SELF MANAGEMENT AND RECOVERY TRAINING

SMART Recovery® NEWS & VIEWS

Bringing Science and Reason to Self-Help with Addictive Behavior
Volume 12, Issue 3 • Summer 2006

A. Thomas Horvath, PhD, President
Emmett Velten, PhD, Editor

President's Letter

SMART Recovery® in Vietnam

In December 2005, Joe Gerstein, founding President of SMART Recovery®, presented a week-long training at the regional psychiatric hospital in Danang, Vietnam. It is a city of more than a million people and was the site of an American military base in what the Vietnamese call "the American war." In April 2006, I followed up with a second week-long training for fifteen hospital staff members, most of them psychiatrists. Three bilingual psychologists—an American, a Canadian, and an Australian—translated. Under the leadership of Bahr Weiss, PhD, a psychology professor at Vanderbilt, they organized the trainings. Bahr arranged for the funding.

It was obvious that the first training was successful because of the levels of competence I observed in the second training. The regional hospital conducts individual and group sessions of SMART Recovery® Therapy, and hopes to be able to offer community groups soon. I saw several meetings being conducted, and any locality would be proud to have them observed. As the number of graduates of the therapy sessions increases, community meetings will likely begin.

A new aspect of the second training was two trips to government-run "drug rehabilitation camps." The primary drug of abuse in Vietnam is heroin. Although alcohol is also widely misused, there is more tolerance of that than for use of heroin. Unlike the United States, it is common in Vietnam for someone to have become dependent on heroin and not to consume much alcohol.

The drug camps are run by the security police, the Vietnamese counterpart to the former Soviet Union's KGB. Drug use is viewed by the security police as an internal security matter. The other psychologists and I were among the first non-Vietnamese to visit these camps. The invitation to attend, and the invitation to begin to use SMART Recovery® Therapy with a selected group of inmates, occurred because the recidivism rate for the camps is very high. It is too soon to say how deeply involved in the camp program SMART Recovery® will be. However, our only "competitor" in the camps is a single daily structure of activities. There is virtually no psychotherapeutic activity.

Currently, first offenders are sentenced to two years at the camp. If a heroin user turns himself in—so far, almost all are male—then a hospital stay rather than at the camp, is mandated. Reintroduction from the camp to society in accompanied by almost no support or transitional services. I made a number of suggestions about how they could allocate their resources to get better outcomes. However, a number of changes in the authorities' perspective will need to occur before their system,

(Continued on page 2)

The SMART Recovery® 4-Point Program℠

The SMART Recovery® (**S**elf-**M**anagement **A**nd **R**ecovery **T**raining) program helps individuals gain independence from addictive behavior.

Our efforts are based on scientific knowledge and evolve as scientific knowledge evolves.

The program offers specific tools and techniques for each of the program points:

Point #1: Enhancing and maintaining motivation to abstain

Point #2: Coping with urges

Point #3: Managing thoughts, feelings and behavior (problem-solving)

Point #4: Balancing momentary and enduring satisfactions (lifestyle balance)

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which is largely oriented around punishment, might shift to a system oriented around achieving good outcomes. In this respect they are unfortunately almost exactly like the United States!

Just as in the camps, in Vietnamese society 12-step groups are essentially unknown. I heard that there might be a few 12-step groups around, but no one seemed to know anything about them! One of the exciting aspects of SMART Recovery's® introduction into Vietnam is that this country is "virgin" territory, unshaped by 12-step influence. There's a chance in Vietnam for a system of services and support groups that honors all available alternatives, including scientifically-based ones, rather than copying the American system. The possibility of SMART Recovery® becoming integrated into their system of care seemed evident from the introductions I got to officials at the drug camp, and at the Danang public health service.

The introduction of SMART Recovery® to Vietnam has also required thinking about the SMART Recovery® program from a cultural perspective. We have not been so pressed to do this before now. Most of our meetings are in English-speaking countries and in ones where the cultural differences from the US may not be large. It is too soon to identify all the nuances that might distinguish a Vietnamese SMART Recovery® meeting from a US one. During our April training we discussed two likely nuances.

The first is based on the reality that the Vietnamese do not have a concept of "lifestyle." Consequently, the 4th point of the 4-Point Program℠ will be translated, in the short versions, as "balance in life" rather than "lifestyle balance." There had been discussion of this point just being dropped (not a solution I was going to accept!) until I was able to persuade them that balance in living was a concept with a long history in Asian thinking.

Second, in the cost-benefit analysis there, the impact of one's use on one's family is usually high on the list of costs, often in the first place. The strong connections individuals feel with their families also lead to high levels of feeling controlled by their families, and to high family shame about family members' drug use. Many users reported that families were so concerned about relapse that the user would be followed continuously by family members. One solution to feeling resentful about attempted control is to perceive oneself instead as loved and supported by these family activities. However, this solution didn't always seem to fit the facts so well! We will need some time to discover how this issue can be addressed realistically in this culture. From a Western perspective, a greater degree of separation between the individual and family would be indicated. Such a solution may not work well in Vietnam.

