is also one reason why so many meth treatments currently fail."

Most adult residential drug treatment programs have been shortened in recent years from 45 or 30 days to only 10 to 14 because of changes in the insurance industry. "The problem is even worse for adolescents. Residential treatment programs for that age group have "dried up" due to budget cuts," Hall said.

Two Weeks Not Enough

"If you are a regular meth user, you will need more time to detox before you can accept the treatments, which are very cognitive," he said. "We don't know exactly how long you need, but we do know the current two-week time isn't sufficient. Likely, a minimum of 30 days of residential treatment allows the meth abuser to regain essential thinking and decision-making skills."

Hall said researchers should determine what residential treatment length would be effective for meth users before using outpatient care.

Treatment Instead of Imprisonment

"Most state and insurance programs will not pay for treatment beyond two weeks, so even if a medical need is confirmed, funding needs also must be addressed," Hall said.

"The emphasis on dealing with meth has been punishment and imprisonment, but we may do well as a society to reserve prison for those who are involved in illegal drug sales or violence and support treatment for abusers," Hall said.

SOURCE: Hall's review article appeared in the April 2003 issue of the *Journal of Substance Abuse Treatment*.

Brain Recovery Possible for Meth Users

From JAMA News Release

Abstinence Can Reverse Some Brain Damage

Adaptive changes in chemical activity in certain regions of the brain of former methamphetamine users who have not used the drug for a year or more suggest some recovery of neuronal structure and function, according to an article in the April 2005 issue of *Archives of General Psychiatry*, one of the JAMA Archives journals.

Methamphetamine use has been shown to cause abnormalities in brain regions associated with selective attention and regions associated with memory, according to background information in the article. Recent animal and human studies suggest that neuronal changes associated with long-term methamphetamine use may not be permanent but may partially recover with prolonged abstinence.

Thomas E. Nordahl, M.D., Ph.D., of the University of California, Davis, and colleagues compared eight methamphetamine users who had not used methamphetamine for one to five years and 16 recently abstinent methamphetamine users who had not used the drug for one to six months with 13 healthy, non-substance-using controls using a method of brain imaging, proton magnetic resonance spectroscopy (MRS), that allows the visualization of biochemical markers that are linked with damage and recovery to the neurons in the brain.

The researchers measured biomarkers in the anterior cingulum cortex, a region of the brain associated with selective attention.

Levels of N-acetylaspartate (NAA), which is present only in neurons, were measured as a marker of the amount of damage (neuronal loss).

Neuronal Recovery

Choline (Cho), which is generated by the creation of new membranes and, the authors write, "may be an ideal marker to track changes consistent with neuronal recovery associated with drug abstinence," was measured as a biomarker of recovery.

Levels of NAA were abnormally low in all the methamphetamine users, the authors found. Levels were lower relative to the length of methamphetamine use, but did not change relative to the amount of time that the methamphetamine users had been abstinent. The researchers found elevated Cho levels in the methamphetamine users who had not used the drug in one to six months, but normalized levels in the longer abstainers.

Normalization of Function

"In the early periods following methamphetamine exposure, the brain may undergo several processes leading to increased membrane turnover. The relative Cho normalization across periods of abstinence suggests that when drug exposure is terminated, adaptive changes occur, which may contribute to some degree of normalization of neuronal structure and function," they write.

"The understanding of how the human brain can recover or partially recover as a function of extended drug abstinence has important implications both for the neurobiology of addiction and substance abuse treatment," the authors conclude. "Additional longitudinal studies…are needed to further understand the underlying physiological changes of stimulant drugs on the human brain."

MSNBC.com

Meth's aphrodisiac effect adds to drug's allure

Illegal substance boosts sexual appetite, researchers say

The Associated Press

Updated: 4:31 p.m. CT Dec 3, 2004

CHATTANOOGA, Tenn. - At a recent task force meeting on the epidemic of methamphetamine use in Appalachia, Gov. Phil Bredesen winced when a federal prosecutor described the illegal drug as an aphrodisiac.

Doctors and government officials don't like to talk much about it, but there is an obvious reason people get hooked on methamphetamine: sex.

Meth eventually destroys the sex drive, but for a short while it can boost sexual appetite and performance more powerfully than drugs such as cocaine, doctors say.

"Who wouldn't want to use it? You lose weight and you have great sex," Assistant U.S. Attorney Paul Laymon said sarcastically at the meeting of the Tennessee task force.

For obvious reasons, government officials want to focus on the misery meth causes.

Linked to brain damage and violent behavior

Use of the addictive drug can cause brain damage, violent behavior and hallucinations, and exposure to the potentially explosive vapors during the manufacture of meth can cause respiratory problems, headaches and nausea. In many gay clubs in New York City and elsewhere, meth is often injected, putting users and their partners at risk for HIV, hepatitis C and other sexually transmitted diseases.

As for why the drug has such a hold on people, Dr. Mary Holley, an obstetrician who runs a Mothers Against Methamphetamine ministry in Albertville, Ala., and has interviewed men and women addicted to meth, said sex is the No. 1 reason people use it.

"The effect of an IV hit of methamphetamine is the equivalent of 10 orgasms all on top of each other lasting for 30 minutes to an hour, with a feeling of arousal that lasts for another day and a half," she said.

The effect doesn't last long.

"After you have been using it about six months or so you can't have sex unless you are high," Holley said. "After you have been using it a little bit longer you can't have sex even when you're high. Nothing happens. It doesn't work."

Dr. John Standridge, an addiction specialist with the Council for Alcohol and Drug Abuse Services in Chattanooga, said meth and other stimulants initially “rev up the dopamine nervous system in the brain. They rev it up and burn it out.”

A National Institute on Drug Abuse survey on drug use and health in 2002 found that 12.4 million Americans at least 12 years old — or about 5 percent of the population — had tried meth at least once in their lifetimes. In a measure of how serious the problem is in Appalachia, a total of 1,083 clandestine methamphetamine labs were cleaned up in Tennessee in 2003 — more than in any other state.

A meth task force appointed by Bredesen is recommending tougher penalties and expanded treatment for addicts.

Meth’s reputation as a sex drug is not unique.

“All substance abuse is frequently marketed as enhancing sex life or making you more attractive or a better social companion,” said John Walters, the drug czar for President Bush. But he added that buying meth as an aphrodisiac is “buying under false pretenses.”

“Hair falls out. Teeth fall out,” Walters said. “That’s not sexy.”

URL: http://www.msnbc.msn.com/id/6646180/

Steroids

Common names: Oral = Anadrol, Oxandrin, Dianobol, Winstrol, and injected = Deca-Durabolin, Durabolin, Depo-Testerone, and Equipoise. The street name for Dehydroepian-Drosterone (DHEA) is Andro, which can be found in health food stores as a dietary supplement.

What is it?

Anabolic steroids are synthetic compounds that are related to the male sex hormone testosterone. They come in either tablet or liquid forms and are taken orally or injected. Bodybuilders, weightlifters, wrestlers, and other athletes use them because they can facilitate increased skeletal muscle growth. These athletes claim that steroids enhance their athletic performance as well. Research has found that steroid use can be highly addictive.

Short-term effects

Steroids may contribute to an increase in body weight and muscular strength. Side effects are a definite outcome of using steroids. These may include but are not limited to psychological reactions such as anger and aggressiveness. Physiological effects may include damage to the liver, heart attacks, acne, cysts, oily hair and skin, and a disruption of the normal production of hormones. In males these can cause a low sperm count, acne, a reduction of the testes, hair loss, male breasts, etc. In females, steroids can cause excessive body hair and loss of scalp hair, coarse skin, enlarged clitoris, a deepening of the voice, etc. In adolescents, steroids can affect bone growth by signaling the bones to stop growing sooner than they should. This effect is irreversible.

Long-term effects

The risk for heart attacks and strokes prior to the age of 30-years-old are significant. Some of the effects listed above are irreversible. Blood clots and liver tumors as well as blood-filled cysts in the liver can happen. Studies in mice have indicated the risk of premature death. Withdrawal symptoms can cause depression, mood swings, fatigue, restlessness, and loss of appetite, loss of sex drive, eating disorders, and other serious complications.

Signs of usage

Some people who actively use anabolic steroids have shown signs of irritability and aggression. These dark moods can lead to fights, armed robbery and other crimes.

Legal status

Several forms of steroids can be found in health food stores under the guise of a dietary supplement (i.e. DHEA or Andro – see above). Most others call for a prescription from a certified physician.

(Adapted from www.nida.nih.gov/researchreports/steroids)

APPENDIX B

Supplemental Resources

(Please refer to individual articles/resources for appropriate citation)

Effective Arguing

Stay on the topic
No "kitchen sinking." Do not bring everything but the kitchen sink into the argument.
If another topic comes up, save it and state that you can discuss it at another time.
Put boundaries around the subject matter so the argument doesn't become a free-for-all.

Avoid putdowns
No name calling or use of shut up.
Use "I feel" statements:

1. I Care – build on your relationship (I care about our family; I care about my/your future)
2. I See – state the facts, not opinion (I see you coming home drunk; I see you so upset….)
3. I Feel – state how the behavior makes you feel (I'm really worried what will happen; I feel angry that this happened)
4. LISTEN – this is the most important step, but can also be the most difficult
5. I Want – express what you want to happen next (I want our family to be peaceful; I want to know your safe)
6. I Will – express what you will or will not do to help the situation (I will call you if I'm going to be late; I will talk to you when I'm feeling angry)

Allow for retreat
State that you need a break/space.
Agree to come back to discussion if needed at a later point.

Use good listening skills
Listen intently and repeat what you understand the other person has said.
Verify correctness of interpretation of what was said.
Take turns – really.
Don't interrupt.

Keep your body in check
Be aware of your body (how loud are you talking/what is your body posture).
Take a few deep breaths.
Count to ten to prevent an explosion.

Choose your battles
You don't need to have an argument over every little thing you don't agree with about the other person's behavior.
Remember to look for the positive things too.
Agree to disagree.

Have a release when done
Engage in an activity to help your body release the stress.
Take a walk, play a video game, take a bath, listen to music, journal/write, do something physical.

Adolescent Brain Development and Drug Abuse

New findings indicate that brain development still in progress during adolescence; immature brain structures may place teenagers at elevated risk of substance abuse and arrested brain development.

Ken C. Winters, Ph.D.
Professor, Department of Psychiatry, University of Minnesota

A Special Report Commissioned by the Treatment Research Institute
Philadelphia, PA
A. Thomas McLellan, Executive Director

New scientific discoveries have put a much different perspective on the understanding of adolescent behavior. Research now suggests that the human brain is still maturing during the adolescent years, with changes continuing into the early 20s. The immature brain of the teenage years may not only explain why adolescents are prone to make poor decisions, but it may also place teenagers at an elevated risk to the harmful effects of drugs.

Work In Progress

Advanced technologies in brain imaging have provided windows to the developing brain. Based on the pioneering work of Jay Giedd and colleagues at the National Institute of Mental Health, evidence is accumulating that the brain is not fully formed at puberty as earlier thought, but continues important maturation that is not complete until about age 24.

Three brain structures that undergo maturation during youth – nucleus accumbens, amygdala and prefrontal cortex – are noteworthy in terms of their implications for understanding adolescent behavior. While scientists caution about suggesting definitive linkages between

neurodevelopmental findings and behavior, the discovery that brain construction is still in progress during adolescence offers several suggestive hypotheses.

The nucleus accumbens, which directs motivated behavior, is responsible for how much effort the organism will expend in order to seek rewards. In teenagers, an immature nucleus accumbens is believed to result in preferences for activities that require low effort yet produce high excitement. Real-world observations bear this out: most teenagers tend to favor activities such as playing video-games, skate boarding and, unfortunately, substance use.

The amygdala is the structure responsible for integrating emotional reactions to pleasurable and aversive experiences. It is believed that a developing amygdala contributes to two behavioral effects: the tendency for adolescents to react explosively to situations rather than with more controlled responses, and the propensity for youth to mis-read neutral or inquisitive facial expressions of others as a sign of anger.

And one of the last areas to mature is the prefrontal cortex, located just behind the forehead. Sometimes referred to as "the seat of sober second thought," it is the area of the brain responsible for the complex processing of information, ranging from making judgments, to controlling impulses, foreseeing consequences, and setting goals and plans. An immature prefrontal cortex is thought to be the neurobiological explanation for why teenagers show poor judgment and too often act before they think.

The Developing Brain and Drug Use

Scientists are now beginning to explore whether these new discoveries may help explain adolescent drug use and related impulsive behaviors. This is an important issue given that adolescence is a time of experimentation and novelty seeking. The 2003 Monitoring the Future study found that 70.1% of high school seniors had used alcohol in the past year and 34.9% had

used marijuana. Over half had tried an illicit drug at least once in their lifetime. Even among 8th graders, 45.6% had already tried alcohol and 22.8% reported illicit drug use in their lifetime (Johnston et al., 2003). And we know that most adult regular smokers begin using in adolescence, as do a majority of adults who meet alcohol abuse or dependence criteria (Clark et al., 1998). Youth who report first using alcohol before age 15 are more than five times as likely to report being an alcoholic compared to persons who first used alcohol at age 21 or older (Substance Abuse and Mental Health Administration, 2004).

From a neurodevelopment standpoint, two central questions merit scientific attention: Do neurodevelopmental factors predispose adolescents to seek out and abuse alcohol and drugs? And, are there any deleterious effects on brain development as result of drug use in adolescence? Evidence from both animal and human data pertain to each question.