Whatever changes in nuance might occur in Vietnamese SMART Recovery® meetings, the SMART Recovery® program is ultimately founded in scientific knowledge and reason, and (to expand the list) human nature. I don't expect the differences between Vietnamese and US meeting to be any larger that the differences we already accept between meetings that might focus on teens vs. adults, inmates vs. community members, opiate users vs. alcohol users, drug users vs. gamblers, drug users vs. overeaters, women vs. men, etc. We may need to work to identify the core principles behind the culturally- or population-bound principle we have thus far articulated, but such work may be a useful challenge for us.

Several of the professionals—Bahr Weiss and Trung Lam—involved in the introduction of SMART Recovery® to Vietnam will attend our annual conference in Boston in November. If you are interested, we all will be glad to discuss the program in Vietnam, so I encourage you to ask about the latest developments there!

Tom Horvath

A smile from the editor re: Tom's having to teach them about "Asian thinking"! Asian professionals may turn out to be more "western" than many American professionals.

SMART Progress

Join us for the Annual Fall 2006 Training Program!

Mark your calendar and make your plans to join us for the fall training programs, November 3-5, at the Crowne Plaza Boston-Natick.

We have an exciting line-up of workshops and training as highlighted on the training grid on page 3.

Two special Workshops will take place on Friday, November 3rd…the *Workshop on Individualized, Evidence-Based Strategies for Managing Addictions*, and *Workshop on the Community Reinforcement and Family Training (CRAFT) Approach*. As an added benefit, a special luncheon presentation on Addiction Psychopharmacology will be provided.

Saturday and a half day on Sunday provide two outstanding training options…the general training program (for individuals who desire to learn more about the program, or to start SMART Recovery® meetings), and the SMART Recovery® Therapy training, designed for treatment professionals who desire to incorporate SMART Recovery® principles into their existing group or individual therapies. And, Saturday also provides an Advanced Organizational Development Program for individuals who have previously attended a training program.

In addition to the excellent programs, the training provides an opportunity to network, share information and success stories, and to develop relationships with Board members, long-time volunteers, and professionals.

Additional information about each program and the registration form can be accessed via the website: **www.smartrecovery.org.**

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SMART Recovery® Training Programs – November 3-5, 2006, Boston, MA – Crowne Plaza Boston-Natick

Workshop on Individualized, Evidence-Based Strategies for Managing Addictions Friday, November 3rd	Workshop on The Community Reinforcement and Family Training (CRAFT) Approach Friday, November 3rd	SMART Recovery® Training Program Saturday, November 4th AND 1/2 day Sun., November 5th	SMART Recovery® Therapy Training Saturday, November 4th (Sunday 1/2 day Program Optional & Free)	Advanced Organizational Development Program Saturday, November 4th
7:30 – 8:30 Registration & Continental Breakfast 8:30 – 12:00 Program 12:00 – 2:00 Lunch * 2:00 – 5:00 Program **Presented by:** Dr. F. Michler Bishop **Audience:** Psychotherapists, counselors, social workers, psychologists, psychiatrists, internists, pastoral counselors, correctional facility counselors **CE Credits:** 7 / **Price:** $99	7:30 – 8:30 Registration & Continental Breakfast 8:30 – 12:00 Program 12:00 – 2:00 Lunch * 2:00 – 5:00 Program **Presented by:** Dr. Robert Meyers **Audience:** While the program is designed for treatment providers, any and all are welcome – including concerned significant others/family members **CE Credits:** 7 / **Price:** $99	**Saturday, Nov. 4 – Day 1** 7:30 – 8:30 Registration & Continental Breakfast 8:30 -12:00 noon Program 12:00 – 1:15 Lunch 1:15 – 5:00 Program **Presented by:** SMART Recovery® Board Members **Sunday, Nov. 5 – Day 2** 8:00 – 9:00 Continental Breakfast 9:00 – 12:15 Program **Presented by:** Jonathan von Breton **Audience:** New facilitators, individuals wishing to start a meeting, persons wishing to learn more about the program **CE Credits:** 10 **Price:** $99 (Free to SMART Recovery® Facilitators & Advisors)	**Saturday, Nov. 4 – Day 1** 7:30–8:30 Registration & Continental Breakfast 8:30 – 12:00 noon Program 12:00 – 1:15 Lunch 1:15 – 5:00 Program **Sunday, Nov. 5 – Optional FREE program** 8:00 – 9:00 Continental Breakfast 9:00 – 12:15 Program **Presented by:** Dr. Michler Bishop, and Fraser Ross on Saturday; Jonathan von Breton on Sunday **Audience:** Licensed or certified health professionals, or interns. **CE Credits:** 7 (+3 for Sunday program) **Price:** $99 (Free to SMART Recovery® Facilitators & Advisors who are registered treatment professionals)	7:30 – 9:00 Registration & Continental Breakfast 9:00 – 12:00 noon Program 12:00 – 1:15 Lunch 1:15 – 5:00 Program **Presented by:** Dr. Tom Horvath **Audience:** Training participants who have previously attended a SMART Recovery® Training Program (prior training attendance required) **Price:** Free to SMART Recovery® Facilitators & Advisors who have previously attended a training program

*Special Presentation, Friday, 12:45 – 2:00 p.m.