Are adolescents more vulnerable than adults to abuse drugs? Several neurodevelopmental findings provide provisional answers to this question. As already noted, an immature prefrontal cortex increases the propensity of teenagers to act impulsively and to ignore the negative consequences of such behavior. In addition, an immature nucleus accumbens increases the adolescent's tendency to seek out activities that are exciting but require little effort. And there is growing evidence that one direct result of a developing amygdala is that adolescents subjectively report greater feelings of social disinhibition when drinking alcohol compared to adults (Spear, 2002). This effect would create a more pleasurable social experience (e.g., feeling less shy) while drinking compared to adults. All these effects of the developing brain – poor impulse control, favoring low-effort yet thrilling experiences, and heightened sensitivity to the social benefits of intoxication – may contribute to an initial decision to use drugs and make the experience rewarding enough to repeat it.

There are other considerations. In studies of adolescent rats, they are observed to be *less* sensitive to the effects of intoxication than adult rats. They typically consume two to three times as much alcohol for their body weight as adults (Spear, 2002). Adolescent humans also show this diminished sensitivity to intoxication; their higher metabolic rates allow them to consume higher amounts of alcohol (Spear, 2002). A lower sensitivity to alcohol's effects would be consistent with the observation that young people are capable of drinking large amounts of alcohol without feeling all that intoxicated. Hormones have a role as well. Hormones encourage novelty seeking and promote social competitiveness. Increased hormonal production during adolescence may promote drug use to the extent that drug involvement represents a novel experience to the youth who is also seeking social approval from peers during the experience.

Arrested development? A limited amount of science suggests that the developing brain is prone to the deleterious effects of alcohol. Adolescent rats exposed to various amounts of alcohol have significantly more brain damage in their frontal cortex than their adult counterparts (Spear, 2002). They also show greater damage to their working memory. With long-term use, adolescent rats have shown massive neuronal loss in their cerebellum, basal forebrain, and neocortex (Spear, 2002). In human brain scanning studies, adolescents with alcohol use disorders had significantly smaller volume in the hippocampus (the primary structure for memory), which led to greater memory retrieval deficits, compared to non-alcohol abusing controls (Brown et al., 2000).

Implications

It is too early to say whether this new understanding of neurodevelopment will lead to revolutionary tools in the treatment of substance abuse, such as new pharmacotherapies or even a "vaccine" against addiction.

Even as researchers explore these questions, the field must examine existing policies and psychosocial treatment approaches in light of the new findings. Creating age-appropriate curriculum to educate youth about their developing brain is one possibility. Another is to incorporate neurodevelopmental information into the educational materials used by prevention specialists and educators.

A third approach is to communicate findings to treatment specialists, helping them adjust therapeutic goals and expectations based on brain maturity. To some degree, older adolescents can engage in more complex cognitive tasks, such as weighing the pros and cons of unhealthy behaviors and considering more sophisticated approaches for resistance and relapse prevention. But younger teenagers will need to be taught relatively concrete strategies.

Finally, there are the public advocates whose role in treatment and prevention cannot be underestimated. An educational effort with these groups could yield empirically derived public service messages and campaigns, ones emphasizing delaying the onset of drug and alcohol use, preferably until adulthood, and/or avoiding permanent neurological damage by abstaining or reducing use during adolescence.

For More Information about Adolescent Brain Development and Substance Abuse Contact Ken Winters, Ph.D. at winte001@umn.edu

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ADHD

ADHD stands for **attention deficit hyperactivity disorder**. ADHD used to be known as **attention deficit disorder**, or ADD. In 1994, it was renamed ADHD. The term ADD is sometimes still used, though, to describe a type of ADHD that doesn't involve hyperactivity.

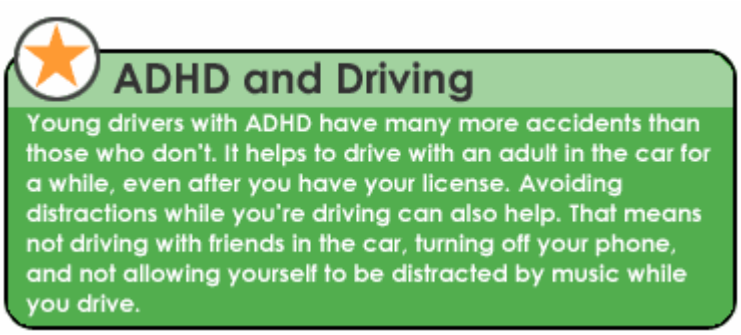
ADHD is a medical condition that affects how well someone can sit still, focus, and pay attention. People with ADHD have differences in the parts of their brains that control attention and activity. This means that they may have trouble focusing on certain tasks and subjects, or they may seem "wired," act impulsively, and get into trouble.

Symptoms and Signs of ADHD

Although ADHD begins in childhood, sometimes it's not diagnosed until a person is a teen — and occasionally not even until someone reaches adulthood.

Because ADHD is a broad category covering different things — attention, activity, and impulsivity — it can show up in different ways in different people. Some of the signs of ADHD are when someone:

- has difficulty paying attention or staying focused on a task or activity
- has problems finishing assignments at school or home and jumps from one activity to another
- has trouble focusing on instructions and difficulty following through
- loses or forgets things such as homework
- is easily distracted, even when doing something fun
- has problems paying close attention to details or makes careless mistakes
- has trouble organizing tasks and activities
- has difficulty waiting one's turn
- interrupts or intrudes on other people
- blurts out answers before questions have been completed
- fidgets with hands or feet or squirms about when seated
- feels restless
- talks excessively and has trouble engaging in activities quietly



Of course, it's normal for everyone to zone out in a boring class, jump into a conversation, or leave their homework on the kitchen table once in a while. But people with ADHD have so much trouble staying focused and controlling their behavior that it affects their emotions and how well they do in school or other areas of their lives. In fact, ADHD is often viewed as a learning disorder because it can interfere so much with a person's ability to study and learn.

Sometimes the symptoms of ADHD become less severe as a person grows older. For example, experts believe that the hyperactivity part of the disorder can diminish with age, although the problems with organization and attention often remain. Although some people may "grow out of" their symptoms, more than half of all kids who have ADHD will continue to show signs of the condition as young adults.

What Causes ADHD?

Doctors and researchers still aren't exactly sure why some people have ADHD. Research shows that ADHD is probably genetic and that it may be inherited in some cases. Scientists are also exploring other things that may be associated with ADHD: For example, ADHD may be more prevalent in kids who are born prematurely. It is also more common in guys than it is in girls.

Doctors do know that ADHD is caused by changes in brain chemicals called **neurotransmitters** (pronounced: nur-oh-**trans**-mih-terz). These chemicals help send messages between nerve cells in the brain. The neurotransmitter dopamine (pronounced: **doe**-puh-meen), for example, stimulates the brain's attention centers. So a person with low amounts of this chemical may show symptoms of ADHD.

How Is ADHD Treated?

Because there's no cure for ADHD, doctors treat people by helping them to manage the symptoms most effectively. Because some people have more trouble with the attention side of the disorder and others have more problems with the activity side, doctors tailor their treatment to the person's symptoms. So different people with ADHD may have different treatments.

Doctors usually follow a **multimodal** (pronounced: mul-tee-**moe**-dul) **approach** to ADHD treatment. This means that they use several different treatment methods for one patient, such as medication, family and

individual counseling, and changes at school to address particular learning styles.

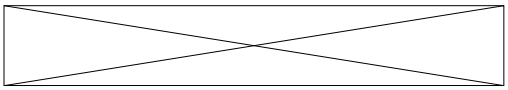
Certain medicines can help people with ADHD by improving their focus and attention and reducing the impulsiveness and hyperactivity associated with ADHD. People with ADHD used to have to take medicine several times a day, but now there are some that can be taken at home once a day in the morning. Scientists are constantly working to develop new medications to treat ADHD.

You can discuss treatment options with your doctor, but always follow the doctor's instructions about medication dosages. If you have been taking medicine for ADHD since you were a kid, your doctor will probably adjust your medication for changes in your symptoms as you get older.

Family counseling helps treat ADHD because it keeps parents informed and also shows them ways they can work with their kids to help. It also helps to improve communication within the family and to solve problems that come up between teens and their parents at home. Individual counseling helps teens with ADHD to better understand their behavior and to learn coping skills. Sometimes lots of teens with ADHD work together in group therapy, which helps them work on coping skills and getting along better with others, if that's been a problem.

Schools are also involved in helping students with ADHD — most will develop a plan that's right for each teen and make changes that allow learning in ways that work best for them.

People with ADHD may also have other problems, such as depression, anxiety, or learning disabilities like dyslexia, that require treatment. They also may be at greater risk for smoking and using drugs, especially if the ADHD is not appropriately treated. That's why proper diagnosis and treatment are critical.



If You or Someone You Know Has ADHD

Most teens with ADHD are diagnosed as kids, but some people aren't diagnosed until they're in their teens or even older. It's normal to feel overwhelmed, scared, or even angry if you've been diagnosed with ADHD. That's one thing counseling can help with. Talking about those feelings and dealing with them often makes the process much easier.

If you have ADHD, you may not be aware that you're behaving in a way that's different from others; you're just doing what comes naturally. This can sometimes cause problems with people who don't understand or know about your condition. For example, you might speak your mind to someone only to get the feeling that you've shocked or offended that person. You may not understand why people get mad at you.

Learning all you can about your condition can be a huge help. The more you understand, the more involved you can be in your own treatment. Here are some of the things you might try to help with school and relationships:

- Sit in the front of class to limit distractions.
- Turn off email, instant messaging, and your phone when doing homework or other tasks that require focused attention. This will help protect you against being distracted.
- Talk openly with your teacher about your condition and work together to be sure you're learning in a way that works for you. For example, some schools will allow people with ADHD more time for taking tests. Some teens may benefit from smaller class sizes and tutorial help.
- Use tools that help you stay organized. Keep a homework notebook to keep track of assignments, including a list of books and readings you'll need to bring home to do them. Write down classes, extracurricular activities, and other appointments in a daily planner so you don't forget. Keeping a daily agenda can also help you avoid making unplanned, impulsive decisions: If you're scheduled to start homework at 4:30, you'll know it's not a good idea to go with your friend to watch her 4:00 soccer practice. The organization skills you develop now will serve you well in the future, too. Even people who don't have ADHD all find they need to develop these skills when they head off to the workplace — so you'll be ahead of the curve!
- Get plenty of exercise. Studies are starting to show that exercise can help people who have ADHD. If you feel hyper during school, talk to a teacher about taking activity breaks so you can stay focused and concentrate better when in class. Take frequent activity breaks while studying or doing homework.
- Practice relaxation and meditation techniques to relax and focus. Try this breathing exercise for starters.
- Let friends know what's going on. Sometimes with our friends, we blurt things out and regret it later or we do silly, impulsive things. If this happens to you, let your friends know that sometimes you just say things without thinking all the way through, apologize if you have hurt someone's feelings, and try to be extra careful in new situations.
- Take pride in the things you do well. Having ADHD is just a different way of being, and people with ADHD have their own abilities and talents.

If you have ADHD, it's natural to feel misunderstood and frustrated at times. It might seem like you're always losing your homework or having trouble following teachers' instructions, or you may have trouble making friends or getting along with your family members. It helps to learn as much as you can about ADHD and to find the methods that will help you work to your full potential — both academically and socially.

The good news is that doctors, counselors, and teachers are learning more about ADHD all the time and have a greater understanding than ever of the challenges people living with it face.

Reviewed by: Mary L. Gavin, MD
Date reviewed: February 2006
Originally reviewed by: W. Douglas Tynan, PhD, and Richard S. Kingsley, MD

Do you ever find yourself getting really irritable for almost no reason? Or suddenly feeling down without knowing why? Going from sadness to anger to joy in a matter of minutes can make many teens feel as though they're losing their grip. But why is the feeling of being on an emotional roller coaster so common among teens?

Dealing with constant change and pressure is part of the answer. Maybe you're starting a new school and not able to see old friends as much. Getting good grades or wanting to be better in sports or other activities can be a concern for many teens. It might feel as though there just isn't enough time to do everything.

Being a teen means struggling with identity and self-image. Being accepted by friends feels extremely important. Teens also may notice, for the first time, a sense of distance from parents and family. You may feel you want to be on your own and make your own decisions, but it can also seem overwhelming and even a bit lonely at times. As fun and exciting as this time is, it also can be a time of confusion and conflict. It can take a while for teens — and their families — to feel comfortable with the transition between childhood and adulthood.

Another important cause for mood swings is biology. When puberty begins, the body starts producing sex hormones. These hormones — estrogen and progesterone in girls and testosterone in guys — cause physical changes in the body. But in some people, they also seem to cause emotional changes — the ups and downs that sometimes feel out of control.

Understanding that almost everyone goes through mood swings during their teen years might make them easier to handle.

When It's More Than Just a Mood

Feeling irritable or short-tempered can be signs of depression. So can feelings of boredom or hopelessness.

Many people think of depression as feeling sad, but depression can also bring feelings of moodiness, impatience, anger, or even just not caring. When depression gets in the way of enjoying life or dealing with others, that's a sign you need to do something about it, like talking to a counselor or therapist who can help you deal with it.

Taking Control

Here are some things you can do that might make those bad moods a bit easier to handle:

- **Recognize you're not alone.** Although not every teen experiences mood changes to the same degree, they are common.

- **Catch your breath**. Or count to 10. Or do something that lets you settle down for a few moments, especially if you're feeling angry or irritable. Try to look at the situation from the point of view of a wise observer.

- **Talk to people you trust**. Friends can help each other by realizing that they're not alone in their feelings. Talking to parents is important, too. Parents can share their own experiences dealing with bad moods. Plus, they'll appreciate it if you try to explain how you feel instead of just slamming a door. Teachers and counselors are often good resources, and a doctor can help sort through questions about development. Keeping feelings inside can make them seem much worse.

- **Exercise.** Regular exercise produces more beta-endorphin, a hormone that controls stress and improves mood. Go for a run, play some tennis, ride your bike, or punch a punching bag.

- **Get enough sleep**. Though it can be hard to find enough time, getting adequate rest is very important. Being tired can lead to more sadness and irritability.

- **Create.** Get involved in some sort of project, like starting a journal or diary, building something out of wood, or starting an art or music piece. Writing can help you organize and express your thoughts and feelings and will make things more manageable. Don't worry about grammar,

spelling, or punctuation; the important thing is just to get your thoughts on paper. Do the same thing with paint, sculpture, music, or other art forms. Put your feelings into your artwork.

- **Cry.** There's nothing wrong with crying; in fact, it often makes a person feel better. However, if you find that you are sad, irritable, bored, or hopeless much of the time, or if you just can't seem to shake the blues, you might be depressed and need help from a counselor or doctor. If you're feeling stressed or angry a lot of the time, getting help could be very useful for you.

- **Wait.** Just as you can get into a bad mood for what seems like no reason at times, that mood can also pass. If your negative mood sticks around too long, though — or if it's interfering with the way you deal with friends, parents, school, or activities — then you may want to talk to a school counselor, parent, or therapist about what you can do to feel better.

Reviewed by: Neil Izenberg, MD
Date reviewed: September 2004
Originally reviewed by: Jonathan A. Schneider, DO

I'm fat. I'm too skinny. I'd be happy if I were taller, shorter, had curly hair, straight hair, a smaller nose, bigger muscles, longer legs.

Do any of these statements sound familiar? Are you used to putting yourself down? If so, you're not alone. As a teen, you're going through a ton of changes in your body. And as your body changes, so does your image of yourself. Lots of people have trouble adjusting, and this can affect their self-esteem.

Why Are Self-Esteem and Body Image Important?

Self-esteem is all about how much people value themselves, the pride they feel in themselves, and how worthwhile they feel. Self-esteem is important because feeling good about yourself can affect how you act. A person who has high self-esteem will make friends easily, is more in control of his or her behavior, and will enjoy life more.

Body image is how a person feels about his or her own physical appearance.

For many people, especially people in their early teens, body image can be closely linked to self-esteem. That’s because as kids develop into teens, they care more about how others see them.

What Influences a Person’s Self-Esteem?

Puberty

Some teens struggle with their self-esteem when they begin puberty because the body goes through many changes. These changes, combined with a natural desire to feel accepted, mean it can be tempting for people to compare themselves to others. They may compare themselves to the people around them or to actors and celebs they see on TV, in movies, or in magazines.

But it's impossible to compare ourselves to others because the changes that come with puberty are different for everyone. Some people start developing early; others are late bloomers. Some get a temporary layer of fat to prepare for a growth spurt, others fill out permanently, and others feel like they stay skinny no matter how much they eat. It all depends on how our genes have programmed our bodies to act.

The changes that come with puberty can affect how both girls and guys feel about themselves. Some girls may feel uncomfortable or embarrassed about their maturing bodies. Others may wish that they were developing faster. Girls may feel pressure to be thin but guys may feel like they don't look big or muscular enough.

Outside Influences

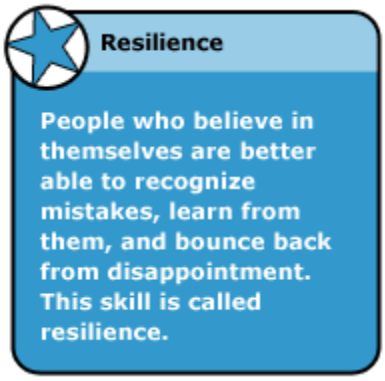
It's not just development that affect self-esteem, though. Lots of other factors (like media images of skinny girls and bulked-up guys) can affect a person's body image too.

Family life can sometimes influence a person's self-esteem. Some parents spend more time criticizing their children and the way they look than praising them. This criticism may reduce a person's ability to develop good self-esteem.

People may also experience negative comments and hurtful teasing about the way they look from classmates and peers. Sometimes racial and ethnic prejudice is the source of such comments. Although these comments often come from ignorance on the part of the person who makes them, sometimes they can affect a person's body image and self-esteem.

Healthy Self-Esteem

If you have a positive body image, you probably like and accept yourself the way you are. This healthy attitude allows you to explore other aspects of growing up, such as developing good friendships, growing more independent from your parents, and challenging yourself physically and mentally. Developing these parts of yourself can help boost your self-esteem.



A positive, optimistic attitude can help people develop strong self-esteem. For example, saying, "Hey, I'm human," instead of "Wow, I'm such a loser," when you've made a mistake. Or not blaming others when things don't go as expected.

Knowing what makes you happy and how to meet your goals can help you feel capable, strong, and in control of your life. A positive attitude and a healthy lifestyle (such as exercising and eating right) are a great combination for building good self-esteem.

Tips for Improving Your Body Image

Some people think they need to change how they look or act to feel good about themselves. But actually all you need to do is change the way you see your body and how you think about yourself.

The first thing to do is recognize that your body is your own, no matter what shape, size, or color it comes in. If you are very worried about your weight or size, check with your doctor to verify that things are OK. But it is no one's business but your own what your body is like — ultimately, you have to be happy with yourself.

Next, identify which aspects of your appearance you can realistically change and which you can't. Everyone (even the most perfect-seeming celeb) has things about themselves that they can't change and need to accept — like their height, for example, or their shoe size.

If there are things about yourself that you want to change and can (such as how fit you are), do this by making goals for yourself. For example, if you want to get fit, make a plan to exercise every day and eat nutritious foods. Then keep track of your progress until you reach your goal. Meeting a challenge you set for yourself is a great way to boost self-esteem!

When you hear negative comments coming from within yourself, tell yourself to stop. Try building your self-esteem by giving yourself three compliments every day. While you're at it, every evening list three things in your day that really gave you pleasure. It can be anything from the way the sun felt on your face, the sound of your favorite band, or the way someone laughed at your jokes. By focusing on the good things you do and the positive aspects of your life, you can change how you feel about yourself.

Where Can I Go if I Need Help?

Sometimes low self-esteem and body image problems are too much to handle alone. A few teens may become depressed, lose interest in activities or friends — and even hurt themselves or resort to alcohol or drug abuse. If you're feeling this way, it can help to talk to a parent, coach, religious leader, guidance counselor, therapist, or an adult friend. A trusted adult — someone who supports you and doesn't bring you down — can help you put your body image in perspective and give you positive feedback about your body, your skills, and your abilities.

If you can't turn to anyone you know, call a teen crisis hotline (check the yellow pages under social services). The most important thing is to get help if you feel like your body image and self-esteem are affecting your life.

Reviewed by: Barbara P. Homeier, MD
Date reviewed: April 2006
Originally reviewed by: Jonathan A. Schneider, DO

ANXIETY DISORDERS

What are anxiety disorders?

Anxiety disorders range from feelings of uneasiness to immobilizing bouts of terror. This fact sheet briefly describes the different types of anxiety disorders. This fact sheet is not exhaustive, nor does it include the full range of symptoms and treatments. Keep in mind that new research can yield rapid and dramatic changes in our understanding of and approaches to mental disorders. If you believe you or a loved one has an anxiety disorder, seek competent, professional advice or another form of support.

Generalized Anxiety Disorder: Most people experience anxiety at some point in their lives and some nervousness in anticipation of a real situation. However if a person cannot shake unwarranted worries, or if the feelings are jarring to the point of avoiding everyday activities, he or she most likely has an anxiety disorder.

Symptoms: Chronic, exaggerated worry, tension, and irritability that appear to have no cause or are more intense than the situation warrants. Physical signs, such as restlessness, trouble falling or staying asleep, headaches, trembling, twitching, muscle tension, or sweating, often accompany these psychological symptoms.

Formal diagnosis: When someone spends at least six months worried excessively about everyday problems. However, incapacitating or troublesome symptoms warranting treatment may exist for shorter periods of time.

Treatment: Anxiety is among the most common, most treatable mental disorders. Effective treatments include cognitive behavioral therapy, relaxation techniques, and biofeedback to control muscle tension. Medication, most commonly anti-anxiety drugs, such as benzodiazepine and its derivatives, also may be required in some cases. Some commonly prescribed anti-anxiety medications are diazepam, alprazolam, and lorazepam. The non-benzodiazepine anti-anxiety medication buspirone can be helpful for some individuals.

Panic Disorder: People with panic disorder experience white-knuckled, heart-pounding terror that strikes suddenly and without warning. Since they cannot predict when a panic attack will seize them, many people live in persistent worry that another one could overcome them at any moment.

Symptoms: Pounding heart, chest pains, lightheadedness or dizziness, nausea, shortness of breath, shaking or trembling, choking, fear of dying, sweating, feelings of unreality, numbness or tingling, hot flashes or chills, and a feeling of going out of control or going crazy.

Formal Diagnosis: Either four attacks within four weeks or one or more attacks followed by at least a month of persistent fear of having another attack. A minimum of four of the symptoms listed above developed during at least one of the attacks. Most panic attacks last only a few minutes, but they occasionally go on for ten minutes, and, in rare cases, have been known to last

for as long as an hour. They can occur at any time, even during sleep.
Treatment: Cognitive behavioral therapy and medications such as high-potency anti-anxiety drugs like alprazolam. Several classes of antidepressants (such as paroxetine, one of the newer selective serotonin reuptake inhibitors) and the older tricyclics and monoamine oxidase inhibitors (MAO inhibitors) are considered "gold standards" for treating panic disorder. Sometimes a combination of therapy and medication is the most effective approach to helping people manage their symptoms. Proper treatment helps 70 to 90 percent of people with panic disorder, usually within six to eight weeks.

Phobias: Most of us steer clear of certain, hazardous things. Phobias however, are irrational fears that lead people to altogether avoid specific things or situations that trigger intense anxiety. Phobias occur in several forms, for example, agoraphobia is the fear of being in any situation that might trigger a panic attack and from which escape might be difficult. Social phobia is a fear of being extremely embarrassed in front of other people. The most common social phobia is fear of public speaking.
Symptoms: Many of the physical symptoms that accompany panic attacks - such as sweating, racing heart, and trembling - also occur with phobias.
Formal Diagnosis: The person experiences extreme anxiety with exposure to the object or situation; recognizes that his or her fear is excessive or unreasonable; and finds that normal routines, social activities, or relationships are significantly impaired as a result of these fears.
Treatment: Cognitive behavioral therapy has the best track record for helping people overcome most phobic disorders. The goals of this therapy are to desensitize a person to feared situations or to teach a person how to recognize, relax, and cope with anxious thoughts and feelings. Medications, such as anti-anxiety agents or antidepressants, can also help relieve symptoms. Sometimes therapy and medication are combined to treat phobias.

Post-traumatic Stress Disorder: Researchers now know that anyone, even children, can develop PTSD if they have experienced, witnessed, or participated in a traumatic occurrence-especially if the event was life threatening. PTSD can result from terrifying experiences such as rape, kidnapping, natural disasters, or war or serious accidents such as airplane crashes. The psychological damage such incidents cause can interfere with a person's ability to hold a job or to develop intimate relationships with others.
Symptoms: The symptoms of PTSD can range from constantly reliving the event to a general emotional numbing. Persistent anxiety, exaggerated startle reactions, difficulty concentrating, nightmares, and insomnia are common. People with PTSD typically avoid situations that remind them of the traumatic event, because they provoke intense distress or even panic attacks.
Formal Diagnosis: Although the symptoms of PTSD may be an appropriate initial response to a traumatic event, they are considered part of a disorder when they persist beyond three months.
Treatment: Psychotherapy can help people who have PTSD regain a sense of control over their lives. They also may need cognitive behavior therapy to change painful and intrusive patterns of behavior and thought and to learn relaxation techniques. Support from family and friends can help speed recovery and healing. Medications, such as antidepressants and anti-anxiety agents to reduce anxiety, can ease the symptoms of depression and sleep problems. Treatment for PTSD often includes both psychotherapy and medication.

For more information, as well as referrals to specialists and self-help groups in your State, contact:

Anxiety Disorders Association of America
8730 Georgia Avenue - Suite 600
Silver Spring, MD 20910
Telephone: 240-485-1001
Fax: 240-485-1035
www.adaa.org

Mental Help Net
CenterSite, LLC
570 Metro Place
Dublin, OH 43017
http://mentalhelp.net/poc/center_index.php?id=1

National Mental Health Association
2001 Beauregard Street, 12th Floor
Alexandria, VA 22311
Telephone: 800-969-6642
Fax: 703-684-5968
(TDD): 800-433-5959
www.nmha.org/infoctr/factsheets/index.cfm

The National Institute of Mental Health's toll-free information line is 1-888-ANXIETY; their web address is www.nimh.nih.gov/anxiety/anxietymenu.cfm.

Note: These are suggested resources. This is not meant to be a complete list.

Dealing With the Effects of Trauma
A Self-Help Guide

Introduction

This is a serious issue. This booklet is just an introduction—a starting point that may give you the courage to take action. It is not meant to be a treatment program. The ideas and strategies are not intended to replace treatment you are currently receiving.