Addiction Psychopharmacology comes of age: Understanding the role of medication in the treatment of addictive disorders

Dr. Alan Wartenberg will address the available options in treatments which deter substance abuse and/or decrease craving, as well as maintenance pharmacotherapies. He will also discuss the expanding role of treatment of underlying psychiatric disorders, and the role which medication can play combined with behavioral interventions. Dr. Wartenberg is the Medical Director of Discovery House programs, a group of outpatient opioid treatment centers, and is in private practice of addiction medicine at Meadows Edge Recovery Center in Rhode Island. He is a general internist with interest in detoxification, medical complications of addiction and education of human service professionals in addiction issues. He is on the faculty of Tufts and Brown Universities.

SMART Recovery® OnLine Update

SMART Recovery® OnLine (SOL) now has nearly nine thousand registered members, doubling its membership in the just the last 12 months of activity. There are participants from the USA, Canada, Australia, Africa, Asia, and Europe - UK, France, Spain and Italy. SOL is truly a worldwide community supporting SMART Recovery® principles in all four corners of the globe.

The online Meeting schedule currently provides three meetings a day, except for Friday, which has two. Most of the meetings take place in Parachat (text only) with some meetings in Evoice (text and talk). This allows

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members to choose between venues and formats that suit both their preferences and capabilities. We have six new facilitators currently fulfilling online training requirements via a combination of home study and working alongside existing facilitators in the regularly scheduled meetings. Meeting attendance is settling at averages of 14 attendees for the early morning EST meetings, with a strong presence from our Australian and European members, to an average of 20 participants, in the mainly US membership evening (EST) meetings.

We are pleased to continue to offer a variety of meetings, including Introduction for Newcomers sessions, held on Thursdays and Sundays. The Topic Meeting on Sunday evening explores SMART Recovery® themes such as REBT, CT and VACIs and the Wednesday evening Point Meeting focuses on the 3rd and 4th Points of the SMART 4-Point Program℠. All the other meetings follow General SMART Recovery® meeting format.

The Message Board remains busy this quarter with the Greeting Café being the first port of call for many. Volunteers from the Welcoming Committee and general members keep a special eye out for first posts to support and welcome those taking initial steps in looking at SMART Recovery® principles. The main Discussions board is where the tools and concepts of the 4-Point Program℠ are vigorously and passionately discussed. The group areas continue to flourish, with focus on early recovery, specific SMART tools, daily and ongoing 'benefits of stopping' quadrant of the CBA, the maintenance stage, and long-term thinking goals.

The online Parachat facility doors are still open 24/7, often with people from all over the world sharing ideas about recovery and discovery, feedback on SMART Recovery® methods and personal stories of success and empowerment with each other, as well as a place for fun and distraction, friendship and support. The chat room volunteers - Paragreeters - help to ensure that new members are welcomed and listened to and are available to answer questions about SMART Recovery®.

The new Member Feedback Group has been working to gather data, via an online survey, regarding how members view and use the SOL facilities. This gives us important information so that we may continue to provide services that are in the self-acknowledged interests of those who use them, while keeping a consistent structure of principles congruent with SMART Recovery® concepts. In addition to member feedback for the general areas, the volunteers continue to work closely with the area Liaisons to facilitate open communication between volunteers and the Director.

As we go into the summer months, SOL continues to provide a safe and welcoming environment for those looking for an online resource to understand and act against addictive behaviors, and work towards realizing new and healthier goals and achievements. Thank you to all that make it so—administrators, volunteers in all areas, and members.

www.smartrecovery.org – Please do come and visit.

SMART Recovery® Program Tools & Techniques

The SMART Recovery® 4-Point Program℠ employs a variety of tools and techniques to help individuals gain independence from addictive behavior.

These tools include:

- Change Plan Worksheet
- Cost/Benefit Analysis
- ABCs of REBT (Rational Emotive Behavior Therapy) for Urge Coping
- ABCs of REBT for Emotional Upsets
- DISARM (**D**estructive **I**mages **S**elf-talk **A**wareness and **R**efusal **M**ethod)
- Brainstorming
- Role-playing and Rehearsing

Participants are encouraged to learn how to use each tool and to practice the tools and techniques as they progress toward Point 4 of the program—achieving lifestyle balance and leading a fulfilling and healthy life.

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Results from a Major Study of Antidepressant Medications—Good News or Bad?

by John Boren, PhD, Member, SMART Recovery® Board of Directors

Several years ago the National Institute on Mental Health (NIMH) funded a major research project on the effectiveness of antidepressant medications in treating depression. The study, funded with $35 million, was the largest trial of antidepressant medications ever conducted. The first results, published earlier this year, may interest SMART Recovery® participants because of the frequent co-occurrence of depression and substance abuse. The two disorders interact so that one typically makes the other worse. In my experience a SMART Recovery® meeting can have several attendees dealing simultaneously with both substance abuse problems and depression. Although targeted psychotherapy and antidepressant medications are both generally recommended for treating depression, many people elect to try only antidepressant medication, possibly because of TV and other advertising. Certainly we don't see any TV ads, saying, "Ask your doctor about psychotherapy." I recall a face-to-face meeting of SMART Recovery® a few months ago where five of the eight attendees disclosed they were taking antidepressants. In that meeting, I asked whether the medications had helped. Some reported yes, some reported no, and some were not sure. How effective in general are antidepressant medications and what percentage of people benefit? Three publications from the recent NIMH study attempted to answer these questions and more.

There is only limited scientific evidence on how to treat depressed patients who have not gotten relief from their first trial of antidepressants. Although it is not well known to the public, a large majority of patients are in this category. The main purpose of the NIMH study was to determine the effectiveness of several follow-up treatments for depressed patients who had not responded well to initial treatment with an antidepressant. Furthermore, the researchers wanted to study real patients in real clinics so that the results could apply to clinical practice in the real world. Past research trials of antidepressants, frequently designed and sponsored by the pharmaceutical companies that sell them, often failed to simulate real world conditions in several ways. The trials were usually short (four to eight weeks), used selected volunteer subjects whose depression is uncomplicated by other psychiatric, medical, or substance abuse problems, used "clinical improvement" in evaluating outcome, and rarely reported a follow-up treatment after the initial medication trial was over. Critics maintain that this sort of research simply does not correspond to the real world of clinical practice where patients often have multiple problems in combination with depression and where continued and varied treatment is the rule. Critics also point out that clinical improvement (a better score on the test assessing depression) is not a useful endpoint. Improvement which leaves the patient with symptoms of depression is too often followed by relapse, continued disabling symptoms, poor work productivity, impaired psychosocial functioning, and a risk of alcohol/drug abuse.

The new NIMH research trial was designed to avoid these criticisms and to study next-step interventions in the many people who failed to benefit from their first treatment with an antidepressant. Unfortunately, the trial did not include a placebo control group that would have permitted an assessment of how much benefit came from the drug and how much from other likely factors, such as a placebo effect, spontaneous recovery, and exceptional psychiatric/medical care.

The entire study, when complete, will have four complicated sequential levels (steps) of treatment. The first two levels have been completed and described in recent 2006 publications, so we will focus on these two levels, which are complicated enough. I will describe the goals of the study, the participants, the treatments, the results, and, finally, a summary and commentary on the study.

The goals: The first goal, addressed in the Level 1 trial, was to treat a large sample of real world outpatients with Celexa, a representative SSRI medication, to determine how many patients would achieve remission from depressive symptoms. The second goal, addressed in the Level 2 trial, was to study two follow-up treatments for the many patients who emerged from Level 1 with either intolerable side effects or continued symptoms of depression. One follow-up treatment was to switch to a different antidepressant, and the other was to augment (add to) the Celexa dose with another medication. The third and final goal was to determine the characteristics of people with depression that will help predict who will or will not do well on antidepressant medications.

The participants: A large number of outpatients, 4790, were screened for possible inclusion in the study. These were real outpatients voluntarily seeking treatment in either primary medical sites or in specialized psychiatric sites, both public and private, throughout the United States. They were informed of the treatments to be studied and had to give their consent to participate at each step. 2876 people (still a large number) were eventually entered into the Level 1 study and treated with citalopram, better known by the trade name Celexa. From among the many antidepressant drugs, Celexa was selected as a prototype SSRI (selective serotonin uptake inhibitor), as good as any and better than some, with no discontinuation problems and few interactions with other medications. The patients were told to consult treating physicians at weeks 2, 4, 6, 9, and 12. At these visits the physicians not only inquired about depression and side effects and adjusted the dosage of Celexa but they also treated general medical conditions including anxiety,

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sexual dysfunction, and sleep problems (symptoms of depression). This level of care, paid for by grant money, is exceptional and rarely found in the real world of clinical treatment.