You may have had one or many very upsetting, frightening, or traumatic things happen to you in your life, or that threatened or hurt something you love—even your community. When these kinds of things happen, you may not "get over" them quickly. In fact, you may feel the effects of these traumas for many years, even for the rest of your life. Sometimes you don't even notice effects right after the trauma happens. Years later you may begin having thoughts, nightmares, and other disturbing symptoms. You may develop these symptoms and not even remember the traumatic thing or things that once happened to you.

For many years, the traumatic things that happened to people were overlooked as a possible cause of frightening, distressing, and sometimes disabling emotional symptoms such as depression, anxiety, phobias, delusions, flashbacks, and being out of touch with reality. In recent years, many researchers and health care providers have become convinced of the connection between trauma and these symptoms. They are developing new treatment programs and revising old ones to better meet the needs of people who have had traumatic experiences.

This booklet can help you to know if traumatic experiences in your life may be causing some or all of the difficult symptoms you are experiencing. It may give you some guidance in working to relieve these symptoms and share with you some simple and safe things you can do to help yourself heal from the effects of trauma.

Some examples of traumatic experiences that may be causing your symptoms include —

- physical, emotional, or sexual abuse
- neglect
- war experiences

- outbursts of temper and rage
- alcoholism (your own or in your family)
- physical illnesses, surgeries, and disabilities
- sickness in your family
- loss of close family members and friends
- natural disasters
- accidents

Some things that may be very traumatic to one person hardly seem to bother another person. If something bothers you a lot and it doesn't bother someone else, it doesn't mean there is something wrong with you. People respond to experiences differently.

Do you feel that traumatic things that happened to you may be causing some or all of your distressing and disabling emotional symptoms? Examples of symptoms that may be caused by trauma include —

- anxiety
- insomnia
- agitation
- irritability or rage
- flashbacks or intrusive memories
- feeling disconnected from the world
- unrest in certain situations
- being "shut down"
- being very passive
- feeling depressed
- eating problems
- needing to do certain things over and over
- unusual fears
- impatience

- always having to have things a certain way
- doing strange or risky things
- having a hard time concentrating
- wanting to hurt yourself
- being unable to trust anyone
- feeling unlikable
- feeling unsafe
- using harmful substances
- keeping to yourself
- overworking

Perhaps you have been told that you have a psychiatric or mental illness like depression, bipolar disorder or manic depression, schizophrenia, borderline personality disorder, obsessive—compulsive disorder, dissociative disorder, an eating disorder, or an anxiety disorder. The ways you can help yourself handle these symptoms and the things your health care providers suggest as treatment may be helpful whether your symptoms are caused by trauma or by a psychiatric illness.

Help From Health Care Providers, Counselors and Groups

You may decide to reach out to health care providers for assistance in relieving the effects of trauma. This is a good idea. The effects of trauma, even trauma that happened many years ago, can affect your health. You may have an illness that needs treatment. In addition, your health care provider may suggest that you take medications or certain food supplements to relieve your symptoms. Many people find that getting this kind of health care support gives them the relief and energy they need to work on other aspects of healing. To find health care providers in your community who have expertise in addressing issues related to trauma, contact your local mental health agency, hospital, or crisis service.

If you possibly can, work with a counselor or in a special program designed for people who have been traumatized. A counselor or people leading the program may refer you to a group. These groups can be very helpful. However, keep in mind that you need to decide for yourself what you are going to do, and how and when you are going to do it. **You must be in charge of your recovery in every way.**

Wherever you go for help, the program or treatment should include the following:

Empowerment–You must be in charge of your healing in every way to counteract the effects of the trauma where all control was taken away from you.

Validation–You need others to listen to you, to validate the importance of what happened to you, to bear witness, and to understand the role of this trauma in your life.

Connection–Trauma makes you feel very alone. As part of your healing, you need to reconnect with others. This connection may be part of your treatment.

If you feel the cause of your symptoms is related to trauma in your life, you will want to be careful about your treatment and in making decisions about other areas of your life. The following guidelines will help you decide how to help yourself feel better.

Have hope. It is important that you know that you can and will feel better. In the past you may have thought you would never feel better—that the horrible symptoms you experience would go on for the rest of your life. Many people who have experienced the same symptoms that you are experiencing are now feeling much better.

They have gone on to make their lives the way they want them to be and to do the things they want to do.

Take personal responsibility. When you have been traumatized, you lose control of your life. You may feel as though you still don't have any control over your life. You begin to take back that control by being in charge of every aspect of your life. Others, including your spouse, family members, friends, and health care professionals will try to tell you what to do. Before you do what they suggest, think about it carefully. Do you feel that it is the best thing for you to do right now? If not, do not do it. You can follow others advice, but be aware that you are choosing to do so. It is important that you make decisions about your own life. You are responsible for your own behavior. Being traumatized is not an acceptable excuse for behavior that hurts you or hurts others.

Talk to one or more people about what happened to you. Telling others about the trauma is an important part of healing the effects of trauma. Make sure the person or people you decide to tell are safe people, people who would not hurt you, and who understand that what happened to you is serious. They should know, or you could tell them, that describing what happened to you over and over is an important part of the healing process.

Don't tell a person who responds with statements that invalidate your experience, like "That wasn't so bad." "You should just forget about it," "Forgive and forget," or "You think that's bad, let me tell you what happened to me." They don't understand. In connecting with others, avoid spending all your time talking about your traumatic experiences. Spend time listening to others and sharing positive life experiences, like going to movies or watching a ball game together. You will know when you have described your trauma enough, because you won't feel like doing it anymore.

Develop a close relationship with another person. You may not feel close to or trust anyone. This may be a result of your traumatic experiences. Part of healing means trusting people again. Think about the person in your life that you like best. Invite them to do something fun with you. If that feels good, make a plan to do something else together at another time—maybe the following week. Keep doing this until you feel close to this person. Then, without giving up on that person, start developing a close relationship with another person. Keep doing this until you have close relationships with at least five people. Support groups and peer support centers are good places to meet people.

Things You Can Do Every Day to Help Yourself Feel Better

There are many things that happen every day that can cause you to feel ill, uncomfortable, upset, anxious, or irritated. You will want to do things to help yourself feel better as quickly as possible, without doing anything that has negative consequences, for example, drinking, committing crimes, hurting yourself, risking your life, or eating lots of junk food.

- **Read through the following list.** Check off the ideas that appeal to you and give each of them a try when you need to help yourself feel better. Make a list of the ones you find to be most useful, along with those you have successfully used in the past, and hang the list in a prominent place—like on your refrigerator door-as a reminder at times when you need to comfort yourself. Use these techniques whenever you are having a hard time or as a special treat to yourself.

- **Do something fun or creative,** something you really enjoy, like crafts, needlework, painting, drawing, woodworking, making a sculpture, reading fiction, comics, mystery novels, or inspirational writings, doing crossword or jigsaw puzzles, playing a game, taking some photographs, going fishing, going to a movie or other community event, or gardening.

- **Get some exercise.** Exercise is a great way to help yourself feel better while improving your overall stamina and health. The right exercise can even be fun.

- **Write something.** Writing can help you feel better. You can keep lists, record dreams, respond to questions, and explore your feelings. All ways are correct. Don't worry about how well you write. It's not important. It is only for you. Writing about the trauma or

traumatic events also helps a lot. It allows you to safely process the emotions you are experiencing. It tells your mind that you are taking care of the situation and helps to relieve the difficult symptoms you may be experiencing. Keep your writings in a safe place where others cannot read them. Share them only with people you feel comfortable with. You may even want to write a letter to the person or people who have treated you badly, telling them how it affected you, and not send the letter.

- **Use your spiritual resources.** Spiritual resources and making use of these resources varies from person to person. For some people it means praying, going to church, or reaching out to a member of the clergy. For others it is meditating or reading affirmations and other kinds of inspirational materials. It may include rituals and ceremonies—whatever feels right to you. Spiritual work does not necessarily occur within the bounds of an organized religion. Remember, you can be spiritual without being religious.

- **Do something routine.** When you don't feel well, it helps to do something "normal"—the kind of thing you do every day or often, things that are part of your routine like taking a shower, washing your hair, making yourself a sandwich, calling a friend or family member, making your bed, walking the dog, or getting gas in the car.

- **Wear something that makes you feel good.** Everybody has certain clothes or jewelry that they enjoy wearing. These are the things to wear when you need to comfort yourself.

- **Get some little things done.** It always helps you feel better if you accomplish something, even if it is a very small thing. Think of some easy things to do that don't take much time. Then do them. Here are some ideas: clean out one drawer, put five pictures in a photo album, dust a book case, read a page in a favorite book, do a load of laundry, cook yourself something healthful, send someone a card.

- **Learn something new.** Think about a topic that you are interested in but have never explored. Find some information on it in the library. Check it out on the Internet. Go to a class. Look at something in a new way. Read a favorite saying, poem, or piece of scripture, and see if you can find new meaning in it.

- **Do a reality check.** Checking in on what is really going on rather than responding to your initial "gut reaction" can be very helpful. For instance, if you come in the house and loud music is playing, it may trigger the thinking that someone is playing the music just to annoy you. The initial reaction is to get really angry with them. That would make both of you feel awful. A reality check gives the person playing the loud music a chance to look at what is really going on. Perhaps the person playing the music thought you wouldn't be in until later and took advantage of the opportunity to play loud music. If you would call upstairs and ask him to turn down the music so you could rest, he probably would say, “Sure!" It helps if you can stop yourself from jumping to conclusions before you check the facts.

- **Be present in the moment.** This is often referred to as mindfulness. Many of us spend so much time focusing on the future or thinking about the past that we miss out on fully experiencing what is going on in the present. Making a conscious effort to focus your attention on what you are doing right now and what is happening around you can help you feel better. Look around at nature. Feel the weather. Look at the sky when it is filled with stars.

- **Stare at something pretty or something that has special meaning for you.** Stop what you are doing and take a long, close look at a flower, a leaf, a plant, the sky, a work of art, a souvenir from an adventure, a picture of a loved one, or a picture of yourself. Notice how much better you feel after doing this.

- **Play with children in your family or with a pet.** Romping in the grass with a dog, petting a kitten, reading a story to a child, rocking a baby, and similar activities have a calming effect which translates into feeling better.

- **Do a relaxation exercise.** There are many good books available that describe relaxation exercises. Try them to discover which ones you prefer. Practice them daily. Use them whenever you need to help yourself feel better. Relaxation tapes which feature relaxing music or nature sounds are available. Just listening for 10 minutes can help you feel better.

- **Take a warm bath.** This may sound simplistic, but it helps. If you are lucky enough to have access to a Jacuzzi or hot tub, it's even better. Warm water is relaxing and healing.

- **Expose yourself to something that smells good to you.** Many people have discovered fragrances that help them feel good. Sometimes a bouquet of fragrant flowers or the smell of fresh baked bread will help you feel better.

- **Listen to music.** Pay attention to your sense of hearing by pampering yourself with delightful music you really enjoy. Libraries often have records and tapes available for loan. If you enjoy music, make it an essential part of every day.

- **Make music.** Making music is also a good way to help yourself feel better. Drums and other kinds of musical instruments are popular ways of relieving tension and increasing well-being. Perhaps you have an instrument that you enjoy playing, like a harmonica, kazoo, penny whistle, or guitar.

- **Sing. Singing helps.** It fills your lungs with fresh air and makes you feel better. Sing to yourself. Sing at the top of your lungs. Sing when you are driving your car. Sing when you are in the shower. Sing for the fun of it. Sing along with favorite records, tapes, compact discs, or the radio. Sing the favorite songs you remember from your childhood.

Perhaps you can think of some other things you could do that would help you feel better.

The Healing Journey

Begin your healing journey by thinking about how it is you would like to feel. Write it down or tell someone else. In order to promote your own healing, you may want to work on one or several of the following issues that you know would help you to feel better.

- Learn to know and appreciate your body. Your body is a miracle. Focus on different parts of your body and how they feel. Think about what that part of your body does for you. Go to your library and review books that teach you about your body and how it works.

- Set boundaries and limits that feel right to you. In all relationships you have the right to define your own limits and boundaries so that you feel comfortable and safe. Say "no" to anything you don't want. For instance, if someone calls you five times a day, you have the right to ask them to call you less often, or even not to call you at all. If someone comes to your home when you don't want them to be there, you have the right to ask them to leave. Think about what your boundaries are. They may differ from person to person. You may enjoy it a lot when your sister comes to visit, but you may not want a visit from your brother or a cousin. You may not want anyone to call you on the phone after 10 p.m. Expect and insist that others respect your boundaries.

- Learn to be a good advocate for yourself. Ask for what you want and deserve. Work toward getting what you want and need for yourself. If you want to get more education for yourself so you can do work that you enjoy, find out about available programs, and do what it is you need to do to meet your goal. If you want your physician to help you find the cause of physical problems, insist that he or she do so, or refer you to someone else. When you are making important decisions about your life, like getting or staying married, going back to school, or parenting a child, be sure the decision you make is really in your best interest.

- Build your self-esteem. You are a very special and wonderful person. You deserve all the best things that life has to offer. Remind yourself of this over and over again. Go to the library and review books on building your self-esteem. Do some of the suggested activities.

- Develop a list of activities that help you feel better (refer to the list in the section "Things you can do to help yourself feel better"). Do some of these activities every day. Spend more time doing these activities when you are feeling badly.

- Every family develops certain patterns or ways of thinking about and doing things. Those things you learn in your family as a child will often influence you as an adult—sometimes making your life more difficult and getting in the way of meeting your personal goals. Think about the ways of thinking and doing things that guide you in your life. Ask yourself if they are patterns, and if you need to change them to make your life the way you want it to be. For example, in your family you may have been taught that you never tell anyone certain family secrets. In fact, it may be very important to share some family secrets with trusted friends or health care providers. Or you may have been taught that you must always do what certain members of your family want you to do. As an adult, it is

important that you figure out for yourself what it is you want to do. In effect you can become your own loving parent.