Results of the Level 1 treatment with Celexa: In planning the study the researchers decided that the primary outcome of interest would be "symptom remission" as defined by a score of 7 or less on a well-known test, the Hamilton Rating Scale for Depression (HRSD). Unless you know the exact test questions, it is hard to comprehend what a score of 7 means, but it represents a very substantial reduction in depression. As mentioned above, remission versus improvement can be easily justified as the goal of treatment because improvement short of remission is more likely to be followed by relapse, poor daily functioning, and substance abuse. Independent assessors, uninformed of a patient's treatment, administered the HRSD by telephone, insuring that investigator bias would not influence the results.

Of the 2876 outpatients treated with Celexa for up to 14 weeks, 790 or 27.5% reached remission. This means that 2086 patients or 72.5% did not. Patients who dropped out of the study, sometimes because of intolerable side effects, were included in the number who did not achieve remission. This lack of treatment success occurred even though the patients received an exceptional level of medical/ psychiatric care at weeks 2, 4, 6, 9, and 12. From other studies we know that this much nonspecific care (nonspecific with respect to depression) should by itself have a therapeutic effect on depression.

Another goal of the study was to determine the characteristics of depressed people who will probably do well on antidepressant therapy and those who probably will not. Questionnaires and interviews revealed that worse outcomes were found in people who were less educated, non-Caucasian, unmarried and living along, and had lower income or were unemployed, more severe depression, more medical problems, more psychiatric problems, more substance abuse, less satisfaction with life, and less private health insurance. In depressed people who have such problems as low education, low income, unemployment, medical disorders, and low social support, maybe we should not expect an antidepressant to help.

Results of Level 2 Treatment: The researchers had expected that a large majority of patients would not benefit from a single course of Celexa. Therefore, they designed the research protocol to offer a second level of treatment. Consistent with the goal of having the research protocol simulate real world treatment, the unsuccessful patients from Level 1 were offered two types of continuing treatment: a switch to one of three other antidepressants, or an augmentation (addition) of a second drug to the Celexa they had taken previously without relief of symptoms. In the "switch" treatment, 727 patients who consented were randomized into three groups to receive Zoloft (sertaline), Effexor (venlafaxin), or Wellbutrin (bupropion). The researchers offered Zoloft, another frequently prescribed SSRI, on the grounds that a different SSRI might work even though Celexa didn't. They offered Effexor, a "dual-action" drug that is believed to inhibit the reuptake of *both* serotonin and norepinephrine, on the grounds that a depressed person's brain might benefit from more serotonin and more norepinephrine. And finally they offered Wellbutrin, an "out-of-class" antidepressant whose neurochemical mechanism of action is unknown (it is not an SSRI), was offered on the grounds that depressed patients might benefit from something entirely different.

In the "switch" wing of the study, the results were remarkably similar for the three drugs. The remission rates measured by the Hamilton Rating Scale for Depression (HRSD) were 17.6% for Zoloft, 24.8% for Effexor, and 21.3% for Wellbutrin. Statistically, there was no significant difference among the three medications. Of the 727 patients who were switched to these three medications, 155 achieved remission. Thus, the overall remission rate was 21.3%. Stated differently, 78.7% were not relieved of depression. This result is puzzling in that medications with different neurochemical actions were approximately equivalent.

In the "augmentation" wing of the study, 565 patients consented to having another medication added to the Celexa they had taken previously without relief of symptoms. They were randomly assigned to have either Wellbutrin or Buspar (buspirone) added. Wellbutrin is another antidepressant but Buspar is not. It is used clinically to treat anxiety and has some mild sedative effects. On the basis of HRSD scores, remission rates differed very little between the group given Celexa plus Wellbutrin (29.7%, or 83 of 279 patients) and the group given Celexa plus Buspar (30.1%, or 86 of 286 patients). If we total the remission results of both augmentations, we find that 169 of 565 patients or 29.9% saw a remission. 70.1% did not. The numbers seem to say that it is somewhat better to augment Celexa with Wellbutrin or Buspar with a 30% remission rate than to switch to other antidepressants with remissions rates ranging from 18% to 25%. However, due to the way the research was designed with different sets of patients consenting or not consenting to be assigned to certain treatments, the switch and augmentation treatments simply cannot be directly compared.