- Work to establish harmony with your family or the people you live with. Plan fun and interesting activities with them. Listen to them without being critical.

- Work on learning to communicate with others so that they can easily understand what you mean. When talking with another person about your feelings, use "I" statements, like "I feel sad" or "I feel upset" rather than accusing the other person. You may want to practice good communication with a friend. Ask your friend to give you feedback on how you can be more easily understood.

- You may have lots of negative thoughts about yourself and your life. Work on changing these negative thoughts to positive ones. The more you think positive thoughts the better you will feel. For instance, you may always think, "Nobody likes me." When you think that thought, replace it with a thought like, "I have many friends." If you often think that you will never feel better, replace that thought with the thought, "Every day I am feeling better and better."

- Develop an action plan for prevention and recovery. This is a simple plan that helps you stay well and respond to upsetting symptoms and events in ways that will keep you feeling well.

Using the activities in the section "Things you can do to help yourself feel better," make lists of things that will help you keep yourself well and will help you to feel better when you are not feeling well. Include lists:

- to remind yourself of things you need to do every day - like getting a half hour of exercise and eating three healthy meals - and also those things that you may not need to do every day, but if you miss them they will cause stress in your life, for example, buying food, paying bills, or cleaning your home;

- of events or situations that may make you feel worse if they come up, like a fight with a family member, health care provider, or social worker, getting a big bill, or loss of something important to you. Then list things to do (relax, talk to a friend, play your guitar) if these things happen so you won't start feeling badly;

- of early warning signs that indicate you are starting to feel worse - like always feeling tired, sleeping too much, overeating, dropping things, and losing things. Then list things to do (get more rest, take some time off, arrange an appointment with your counselor, cut back on caffeine) to help yourself feel better;

- of signs that things are getting much worse, like you are feeling very depressed, you can't get out of bed in the morning, or you feel negative about everything. Then list things to do that will help you feel better quickly (get someone to stay with you, spend extra time doing things you enjoy, contact your doctor); and

- of information that can be used by others if you become unable to take care of yourself or keep yourself safe, such as signs that indicate you need their help, who you want to help you (give copies of this list to each of these people), the names of your doctor, counselor and pharmacist, all prescriptions and over-the-counter medications, things that others can do that would help you feel better or keep you safe, and things you do not want others to do or that might make you feel worse.

Barriers to Healing

Are there any things you are doing that are getting in the way of your healing, such as alcohol or drug abuse, being in abusive or unsupportive relationships, self-destructive behaviors such as blaming and shaming yourself, and not taking good care of yourself? Think about the possible negative consequences of these behaviors. For instance, if you get drunk, you might lose control of yourself and the situation and be taken advantage of. If you overeat, the negative consequences might be weight gain, poor body image, and poor health. You may want to work on changing these behaviors by using self-help books, working with a counselor, joining a support group, or attending a 12-step program.

Moving Forward on Your Healing Journey

If you are now about to begin working on recovering from the effects of trauma, or if you have already begun this work and are planning to continue making some changes based on what you have learned, you will need courage and persistence along the way. You may experience setbacks. From time to time you may get so discouraged that you feel like you want to give up. This happens to everyone. Notice how far you've come. Appreciate even a little progress. Do something nice for yourself and continue your efforts. You deserve an enjoyable life.

Always keep in mind that there are many people, even famous people, who have had traumatic things happen to them. They have worked to relieve the symptoms of this trauma and have gone on to lead happy and rewarding lives. You can too.

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services
Web site: www.samhsa.gov

Controlling Anger -- Before It Controls You

We all know what anger is, and we've all felt it: whether as a fleeting annoyance or as full-fledged rage.

Anger is a completely normal, usually healthy, human emotion. But when it gets out of control and turns destructive, it can lead to problems—problems at work, in your personal relationships, and in the overall quality of your life. And it can make you feel as though you're at the mercy of an unpredictable and powerful emotion. This brochure is meant to help you understand and control anger.

What is Anger?

The Nature of Anger

Anger is "an emotional state that varies in intensity from mild irritation to intense fury and rage," according to Charles Spielberger, PhD, a psychologist who specializes in the study of anger. Like other emotions, it is accompanied by physiological and biological changes; when you get angry, your heart rate and blood pressure go up, as do the levels of your energy hormones, adrenaline, and noradrenaline.

Anger can be caused by both external and internal events. You could be angry at a specific person (Such as a coworker or supervisor) or event (a traffic jam, a canceled flight), or your anger could be caused by worrying or brooding about your personal problems. Memories of traumatic or enraging events can also trigger angry feelings.

Expressing Anger

The instinctive, natural way to express anger is to respond aggressively. Anger is a natural, adaptive response to threats; it inspires powerful, often aggressive, feelings and behaviors, which allow us to fight and to defend ourselves when we are attacked. A certain amount of anger, therefore, is necessary to our survival.

On the other hand, we can't physically lash out at every person or object that irritates or annoys us; laws, social norms, and common sense place limits on how far our anger can take us.

People use a variety of both conscious and unconscious processes to deal with their angry feelings. The three main approaches are expressing, suppressing, and calming. Expressing your angry feelings in an assertive—not aggressive—manner is the healthiest way to express anger. To do this, you have to learn how to make clear what your needs are, and how to get them met, without hurting others. Being

assertive doesn't mean being pushy or demanding; it means being respectful of yourself and others.

Anger can be suppressed, and then converted or redirected. This happens when you hold in your anger, stop thinking about it, and focus on something positive. The aim is to inhibit or suppress your anger and convert it into more constructive behavior. The danger in this type of response is that if it isn't allowed outward expression, your anger can turn inward—on yourself. Anger turned inward may cause hypertension, high blood pressure, or depression.

Unexpressed anger can create other problems. It can lead to pathological expressions of anger, such as passive-aggressive behavior (getting back at people indirectly, without telling them why, rather than confronting them head-on) or a personality that seems perpetually cynical and hostile. People who are constantly putting others down, criticizing everything, and making cynical comments haven't learned how to constructively express their anger. Not surprisingly, they aren't likely to have many successful relationships.

Finally, you can calm down inside. This means not just controlling your outward behavior, but also controlling your internal responses, taking steps to lower your heart rate, calm yourself down, and let the feelings subside.

As Dr. Spielberger notes, "when none of these three techniques work, that's when someone—or something—is going to get hurt."

Anger Management

The goal of anger management is to reduce both your emotional feelings and the physiological arousal that anger causes. You can't get rid of, or avoid, the things or the people that enrage you, nor can you change them, but you can learn to control your reactions.

Are You Too Angry?

There are psychological tests that measure the intensity of angry feelings, how prone to anger you are, and how well you handle it. But chances are good that if you do have a problem with anger, you already know it. If you find yourself acting in ways that seem out of control and frightening, you might need help finding better ways to deal with this emotion.

Why Are Some People More Angry Than Others?

According to Jerry Deffenbacher, PhD, a psychologist who specializes in anger management, some people really are more "hotheaded" than others are; they get angry more easily and more intensely than the average person does. There are also those who don't show their anger in loud spectacular ways but are chronically irritable and grumpy. Easily angered people don't always curse and throw things; sometimes they withdraw socially, sulk, or get physically ill.

People who are easily angered generally have what some psychologists call a low

tolerance for frustration, meaning simply that they feel that they should not have to be subjected to frustration, inconvenience, or annoyance. They can't take things in stride, and they're particularly infuriated if the situation seems somehow unjust: for example, being corrected for a minor mistake.

What makes these people this way? A number of things. One cause may be genetic or physiological: There is evidence that some children are born irritable, touchy, and easily angered, and that these signs are present from a very early age. Another may be sociocultural. Anger is often regarded as negative; we're taught that it's all right to express anxiety, depression, or other emotions but not to express anger. As a result, we don't learn how to handle it or channel it constructively.

Research has also found that family background plays a role. Typically, people who are easily angered come from families that are disruptive, chaotic, and not skilled at emotional communications.

Is It Good To "Let it All Hang Out?"

Psychologists now say that this is a dangerous myth. Some people use this theory as a license to hurt others. Research has found that "letting it rip" with anger actually escalates anger and aggression and does nothing to help you (or the person you're angry with) resolve the situation.

It's best to find out what it is that triggers your anger, and then to develop strategies to keep those triggers from tipping you over the edge.

Strategies To Keep Anger At Bay

Relaxation

Simple relaxation tools, such as deep breathing and relaxing imagery, can help calm down angry feelings. There are books and courses that can teach you relaxation techniques, and once you learn the techniques, you can call upon them in any situation. If you are involved in a relationship where both partners are hot-tempered, it might be a good idea for both of you to learn these techniques.

Some simple steps you can try:

- Breathe deeply, from your diaphragm; breathing from your chest won't relax you. Picture your breath coming up from your "gut."
- Slowly repeat a calm word or phrase such as "relax," "take it easy." Repeat it to yourself while breathing deeply.
- Use imagery; visualize a relaxing experience, from either your memory or your imagination.
- Nonstrenuous, slow yoga-like exercises can relax your muscles and make you feel much calmer.

Practice these techniques daily. Learn to use them automatically when you're in a

tense situation.

Cognitive Restructuring

Simply put, this means changing the way you think. Angry people tend to curse, swear, or speak in highly colorful terms that reflect their inner thoughts. When you're angry, your thinking can get very exaggerated and overly dramatic. Try replacing these thoughts with more rational ones. For instance, instead of telling yourself, "oh, it's awful, it's terrible, everything's ruined," tell yourself, "it's frustrating, and it's understandable that I'm upset about it, but it's not the end of the world and getting angry is not going to fix it anyhow."

Be careful of words like "never" or "always" when talking about yourself or someone else. "This !&*%@ machine never works," or "you're always forgetting things" are not just inaccurate, they also serve to make you feel that your anger is justified and that there's no way to solve the problem. They also alienate and humiliate people who might otherwise be willing to work with you on a solution.

Remind yourself that getting angry is not going to fix anything, and that it won't make you feel better (and may actually make you feel worse).

Logic defeats anger, because anger, even when it's justified, can quickly become irrational. So use cold hard logic on yourself. Remind yourself that the world is "not out to get you," you're just experiencing some of the rough spots of daily life. Do this each time you feel anger getting the best of you, and it'll help you get a more balanced perspective. Angry people tend to demand things: fairness, appreciation, agreement, willingness to do things their way. Everyone wants these things, and we are all hurt and disappointed when we don't get them, but angry people demand them, and when their demands aren't met, their disappointment becomes anger. As part of their cognitive restructuring, angry people need to become aware of their demanding nature and translate their expectations into desires. In other words, saying, "I would like" something is healthier than saying, "I demand" or "I must have" something. When you're unable to get what you want, you will experience the normal reactions—frustration, disappointment, hurt—but not anger. Some angry people use this anger as a way to avoid feeling hurt, but that doesn't mean the hurt goes away.

Problem Solving

Sometimes, our anger and frustration are caused by very real and inescapable problems in our lives. Not all anger is misplaced, and often it's a healthy, natural response to these difficulties. There is also a cultural belief that every problem has a solution, and it adds to our frustration to find out that this isn't always the case. The best attitude to bring to such a situation, then, is not to focus on finding the solution, but rather on how you handle and face the problem.

Make a plan, and check your progress along the way. Resolve to give it your best, but also not to punish yourself if an answer doesn't come right away. If you can approach it with your best intentions and efforts and make a serious attempt to face

it head-on, you will be less likely to lose patience and fall into all-or-nothing thinking, even if the problem does not get solved right away.

Better Communication

Angry people tend to jump to—and act on—conclusions, and some of those conclusions can be very inaccurate. The first thing to do if you're in a heated discussion is slow down and think through your responses. Don't say the first thing that comes into your head, but slow down and think carefully about what you want to say. At the same time, listen carefully to what the other person is saying and take your time before answering.

Listen, too, to what is underlying the anger. For instance, you like a certain amount of freedom and personal space, and your "significant other" wants more connection and closeness. If he or she starts complaining about your activities, don't retaliate by painting your partner as a jailer, a warden, or an albatross around your neck.

It's natural to get defensive when you're criticized, but don't fight back. Instead, listen to what's underlying the words: the message that this person might feel neglected and unloved. It may take a lot of patient questioning on your part, and it may require some breathing space, but don't let your anger—or a partner's—let a discussion spin out of control. Keeping your cool can keep the situation from becoming a disastrous one.

Using Humor

"Silly humor" can help defuse rage in a number of ways. For one thing, it can help you get a more balanced perspective. When you get angry and call someone a name or refer to them in some imaginative phrase, stop and picture what that word would literally look like. If you're at work and you think of a coworker as a "dirtbag" or a "single-cell life form," for example, picture a large bag full of dirt (or an amoeba) sitting at your colleague's desk, talking on the phone, going to meetings. Do this whenever a name comes into your head about another person. If you can, draw a picture of what the actual thing might look like. This will take a lot of the edge off your fury; and humor can always be relied on to help unknot a tense situation.

The underlying message of highly angry people, Dr. Deffenbacher says, is "things oughta go my way!" Angry people tend to feel that they are morally right, that any blocking or changing of their plans is an unbearable indignity and that they should NOT have to suffer this way. Maybe other people do, but not them!

When you feel that urge, he suggests, picture yourself as a god or goddess, a supreme ruler, who owns the streets and stores and office space, striding alone and having your way in all situations while others defer to you. The more detail you can get into your imaginary scenes, the more chances you have to realize that maybe you are being unreasonable; you'll also realize how unimportant the things you're angry about really are. There are two cautions in using humor. First, don't try to just "laugh off" your problems; rather, use humor to help yourself face them more constructively. Second, don't give in to harsh, sarcastic humor; that's just another

form of unhealthy anger expression.

What these techniques have in common is a refusal to take yourself too seriously. Anger is a serious emotion, but it's often accompanied by ideas that, if examined, can make you laugh.

Changing Your Environment

Sometimes it's our immediate surroundings that give us cause for irritation and fury. Problems and responsibilities can weigh on you and make you feel angry at the "trap" you seem to have fallen into and all the people and things that form that trap.

Give yourself a break. Make sure you have some "personal time" scheduled for times of the day that you know are particularly stressful. One example is the working mother who has a standing rule that when she comes home from work, for the first 15 minutes "nobody talks to Mom unless the house is on fire." After this brief quiet time, she feels better prepared to handle demands from her kids without blowing up at them.

Some Other Tips for Easing Up on Yourself

Timing: If you and your spouse tend to fight when you discuss things at night—perhaps you're tired, or distracted, or maybe it's just habit—try changing the times when you talk about important matters so these talks don't turn into arguments.

Avoidance: If your child's chaotic room makes you furious every time you walk by it, shut the door. Don't make yourself look at what infuriates you. Don't say, "well, my child should clean up the room so I won't have to be angry!" That's not the point. The point is to keep yourself calm.

Finding alternatives: If your daily commute through traffic leaves you in a state of rage and frustration, give yourself a project—learn or map out a different route, one that's less congested or more scenic. Or find another alternative, such as a bus or commuter train.

Do You Need Counseling?

If you feel that your anger is really out of control, if it is having an impact on your relationships and on important parts of your life, you might consider counseling to learn how to handle it better. A psychologist or other licensed mental health professional can work with you in developing a range of techniques for changing your thinking and your behavior.

When you talk to a prospective therapist, tell her or him that you have problems with anger that you want to work on, and ask about his or her approach to anger management. Make sure this isn't only a course of action designed to "put you in touch with your feelings and express them"—that may be precisely what your problem is. With counseling, psychologists say, a highly angry person can move closer to a middle range of anger in about 8 to 10 weeks, depending on the circumstances and the techniques used.

What About Assertiveness Training?

It's true that angry people need to learn to become assertive (rather than aggressive), but most books and courses on developing assertiveness are aimed at people who don't feel enough anger. These people are more passive and acquiescent than the average person; they tend to let others walk all over them. That isn't something that most angry people do. Still, these books can contain some useful tactics to use in frustrating situations.

Remember, you can't eliminate anger—and it wouldn't be a good idea if you could. In spite of all your efforts, things will happen that will cause you anger; and sometimes it will be justifiable anger. Life will be filled with frustration, pain, loss, and the unpredictable actions of others. You can't change that; but you can change the way you let such events affect you. Controlling your angry responses can keep them from making you even more unhappy in the long run.

Helping Teenagers Cope With Stress

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Teenagers, like adults, may experience stress everyday and can benefit from learning stress management skills. Most teens experience more stress when they perceive a situation as dangerous, difficult, or painful and they do not have the resources to cope. Some sources of stress for teens might include:

- school demands and frustrations
- negative thoughts and feelings about themselves
- changes in their bodies
- problems with friends and/or peers at school
- unsafe living environment/neighborhood
- separation or divorce of parents
- chronic illness or severe problems in the family
- death of a loved one
- moving or changing schools
- taking on too many activities or having too high expectations
- family financial problems

Some teens become overloaded with stress. When it happens, inadequately managed stress can lead to anxiety, withdrawal, aggression, physical illness, or poor coping skills such as drug and/or alcohol use.

When we perceive a situation as difficult or painful, changes occur in our minds and bodies to prepare us to respond to danger. This "fight, flight, or freeze" response includes faster heart and breathing rate, increased blood to muscles of arms and legs, cold or clammy hands and feet, upset stomach and/or a sense of dread.

The same mechanism that turns on the stress response can turn it off. As soon as we decide that a situation is no longer dangerous, changes can occur in our minds and bodies to help us relax and calm down. This "relaxation response" includes decreased heart and breathing rate and a sense of well being. Teens that develop a "relaxation response" and other stress management skills feel less helpless and have more choices when responding to stress.

Parents can help their teen in these ways:

- Monitor if stress is affecting their teen's health, behavior, thoughts, or feelings
- Listen carefully to teens and watch for overloading

- Learn and model stress management skills
- Support involvement in sports and other pro-social activities

Teens can decrease stress with the following behaviors and techniques:

- Exercise and eat regularly
- Avoid excess caffeine intake which can increase feelings of anxiety and agitation
- Avoid illegal drugs, alcohol and tobacco
- Learn relaxation exercises (abdominal breathing and muscle relaxation techniques)
- Develop assertiveness training skills. For example, state feelings in polite firm and not overly aggressive or passive ways: ("I feel angry when you yell at me" "Please stop yelling.")
- Rehearse and practice situations which cause stress. One example is taking a speech class if talking in front of a class makes you anxious
- Learn practical coping skills. For example, break a large task into smaller, more attainable tasks
- Decrease negative self talk: challenge negative thoughts about yourself with alternative neutral or positive thoughts. "My life will never get better" can be transformed into "I may feel hopeless now, but my life will probably get better if I work at it and get some help"
- Learn to feel good about doing a competent or "good enough" job rather than demanding perfection from yourself and others
- Take a break from stressful situations. Activities like listening to music, talking to a friend, drawing, writing, or spending time with a pet can reduce stress
- Build a network of friends who help you cope in a positive way

By using these and other techniques, teenagers can begin to manage stress.

If a teen talks about or shows signs of being overly stressed, a consultation with a child and adolescent psychiatrist or qualified mental health professional may be helpful.

Perhaps the only thing more difficult than being a teenager is parenting one.

While hormones, the struggle for independence, peer pressure, and an emerging identity wreak havoc in the soul of the adolescent, issues of how much autonomy to grant, how much "attitude" to take, what kind of discipline is effective, which issues are worth fighting about, and how to talk to offspring-turned-alien challenge parental creativity, patience, and courage.

If adolescence can be conceptualized as a journey from childhood to adulthood, parenting adolescents can also be thought of as a journey.

To guide a child to adulthood, to ingrain values, to help negotiate social relationships, and to see new ideas, ideals, goals, and independence emerge in a child can be the adventure of a lifetime. Like any adventure, the thrill is in the journey.

Challenges conquered sweeten success, and while failure is in part unavoidable, no one can know how the balance of success and failure measures out until the journey is complete. As long as the journey continues, there is hope: a chance to turn failures into success, weaknesses to strengths.

Like any adventure, the challenges are unique to each traveler. Even the same parent will experience different challenges as each child is guided through adolescence. Because each journey is unique, there is no way to smooth all the bumps, anticipate all the challenges, or detonate all the land mines beforehand. However, there are aspects of the journey that appear to be universal.

Although teenagers will make their own choices, a good home life can increase the odds that kids will avoid many of the pitfalls of adolescence. Particularly, a kind, warm, solid relationship with parents who demonstrate respect for their children, an interest in their children's activities, and set firm boundaries for those activities may directly or indirectly deter criminal activity, illegal drug and alcohol use, negative peer pressure, delinquency, sexual promiscuity, and low self-esteem.

There is not only growing consensus that some parenting techniques are better than others, but also contribute to the development of emotional stability and social responsibility in children.

There are three major areas that are crucial to the parent-adolescent relationship -- **connection**, **monitoring**, and **psychological autonomy**.

First, a sense of connection between a teenager and parent provides a backdrop against which all other interaction takes place. If the parent-child connection is consistent, positive, and characterized by warmth, kindness, love, and stability, children are more likely to flourish socially.

Adolescents who describe their relationship with their parents as warm, kind, and consistent are more likely to initiate social interaction with other adolescents and with other adults. They are more likely to respond to others positively and with greater empathy. They are more likely to be self-confident in their relationships with others, and to be more cooperative with others. Also, teens with these kinds of positive relationships with their parents on the whole struggle less with depression, and have higher self-esteem. Relationships characterized by kindness and devoid of unkind words or acts appear to be important to healthy adolescent development.

In addition to the sense of connection between parent and teenager, the monitoring process is crucial to successful parenting. Teenagers who report that their parents take a genuine interest in their activities are more likely to avoid trouble. Teens whose parents know who their friends are and what they do in their free time are less likely to get into trouble than their peers. In the context of a warm, kind relationship, parental monitoring of teen activities comes across as caring rather than intrusive. Teenagers whose parents monitor them are more likely to avoid activities like lying, cheating, stealing, and using alcohol and illegal drugs. Parental monitoring of adolescent behavior inhibits not only the opportunity for delinquent activity, but negative peer pressure to be involved in such activity as well.

Finally, parents need to encourage the development of psychological autonomy in their teenage children. Psychological autonomy is nurtured in children when parents genuinely respect their teen's ideas, even when the ideas are contrary to their own. Encouraging independent thinking and the expression of original ideas and beliefs, validating feelings, and expressing unconditional love are ways to nurture psychological autonomy. The opposite of psychological autonomy is psychological control, which is characterized by changing the subject, making personal attacks, withdrawing love, or inducing guilt to constrain intellectual, emotional, or psychological expression by the adolescent that is incongruent with the parent's way of thinking. Adolescents who report that their parents are likely to use techniques associated with psychological control are more apt to struggle with depression and to exhibit anti-social behavior.

The combination of **connection**, **monitoring**, and **psychological autonomy** may sound simple, but the simplicity of the directions can be frustrating to navigators when they are lost. Translating general ideas into specific behaviors, and then into patterns of interaction can be a challenge, especially if one or both parties are already entrenched in less productive patterns of interaction. The task of establishing a warm, caring, positive, relationship characterized by kindness with a teenager whose favorite phrases are "you just don't understand" and "leave me alone" can be daunting.

While it is true that one of the main developmental tasks of adolescence is to separate from parents, and that peer influence takes on greater and greater importance during teen years, there is still no substitute for the parent-teen relationship.

It is important to spend time with teenagers.

Parents who wish to enhance their connection with their teenager often find that choosing leisure activities wisely can do much to further the cause. In addition to the opportunity to spend time together amiably, engaging teenagers in fun activities that foster sportsmanship, service, creativity, intellectual development, etiquette, honesty, and respect for each other brings all of those aspects into the parent-child relationship, providing an enjoyable forum for both teenagers and parents to practice those skills with one another.

Engaging in recreational activities with teenagers is a way to connect regularly in a pleasant setting. Regular, positive interaction is crucial if discipline is to be effective. When the parent/child relationship

is built on a foundation of warmth and kindness, it can withstand the unpleasantness of discipline. Parties to relationships void of such a foundation often either disengage or become conflicted in the face of the uncomfortable consequences imposed by discipline.

Spending leisure time together also gives parents a leg-up on the monitoring process. First, it cuts down on the amount of free time kids spend without supervision. Second, discussions about friends and other leisure activities tend to come up easily, and can be discussed in a relaxed atmosphere. Often, parents get a chance to know their teenager's friends through recreational activities, either by attending school or team performances in which their child is involved with friends, or by allowing a child to invite a friend along on a family outing.

Perhaps the most difficult thing about the monitoring process is that it is a delicate balance between too much and too little, and it requires the energy to set firm limits when it would just be easier to let things slide. It requires continued vigilance on the part of parents to ensure that they know where children are and what they are doing. It also requires that parents enforce consequences when family rules are broken. Although discipline is genuinely unpleasant for all involved, attention to monitoring activities and providing consequences for inappropriate behavior on a daily basis will alleviate major heartache later.

Parents should remember that the prime directive of adolescence ("independence or bust") prohibits teenagers from admitting that having parents set firm boundaries is actually reassuring.

Adolescence is a time of change and upheaval.

Family rules and boundaries can provide a sense of stability to teens who are struggling to decipher relationships, roles, and even their own personalities. Although they may protest loudly against being required to live up to certain standards, when they have a hand in crafting those standards, and when those standards are demanding but fair, teenagers will flourish. Having something steady, firm, and predictable in a head spinning world is like being handed a map, with NORTH plainly marked. Clear boundaries and standards are the gauge by which all other information is measured.

Disciplining teenagers is difficult, but it is critical if teens are to learn that their behavior has consequences.

Some of the odiousness of enforcing rules can be eliminated by engaging children in the process of setting the rules and assigning consequences before the rules are broken.

When parents include teenagers in establishing clear rules about appropriate behavior and consequences, the arguments over rules and punishment end. Children can no longer claim that punishments or expectations are unfair, and parents can take on the role of calmly enforcing the pre-arranged consequences instead of having to impress upon the child the seriousness of the problem and scramble to find an appropriate punishment**.**

The temptation to react emotionally when children break rules is alleviated because a breach of the rules is no longer perceived as an assault on parental authority, since it is by the authority of the family, not the authority of the parents, that the rules were established. Helping to set the rules may not

dissuade teenagers from breaking them sometimes, but it can help parents to avoid a power struggle with their teenagers.

Another big trap in parent-teen relationships is the confusion of psychological control (the opposite of psychological autonomy) with discipline. Demanding a certain level of behavior of children does not exclude allowing, or even encouraging them to think and express opinions different than one's own.

Too many parents get caught up in focusing on controlling their child, believing that controlling the way their child thinks will translate into controlling what their child does. By using guilt, withdrawing love, or invalidating feelings or beliefs, the parent hopes to make the child see things the parent's way, ensuring compliance with parental expectations.