Summary and Commentary: We often see TV ads or newspaper articles suggesting that antidepressant medications work because they prevent the reuptake of brain serotonin. However, the "switch" study showed that medications with various neurochemical actions were all roughly equivalent. What can we possibly infer about the presumed neurochemical action of antidepressants? At this point we need to understand that the widely reported mechanisms of action of antidepressants are presumptive and not scientifically established as causal. If we look up the various

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antidepressants in the Physicians' Desk Reference where the information must be FDA approved, we always find the phrases, "is presumed to be" and "is believed to be." For example, the lead sentence describing the pharmacology of Zoloft reads as follows: "The mechanism of action of sertraline *is presumed to be linked to* its inhibition of CNS neuronal uptake of serotonin." In the pharmacology section on Effexor, we read, "The mechanism of the antidepressant action of venlafaxine in humans *is believed to be associated* with its potentiation of neurotransmitter activity in the CNS." The basis of the presumption usually comes from animal studies where the laboratory investigator can extract samples from an animal's brain after injections of the antidepressant drug. In the animal studies, it can be shown that an SSRI drug increases brain serotonin. However, even if the drug has the same biochemical action in humans and also helps depression, it is a logical leap to assume that a particular biochemical action was responsible. All drugs have multiple actions in various sites in the human body. When we observe a biochemical event (more serotonin) and at the same time another event (less depression), we have observed a correlation. We have not established that the first event *caused* the second. The cock's crow in early morning accompanies the sunrise (a correlation), but it would be quite a leap in logic to think the cock's crowing caused the sunrise. No doubt brain chemistry changes when a person becomes depressed or undepressed, but what causes what is not established and the relationships are likely to be complex.

For sufferers from depression, are the results of this large NIMH study of sequenced drug treatments to relieve depression good news or bad news? Suppose for the moment we look on the bright side and take the results at face value. A depressed person, even if he/she may have complications from substance abuse and other disorders, has about a 28% chance of getting relief after a single three-month course of an antidepressant drug (Celexa). People who did not get relief can persist with a second three-month course of medication, either by switching to another drug or by augmenting the original drug with a second one, and have a 21% chance of relief with one strategy and a 30% chance with the other. Although a statistician might tell us we are playing a little fast and loose with the numbers, we can estimate that the people who plan to persist through *both* levels of treatment have about a 43% chance of getting remission in the worst case and a 50% chance in the best case. This outcome could be viewed as good news to a depression sufferer because depression is an exceedingly unpleasant disorder, and six months of treatment, even if the drugs are expensive and the side effects are disagreeable, might well be worth it.

By taking the results of the study at face value, however, we are assuming that the antidepressant medication was responsible for the remissions. There are at least three other factors that probably contributed to the observed remissions. One is spontaneous recovery. A number of studies have shown that many depressed people recover on their own, perhaps with the help of family, friends, exercise, a deliberate return to their life's normal activities, etc. A second factor is the large amount of individualized psychiatric and medical care that patients received at weeks 2, 4, 6, 9, and 12. Following the standard study protocol, treating physicians talked to the patient, evaluated depressive symptoms and side effects at each visit, adjusted the dose of medication, and treated medical problems as well. Few patients in the real world receive this level of care. How much difference could this exceptional care make? A *Washington Post* article, based on interviews of lead researchers of the study, stated the following: "If patients in this study had received the kind of care that patients receive on average, the researchers said, the remission rate probably would have been significantly lower—perhaps even in the single digits."

The third factor that probably contributed to the observed remissions is the placebo effect. A substantial number of depressed people will get better if they think they are getting an effective medication, even though the pill is an inert placebo. The pool of participants in Level 1 had all consented to treatment with Celexa, and the pool in Level 2 consented to continued drug treatment. It is not unreasonable to believe that most people who gave informed consent to participate in the study must have expected to benefit from medication. A placebo control group, if it had been included in the study, would have benefited from the placebo effect plus the medical/psychiatric care plus a six-month opportunity for spontaneous recovery. How much remission can be expected in this sort of placebo control group? In 2002 Kirsch et al. reanalyzed 47 placebo-controlled trials of the six most widely prescribed antidepressants. These trials, supported by the pharmaceutical manufacturers of the drugs, were reported to the FDA to gain approval of their medications. Kirsch's analysis showed that, *although a positive response to antidepressants occurred, the response to inert placebos was almost as great*. The average difference, though statistically significant, was about two points on the Hamilton Rating Scale for Depression. Kirsch et al. concluded that *82% of the drug response was accounted for by the placebo effects. More than half the 47 clinical trials sponsored by the pharmaceutical companies failed to find any significant differences between placebo and drug.*

The bad news, then, is that it is very hard to tell how much, if any, of the reported positive outcomes were due to the medications. An individual seeking relief from depression may find it hard to justify the high expense of medication and the disagreeable adverse side effects when a positive outcome is so uncertain and might be due to factors other than the medication.

It appears that the drug industry may have biased the public's understanding of the effec-

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tiveness of antidepressant medications. If anyone would like to know more about how the drug industry in league with biological psychiatry has also biased our understanding of the basis of depression, a recent book, "The Myth of Depression as a Disease" by Leventhal and Martell (2006), is well worth reading. The authors view depression, not as a brain disease, but rather as a mood and behavioral disorder resulting from adverse life situations. "It's Not Your Brain; It's Your Life" is the title of one of their chapters. When a person encounters extremely adverse life situations and becomes locked in depression, it may well be that his brain chemistry changes as a result. However, the authors could not find scientific evidence for the widespread belief, fostered by pharmaceutical companies and biological psychiatrists, that depression is caused by defects in brain chemistry. Some people may indeed inherit a predisposition, quite possibly via brain chemistry, to develop depression, but without an interaction with adverse life events, the predisposition would be unlikely to affect them. The book also presents studies on the effectiveness of behavioral therapies in treating depression. The gist of the findings: depression-targeted behavior therapy is at least as effective as medication as a treatment for depression in the short term but is more effective in the long term because the relapse rate is lower after treatment is discontinued.

Unbiased, science-based information on treatments for depression is not easy to come by, but if a person seeking treatment can get the facts, he/she has an opportunity to make a sound decision. The information in this article might help.

The Virtues of DISARM

by Hank Robb, PhD, ABPP

I'm going to spend a little time touting the virtues of DISARM (Destructive Images Self-talk Awareness and Refusal Method) – a method for recognizing destructive tendencies and refusing to go along with them. As a long time member of the REBT community, it is second nature for me to look for Irrational Beliefs and dispute them. However, there is one disadvantage to doing this with yourself. Namely, the part of you that does the disputing is no smarter than the part of you that produces the stuff that needs disputing in the first place. With DISARM, I don't have to show myself why my nonsense is, indeed, nonsense. I can just refuse to go along with it.

I often think sexual seduction is a good model for dealing with self-defeating tendencies from the DISARM perspective because most people have had some experience with sexual seduction. If at some point the would-be-seducer gets blocked, the next move is, "Well, can't we at least talk about it?"

Now folks, if you've been there, you know this is not a "neutral" move. Instead it is the next move in a general program of seduction. Here's why. "Can't we at least talk about it" is not going to include a discussion of whether the "seducer" is going to give up his or her interest in seduction. In the "discussion" the seducer is going to stay focused on why the potential seducee should give in.

So, the first step is RECOGNIZING that seduction is in progress. Actually, this isn't too hard. Just ask yourself what is going to happen if you go along with the thought, image, sensation, or combination of those. If the answer is that you'll be doing the behavior you already decided to abstain from, then seduction is underway.

Be on the look out for the best move of all for the "seducer" in this situation, "Yes, you will be drinking, snorting, injecting, gambling, etc. but you really won't be." Folks, you can't use and not use at the same time any more than you can have sex and not have sex at the same time. The notion that you can is just more seduction.

Now comes the best part, REFUSAL. Make Nancy Reagan happy and, "Just say no!" Now Nancy seemed to think that would be the end of it, but, of course, it won't. And, you can move to, "No!," "Hell No!," and "Go screw yourself because I ain't doing it!"

Then comes, "Well can't we at least talk about it?"

"NO!"

"Well that's just not rational."

"Yep."

"Well you're supposed to be rational about your addictive behavior, so let's discuss this."

"Very interesting, but I'm doing something else now."

The truth is you don't HAVE TO be reasonable or sensible or rational or anything else. You don't HAVE TO abstain either. But, you can CHOOSE to abstain. Why would you? Simply because engaging in your addictive behavior doesn't work for you. You don't HAVE TO first "win the argument" and "vanquish your irrationality." You can just move your hands, arms, feet and mouth in a different direction.

Of course "Blah, blah blah" is likely to come right along with you. The thoughts, images and sensations inside you can't just be dropped off at the corner like an empty six-pack, crack pipe or racing form. You might have to keep on hearing the seduction, but you don't have to really listen. I bet I'm not the only one in life who has responded to, "Do you hear what I am telling you?" with "Yes," and at the same time wasn't really listening.

Disputing your irrational beliefs is an important part of the SMART Recovery® program. However, it's often nice to have alternatives in life. RECOGNIZING invitations to engage in your addictive behavior and REFUSING to go along with them can be an additional alternative. Check it out for yourself.

Editor's note: Not listening to destructive imagery and self-talk is as rational as it gets.

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People Power

A Heartfelt Congratulations!

Linda Carter Sobell, Ph.D., ABPP, member of the SMART Recovery® International Advisory Council, will receive the Betty Ford Award from the Association for Medical Education and Research in Substance Abuse on November 3, 2006. The award is presented for making a significant impact on the field of alcohol and drug abuse. Congratulations, Linda!

Nice Notes of Thanks

A number of the members of the Edina, Minnesota SMART Recovery® group took the time to say thanks for the ***News & Views***. Their comments and encouraging words were greatly appreciated! Here are several excerpts from their letters:

In the latest issue, I found Tom Horvath's article on substitute addictions, and Hank Robb's piece on "True Explanations" to be extremely useful. Consistent with Dr. Robb's piece, Dr. Tate's article on "3 Minute REBT" provided directly actionable know-how. I also want to thank Stuart Anderson for sharing his story and to wish him continued success. His openness about his own journey increased my hope for my own future.