There is a fine line here; one of the roles of parents is to help children make sense of the world by offering explanations or interpretations of events. It is when these parental offerings take on the tone of exclusiveness -- when parents cannot respectfully consider and discuss a teenager's interpretation of his or her own experience -- that psychological control has taken over.

Parents should also be aware that it is the teenager's perspective on the forcefulness of the suggestion which counts. Psychological control is damaging if it is perceived by the teenager, regardless of parental intention. While a parent may feel that a discussion has taken on the tone of a healthy debate, to a teenager the same interchange can feel absolutely crushing.

Interestingly, boys are more likely to report that their parents squelch their psychological autonomy than are girls. Whether this is a difference in the way parents actually relate to teenage boys versus teenage girls, or whether it is a difference in perception of boys versus girls is unclear.

When discipline becomes a matter of calmly enforcing family rules about behavior, many of the problems associated with psychological control are alleviated.

When children have a problem with delinquency, parents generally tend to respond to it with less behavioral control, and more psychological control as time goes by. This appears to set up a vicious cycle, as teenagers respond to both lack of monitoring and the presence of psychological control by acting out, or becoming more delinquent.

If parents can break this cycle by treating delinquent behavior with increased monitoring rather than attempting to control it by inducing guilt, withdrawing love, or other means of psychological control, teenagers are more likely to respond with better behavior.

In short, parents who concentrate on trying to control their child's behavior rather than trying to control their child are going to have much more success and a lot less grief.

Parents who expect that children will sometimes act in ways that are inappropriate or

undesirable, but prepare for such behavior by involving their children in the formulation of rules and consequences, may discover that the joy is in the journey, and heaven is found along the way.

Parents would do well to concentrate on a three-pronged approach to managing the journey.

First, *a positive relationship* with their child is essential to success. When parent-child interactions are characterized by warmth, kindness, consistency, respect, and love, the relationship will flourish, as will self-esteem, mental health, spirituality, and social skills.

Second, *being genuinely interested* in children's activities allows parents to monitor behavior, which is crucial in keeping teens out of trouble. When misbehavior does occur, parents who have involved their children in setting family rules and consequences can expect less flack from their children as they calmly enforce the rules. Parents who, together with their children, set firm boundaries and high expectations may find that their children's abilities to live up to those expectations grow.

Third, parents who *encourage independent thought and expression* in their children may find that they are raising children who have a healthy sense of self and an enhanced ability to resist peer pressure.

Parents who give their teenagers their love, time, boundaries, and encouragement to think for themselves may find that they actually enjoy their children's adventure through adolescence.

As they watch their sons and daughters grow in independence, make decisions, and develop into young adults, they may find that the child they have reared is, like the breathtaking view of the newborn they held for the first time, even better than they could have imagined.

This information and advice comes primarily from researchers at Brigham Young University. With the largest number of family scholars in the nation, and a strong commitment to cross-disciplinary research, Brigham Young University's Family Studies Center is committed to supporting and developing high-quality research on the family.

Appendix C

COPY-READY WORKSHEETS FOR BRIEF INTERVENTION

Forms For Adolescent Sessions

CLIENT QUESTIONNAIRE

Name:_____ Date:_____

- This questionnaire asks about you and your experiences. Some questions ask how often you have used alcohol and other drugs. Others ask how much you agree with a statement.
- Please read each question carefully. Circle the answer that is right for you.
- Please answer every question.

PART I

DURING THE PAST 12 MONTHS, HOW MANY TIMES (IF ANY)	**Never**	**1-2**	**3-5**	**6-9**	**10-19**	**20-39**	**40+**
1. Have you had alcoholic beverages (including beer, wine, and liquor) to drink?	1	2	3	4	5	6	7
2. Have you used marijuana (grass, pot) or hashish (hash, hash oil)?	1	2	3	4	5	6	7
3. Have you used drugs other than alcohol and marijuana?	1	2	3	4	5	6	7

4. If you have used other drugs, put an **X** in the space next to each drug that you have used at least **once during the past 12 months.**

_____ cocaine (coke, crack)
_____ amphetamines (such as uppers, speed, bennies)
_____ barbiturates (such as downs, goofballs, yellows, blues)
_____ heroin (smack, horse, skag)
_____ other narcotics (such as methadone, opium, morphine, codeine, Demerol)
_____ tranquilizers (such as Librium, valium)
_____ psychedelics (such as LSD, PCP)
_____ inhalants (such as glue, aerosol cans, gases, white-out)
_____ club drugs (meth, Ecstasy, MDMA, Special K, GHB, roofies)
_____ over the counter drugs (DXM, cough syrup, NoDoz)
_____ prescription drugs (not taken as prescribed)

PART II (PRQ)

The next set of questions asks whether you disagree or agree with these statements. Make a check mark in the appropriate blank.

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1. My use of alcohol or drugs has caused many problems in my life…….	_____	_____	_____	_____
2. I can quit using alcohol or drugs on my own…….	_____	_____	_____	_____
3. I am glad to be in this program…….….	_____	_____	_____	_____
4. My problems are caused by alcohol or drugs ……	_____	_____	_____	_____
5. I believe I have a problem with alcohol or drugs…….……	_____	_____	_____	_____
6. My use of alcohol or drugs has hurt others	_____	_____	_____	_____
7. I want to change my life and get away from alcohol and drugs……	_____	_____	_____	_____
8. I came to this program on my own……..	_____	_____	_____	_____
9. There are many good reasons for me to stop using alcohol or drugs…….	_____	_____	_____	_____
10. I am in this program because of bad luck……	_____	_____	_____	_____
11. I know why people are so upset about my alcohol or drug use……	_____	_____	_____	_____
12. I need help for my alcohol/drug problems	_____	_____	_____	_____
13. Using alcohol or drugs is a real problem in my life……..	_____	_____	_____	_____

	Strongly Disagree	Disagree	Agree	Strongly Agree
14. I can control my alcohol or drug use……	_____	_____	_____	_____
15. I have a bad alcohol or drug problem…..	_____	_____	_____	_____
16. I came to this program because of school or legal problems……	_____	_____	_____	_____
17. It will be a struggle for me to stop using alcohol or drugs……	_____	_____	_____	_____
18. People sent me to this program to get me out of the way……..	_____	_____	_____	_____
19. It's okay for me to use alcohol or drugs now and then…….	_____	_____	_____	_____
20. I need to stop using alcohol or drugs completely……	_____	_____	_____	_____
21. I have more important things to do than to be in this program……	_____	_____	_____	_____
22. I need help to stop using alcohol or drugs	_____	_____	_____	_____
23. I am willing to give up my old friends so I can stop using drugs or drinking……	_____	_____	_____	_____
24. I was forced into coming to this program	_____	_____	_____	_____
25. I think some type of help for my alcohol or drug use is a good thing for me	_____	_____	_____	_____

Scoring PART II (PRQ) of the Client Questionnaire

1. Assign these values to the response options:

Strongly Disagree	= 1
Disagree	= 2
Agree	= 3
Strongly Agree	= 4

2. Compute unweighted total score on the PRQ using these four steps:
(Note: Some items have reverse scoring and some are not scored)

Step 1	Compute:	Q1 + Q3 + Q4 + Q5 + Q6 + Q7 + Q9 + Q11 + Q12 + Q13 + Q15 + Q17 + Q20 + Q22 + Q23 + Q25 = **PRQ1**
Step 2	Note:	Reverse the scores assigned to Q2, Q14, Q19, Q21, and Q24 Such that: 1 = 4, 2 = 3, 3 = 2, 4 = 1
Step 3	Compute:	Q2 + Q14 + Q19 + Q21 + Q24 = **PRQ2**
Step 4	Compute:	**PRQ1 + PRQ2 = PRQ Score**

3. Interpretation guidelines

Low recognition of a problem:	**PRQ Score = 21 – 39**
Moderate recognition of a problem:	**PRQ Score = 40 – 59**
High recognition of a problem:	**PRQ Score = 60+**

PROS AND CONS WORKSHEET

Name/ID:_____ **Date:** _____

In the space below, write down some of the positive reasons for your continued substance use. Be specific.

1. The pros of my using are:

A. _____

B. _____

C. _____

D. _____

In the space below, write down some of the negative reasons for your continued substance use.

2. The cons of my using are:

A. _____

B. _____

C. _____

D. _____

Now think of some of the positive and negative outcomes would be with changing your substance use. Write some ideas below.

3. The pros of my choice to change my using habits are:

A. _____

B. _____

C. _____

D. _____

4. The cons of my choice to change my using habits are:

A. _____

B. _____

C. _____

D. _____

My friends think: _____

My parents/guardians think: _____

My siblings/extended family think: _____

The attitudes of all these people affect my decision about using by: _____

_____

TRIGGERS AND CRAVINGS WORKSHEET

Name/ID_____ **Date**_____

Circle the reason or reasons for your own drug or alcohol use.

- **Boredom –** feeling that there is nothing else to do that is worthwhile. Some people use drugs or alcohol to make the boredom pass more quickly or to make boring activities seem more fun.

- **Escape –** to avoid uncomfortable situations, arguments, memories, or actual physical pain. Some people want to escape from their pain and use drugs and/or alcohol to make themselves feel numb or to forget.

- **Relaxation –** to unwind and reduce tension. Some people don't know how to relax without using drugs.

- **Socialization –** involves social settings such as a party or family gathering. Many people who are shy or uncomfortable in these situations use alcohol and drugs to help to reduce this uncomfortable feeling in themselves and to help them relax in this type of situation.

- **Improved self-image –** to make one's self look better in the eyes of others.

- **Attraction or Romance –** to invoke excitement or the feeling of being in love or having someone be attracted to one's self.

- **To hell with it –** when a person has just given up trying to reach any worthwhile goal. This is a person that feels that nothing matters and there is no reason for them to try.

- **No control –** a person who gives up trying to control his or herself. People who feel like this think that they just don't want to make any more effort to fight the urge to drink or use drugs.

Other – please describe: _____

_____

_____

WHAT SETS OFF YOUR DRUG AND/OR ALCOHOL USE WORKSHEET
HOW CAN YOU RESPOND?

Name/ID: _____ Date: _____

In the first column, list the reasons/triggers of what sets off the student's use of drugs and/or alcohol. In the second column, list several alternatives to prevent or control these causes and influences.

TRIGGER	**ALTERNATIVE**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**

Assist the youth in envisioning situations in which triggers or cravings may appear, then finding alternative situations or activities to modify those triggers. Suggested scenarios are listed below.

TRIGGERS AND CRAVINGS SCENARIOS

1. You are at a party with your friends and someone passes you a joint. You don't feel like smoking it just now. What would you do? Is there another way/healthier way that you could handle this situation?

_____

_____

_____

_____

2. You have had a really hard day. You got an "F" on your test, your best friend has turned on you and you are really frustrated. How would you have handled this situation in the past? What can you do now instead of using drugs and/or alcohol?

_____

_____

_____

_____

3. You have a big presentation in front of the entire school tomorrow. You are really nervous and are having a hard time falling to sleep. What have you done in the past to relieve this anxiety? What else could you do?

_____

_____

_____

READY TO CHANGE WORKSHEET I

Name/ID: _____ Date: _____

Here is a scale that will help us to determine how ready you are to change your use of alcohol and/or drugs. Place a number on the scale that indicates how you feel about this right now.

1 2 3 4 5 6 7 8 9 10

Not ready somewhat ready very ready

Please circle below one of the following that best describes you right now.

1. I don't want to quit/reduce using drugs and/or alcohol.

2. I don't really like to use drugs and/or alcohol but I don't want to stop/reduce right now.

3. I am thinking about stopping/reducing my use of drugs and/or alcohol.

4. I have definitely decided that I want to stop/reduce using drugs and/or alcohol.

5. I have already stopped/reduced using drugs and/or alcohol.

ESTABLISH GOALS WORKSHEET

Name/ID: _____ Date: _____

In the space below, write down some healthy goals that you will work on during the next week, including at least one drug or alcohol goal.

1. _____

2. _____

3. _____

4. _____

What might get in the way of trying to reach these goals?

1. _____

2. _____

3. _____

4. _____

Where does this leave us now? What can you do to prevent these obstacles?

1. _____

2. _____

3. _____

4. _____

ADVANTAGES OF NOT USING

- Keep your head clear
- Better relationship with family
- Feel better physically
- Save money
- Would not have to hide it anymore
- Feel better about yourself
- Think more clearly
- More time to enjoy hobbies, sports, etc.
- Better able to control moods and feelings
- Good for my weight (less calories)
- Don't have to worry about making a fool of yourself at parties
- Don't wake up wondering what happened the night before
- No more hangovers
- Self-confidence from overcoming the urge to use
- Wouldn't have a bad reputation
- Wouldn't regret things
- Health reasons
- Improved communication skills – not so snappy
- Better sleep
- Not so worried about others knowing
- Improved relationships with others, including family
- More time for yourself and your family and friends
- Able to plan for your future more clearly

SOCIAL SUPPORT WORKSHEET

Name/ID: _____ Date: _____

Answer the following questions to the best of your ability

1. Who do you think may be able to offer you support?

_____

_____

_____

Suggestions:

- Think of people who have been helpful to you in the past such as friends, family members or other people that you know.
- Find people who are not biased. Those who will not pick sides.
- If you can't think of people who can be of help to you now, think of those who may be helpful later on.

2. Think of ways that these supportive people can help you. List at least three.

_____

_____

_____

3. Name someone to whom you are supportive?. Tell how you support them.

_____

_____

(Adapted from Sampl, S. and Kadden, R. (2001). Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.)

READY TO CHANGE WORKSHEET - II

Name/ID: _____ Date: _____

1. Are you seriously thinking about changing your drug and/or alcohol use within ***the next six months***?

YES MAYBE NO

2. Are you seriously thinking about changing your drug and/or alcohol use within ***the next month***?

YES MAYBE NO

Here is the same scale that you have seen before. This will help us to determine how ready you are now to change your use of drugs and/or alcohol. Place a number on the scale that indicates how you feel about this today.

1 2 3 4 5 6 7 8 9 10

Not ready Somewhat ready Very ready

Please circle below one of the following that best describes you right now.

3. I don't want to quit/reduce using drugs and/or alcohol.
4. I don't really like to use drugs and/or alcohol but I don't want to stop/ cut down right now.
4. I am thinking about stopping/reducing my use of drugs and/or alcohol.
5. I have definitely decided that I want to stop/reduce using drugs and/or alcohol.
6. I have already stopped/reduced using drugs and/or alcohol.

RESTABLISH GOALS WORKSHEET

Name/ID: _____ Date: _____

Therapist, write down revised goals discussed for the immediate future (up to the next event, holiday etc).

1. _____

2. _____

3. _____

Therapist, write down revised goals discussed for 1 year from now.

1. _____

2. _____

3. _____

Where does this leave us now? What can you do to prevent these obstacles?

1. _____

2. _____

3. _____

4. _____

Alternatives to saying "no" to alcohol and other drugs

- Not now, I'm not ready
- Just say "no thank you" and leave it at that
- Give a reason or excuse (e.g., "no thanks, I have a test/big game tomorrow")
- Broken record – keeping saying no over and over again
- Walk away – ignore the person and the situation
- Avoid the situation – if you know there will be drugs/alcohol at the party don't go
- Change the subject – start talking about something else
- Strength in numbers – be with friends that you can trust
- Use humor – make a joke of the situation
- Use your health as an excuse – (e.g., "I'm allergic to smoke")
- Reverse the pressure - (e.g., "If you want a beer so badly get one yourself")
- Be honest tell them you are not into it – (e.g., "It's just not my thing")
- Suggest an alternative – try something else to do

Immediate Goals up to _____(list event, holiday, etc.)

1. _____
2. _____
3. _____

Goals 1 YEAR from now

1. _____
2. _____
3. _____
4. _____

Forms For Parent or Guardian Session

PARENT/GUARDIAN WORKSHEET

Name/ID: _____ Date: _____

I would like to start by asking a few questions about (child's name) experiences and relationships that might help us get a better feel for what we can focus on to help her/him make healthy choices. Feel free to ask any questions that you may have as we go along.

1. Can you tell me a little about your son/daughter's interests/hobbies? What are his/her strengths? What are things that are difficult for her/him. (*Try to find out level of activity. Is he/she in groups., clubs, etc.)*

_____

_____

_____

2. How is (child's name) connection with school? How is his/her school performance? Have there been changes with his/her performance/connection to school? How do you feel about the friends he/she hangs out with?

_____

_____

3. Understanding that adolescence is a time of building independence from parents, does _(child's name)_ do things with the family much? How would you describe the relationship you (or other members of the family) with him/her? How satisfied are you with these relationships?

_____

_____

_____

4. Regarding (child's name) use of alcohol or other drug, what do you think has contributed to his or her use? [*Discuss factors that contribute to drug use among teens (e.g., poor school connection, friends that use, lack of involvement with activities, etc.) Use this as a segue to discuss family factors that contribute including genetic and environmental factors. Inquire about individuals in the home who may have difficulties with drug use]. If others have a history of use*, what has your child's reaction to their use been?

_____

_____

_____

5. Have you discussed with any friends or other family members about what to do about your son/daughter's using? Has there been anyone who has been supportive and/or helpful in this journey to help your child?

_____

_____

_____

6. What steps, if any, have you taken already to try to prevent or reduce your son/daughter's use? In what ways have you shown support? (Reinforce positive steps. Give examples if needed, "do special activities together, earn privileges, etc.")

_____

_____

7. In what ways have you tried control or discipline to prevent or reduce your son/daughter's use? (Probe for skills related to monitoring and supervision. Offer some other suggestions if needed (i.e., one of the parents I worked with said they took the door off their daughter's room until she earned it back.)

_____

_____

Family Rules about Alcohol and Other Drug Use

Name/ID: _____ Date: _____

1. Studies have shown that it can helpful to include your child or children in creating your household rules or expectations about alcohol or drug. Do you have rules about this in your household? If so, would you be willing to share them with me?

_____

_____

_____

2. Sometimes these rules are assumed or unsaid among family members. How have these rules been communicated to your child/ren?

_____

_____

_____

3. I recognize that adolescence can be stressful time for parents especially when alcohol/drug use is involved. With this in mind, do you have people close to you that you can turn to for support?

If Yes, how are they supportive?
If No, what types of resources are (can) you using (use) to assist you in dealing with this problem?

_____

_____

_____

_____

(Adapted from Walking the Talk: A Program for Parents about Alcohol, Tobacco and Other Drug Use and Nonuse - A Participant Workbook. Developed by The Center for Substance Abuse Prevention, Rockville, MD, 2001).

Parent (Guardian) Questionnaire

Name/ID:_____ **Date:**_____

Please answer whether you disagree or agree with these statements about your child by making a check in the appropriate blank. Your answers will be kept confidential.

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1. As a parent/guardian, I have great concerns about my child's use of alcohol and/or drugs…..	_____	_____	_____	_____
2. I want my child to receive help for his/her alcohol and/or drug use…….	_____	_____	_____	_____
3. I want my child to quit using alcohol and/or drugs……..……	_____	_____	_____	_____
4. I want my child to reduce their usage of alcohol and/or drugs……..	_____	_____	_____	_____
5. As a parent/guardian, I am willing to do whatever is takes to stop my child from using…..	_____	_____	_____	_____
6. I believe that my child has a problem with alcohol and/or drugs……..	_____	_____	_____	_____
7. My child's use of alcohol and/or drugs is just "typical teenage behavior"…….	_____	_____	_____	_____
8. I think it's okay for my child to use alcohol and/or drugs every now and then……...	_____	_____	_____	_____
9. My alcohol and/or drug use is not a concern…	_____	_____	_____	_____
10. I tried to help my child to change his or her alcohol and/or drug use but it didn't work out….....	_____	_____	_____	_____
11. I believe my child can change his or her alcohol and/or drug use without help…….	_____	_____	_____	_____
12. I will make time to help my child with his or her alcohol and/or drug use problems……	_____	_____	_____	_____

RISK AND PROTECTIVE FACTORS

What can **Increase the Risk** of an adolescent developing a drug or alcohol problem?

- **Early age of first use**
- **Poor social coping skills (depression, anxiety, aggression, impulsivity)**
- **Feeling unloved by family; low mutual attachment with parents**
- **Ineffective parenting (supervision, monitoring, consequences, modeling)**
- **Perceived external approval of drug use (peers, family, community)**
- **Affiliation with deviant peers**
- **Having easy access to money from a job or above average disposable income**
- **Chaotic home environment**
- **Past or current drug or alcohol problems within the family**
- **Past or current family emotional, physical, or sexual abuse or neglect (especially depression)**
- **_____Other - Specific to adolescent**

What can **Reduce the Risk** of an adolescent development a drug or alcohol problem?

- **Feeling connected with and valued by family and other significant adults**
- **Parental supervision**
- **Child involvement in activities that provide joy, enhance self-esteem, prevent idol time**
- **Parent involvement with child's activities**
- **High educational aspirations of parents and child**
- **Academic success**
- **Feeling connected with school and valuing academic achievement**
- **Strong bonds w/ social institutions (school, community, extra-curr. act., church)**
- **Personal disapproval of drug and alcohol use**
- **Personal belief that drug and alcohol use is dangerous and harmful**
- **Parents who verbalize expectations/consequences for using alcohol or drugs**
- **Follow through on consequences**

Adapted from: Falkowski, Carol (2002). ***Dangerous Drug: An Easy–to-Use Reference for Parents and Professions.*** **Hazelden, Center City, MN.**

What a Drug Problem May Look Like

FAMILY

- ❑ **Arguments**
- ❑ **Withdrawal from family**
- ❑ **Fighting**
- ❑ **Irresponsibility**
- ❑ **Coming in late or not at all**
- ❑ **Scapegoat behavior**
- ❑ **Physically/verbally abusive**
- ❑ **Dishonesty, sneakiness**
- ❑ **Defiant, hostile**
- ❑ **Secretive, silent**
- ❑ **Destructive**
- ❑ **Money or articles missing**
- ❑ **Finding drugs or paraphernalia**

SCHOOL

- ❑ **Skipping school regularly**
- ❑ **Chronic tardiness**
- ❑ **A drop in grades**
- ❑ **Getting caught using in/before school**
- ❑ **Change in attitude & behavior**
- ❑ **Conflict with school staff or students**
- ❑ **School staff concerned**
- ❑ **Suspension, detention**

JOB

- ❑ **Chronic late arrival**
- ❑ **Inability to get along with others**
- ❑ **Irresponsibility**
- ❑ **Missing work repeatedly**
- ❑ **Accidents on the job**
- ❑ **Working below potential**
- ❑ **Fired**

SEXUAL

- ❑ **Negative change in sexual values**
- ❑ **Promiscuity**
- ❑ **Seductive dress/talk/behavior**
- ❑ **STDs**

SPIRITUAL

- ❑ **Hopelessness**
- ❑ **Extreme self-centeredness**
- ❑ **"I don't care" attitude**
- ❑ **Negative changes in values**
- ❑ **Drops interests, activities that used to be important**
- ❑ **Creative activities (i.e. art, music) accompanied by drug use**

PHYSICAL

- ❑ **Lazy, lethargic**
- ❑ **Change in appearance**
- ❑ **Regularly tired**
- ❑ **Hangovers, "sick"**
- ❑ **Broken bones**
- ❑ **Car accidents**
- ❑ **Red eyes/using Visine**
- ❑ **Blackouts, passing out**
- ❑ **Weight loss/gain**
- ❑ **Getting in fights, beat up**
- ❑ **Suicide talk or behavior**
- ❑ **Overdosing**
- ❑ **Caught high/drunk**

EMOTIONAL

- ❑ **Mood swings**
- ❑ **Flat affect**
- ❑ **Out of touch with feelings**
- ❑ **Extreme anger, depression**
- ❑ **Irritability**
- ❑ **Hopeless, "who cares" attitude**
- ❑ **Defensive**
- ❑ **Non-communicative**

LEGAL

- ❑ **Minor consumption**
- ❑ **Possession charges**
- ❑ **Shoplifting**
- ❑ **Stealing**
- ❑ **Vandalism**

MENTAL

- ❑ **Poor concentration**
- ❑ **Distracted**
- ❑ **Memory loss**
- ❑ **Lower attention span**
- ❑ **Lack of motivation**

SOCIAL

- ❑ **Negative change in friends**
- ❑ **Secretive about friends**
- ❑ **Social activities increasingly drug-oriented**
- ❑ **Dropping activities not associated with drug use**
- ❑ **Unexplained coming/going, phone calls, etc**

Six Steps: Talking to kids about alcohol and other drugs

Step One – "I care"
Tell your child that you care about him or her. Attempt to build upon your relationship to help to reduce the potential defensiveness in your child. An example of this approach is, "I care about you and I don't want you to get hurt."

Step Two – "I see"
In this step, you need to tell your child what they have done that has caused you concern. Just give the facts, not your opinion, based upon what you have seen or found. An example of this is, "when you came in last night you were three hours late and smelled like alcohol."

Step three – "I feel"
This is where you tell your child about how this behavior or discovery has made you feel. Be sure to take away any blame from this step. For example, "I am really worried that you might get hurt or killed."

Step four – "Listen"
This has to be one of the most important steps. You will need to listen to what the adolescent has to say about their drug use or drinking behaviors. Some may not say anything at all at this point but it is useful to allow this opportunity for the young person to tell their side. It is possible that your child is not ready to talk. You can tell them that you are available to listen to what they have to say at another time.

Step five – "I want"
After hearing your child's side you need to tell them what you want to happen next and what you want them to do. For example, "I don't want you to use drugs at all." Reinforce that you "want" him or her to continue seeing the therapist if the problem does not get better.

Step six – "I will"
This final step is where you tell your child what you will and will not do in order to help them with this problem. Some may choose to be available to just listen when the young person chooses to discuss the issue. Other parents may choose to make an appointment with a chemical health counselor. The best time to talk is when you have calmed down from the initial shock of learning about your child's use of alcohol or other drugs. You will need to find a place to talk where you cannot be interrupted. The time to talk is not while your child is still under the influence of drinking or using other drugs. If the problem persists, encourage your child to make an appointment with the therapist.

(Adapted from Walking the Talk: A Program for Parents about Alcohol, Tobacco and Other Drug Use and Nonuse - A Participant Workbook . Developed by The Center for Substance Abuse Prevention, Rockville, MD, 2001).

HELPFUL RESOURCES FOR PARENTS

Partnership for a Drug Free America
http://www.drugfree.org/parent

Parents The Anti-Drug
http://www.theantidrug.com

4parents
http://www.4parents.gov/

Family Guide
http://www.family.samhsa.gov

Immediate Goals up to _____(list event, holiday, etc.)

1. _____
2. _____
3. _____
4. _____

Goals 1 YEAR from now

1. _____
2. _____
3. _____
4. _____