Your article on Jim DeSena's book was a breath of fresh air. I know that everyone, along with their addictions and recovery, are different, and have to agree with Jim DeSena's views. I would gladly recommend this book to folks new to "alternatives".

Especially helpful was "An Empowering Alternative", which very plainly states the bias towards any treatment which is not faith-based and traditional. I feel very lucky to have information I can use as proof that there is hope for recovery – COMPLETE recovery, not a lifetime of still believing that I am a problem, rather than that I have one. Please keep the good articles coming!

The newsletter is useful to those thoughtfully engaged in both the personal and professional practice of recovery.

Letter to the Editor

Dear Editor, Pub hours in Great Britain

While remaining an enthusiastic supporter of SMART Recovery®, I must protest at the way this topic was covered in the Spring Issue of *SMART Recovery®* ***News & Views*** (p.8). For one thing, the piece seemed to take the extraordinary position that the statement of a government minister on the effects of the extension of opening hours, particularly a minister who was responsible for implementing the legislation, can actually be believed!

The facts are that the early changes the minister referred to, even assuming the figures are accurate, could equally well be due to changes in police behaviour as to real changes in crime and violence and that the government has made no provision for the effects of the new laws to be evaluated in any scientifically credible manner. In other countries in which opening hours have been extended – Iceland, Australia and Ireland—subsequent increases in alcohol-related violence were well documented. References for these assertions could easily be provided.

The extension of pub opening hours must be seen in the context of the UK showing the steepest increase in rates of cirrhosis mortality over the last 10 years in western Europe and of British teenagers being among the heaviest drinkers among their age-group in Europe – certainly far higher than those in the USA. As anyone who has lived in the UK recently will know, the centres of cities, large or even medium-sized towns throughout the country have become "no-go areas" for adults late on Friday or Saturday nights owing to drunken disorder among young people spilling out on to the streets from a multitude of "super-pubs," disco bars and night-clubs. It is little exaggeration to say that British urban centres at weekends have begun to resemble a painting by Hieronymus Bosch. Combined with the alcohol industry's advertising and promotional activities, one consequence is that British teenage girls now binge drink more frequently than boys and that the rate of liver disease among young women has shown an alarming increase in the last few years. The government not only appears completely unconcerned about these developments but is actually prepared to risk aggravating the situation by making alcohol even more easily available. Most observers of the British scene have concluded that the government is far more interested in pleasing its friends in the alcohol industry than in taking any effective measures to limit the damage done by the industry's products.

As to the idea that the supposedly benign effects of extended opening hours are "yet another disconfirmation of the Disease Theory of Addiction's 'loss of control/out of control' hypotheses", this is patent nonsense. If there is a predetermined disease called "alcoholism," it cannot matter how early or late the pubs shut to those who are predisposed to develop the disease if they drink at all. The relationship between the availability of alcohol, whatever exactly that relationship is, and alcohol-related harm is clearly part of a social learning account of drinking and its attendant problems. And the main kinds of harm resulting from increases

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in alcohol's availability are medical damage and the consequences of acute intoxication, not alcohol dependence.

Many people, including myself, are worried about recent changes in the level and manner of alcohol consumption in the UK and the effects this is going to have on the next generation but feel we are fighting an uphill battle against government indifference and alcohol industry irresponsibility and greed. It is disappointing to find the latter tendencies given support in the pages of *Smart Recovery® **News & Views***.

Yours faithfully,
Nick Heather PhD

Emeritus Professor of Alcohol
& Other Drug Studies,
Northumbria University,
Member, SMART Recovery®
International Advisory Council

Editor's note: Nick is a respected colleague, and when he speaks, I listen. He makes some surprising and stimulating points. It had not occurred to me that the British government statistics might be doctored, or that the police might have changed their behavior. Arizona extended its pub hours about a year ago to 2:00 a.m. from 1:00 a.m. According to the Governor's Office of Highway Safety and the Department of Liquor Licenses and Control, the timing of alcohol-related wrecks and DUI arrests has shifted to later, but the numbers have not increased. The purpose of the increase was to increase revenue. I don't know whether that has happened, but again, I suppose the accident and arrest figures here could also be "massaged." Figures from the U.S. National Highway Traffic Safety Administration show that the proportion of alcohol-related deaths are 44.4% (of all traffic deaths) in states whose bars close at 1:00 or 1:30 a.m., 41.8% in states whose bars close at 2:00 or 2:30 a.m., and 38.6% in states whose bars close at 3:00 or 3:30 a.m.

It remains possible for alcohol-related crime to decrease, and alcohol-increased-availability-related health problems to increase. However, it seems to me that unless alcohol has been becoming more and more available, that upward trends in health problems could not be related to that factor.

Consideration of Self is the Prerequisite

by Barry A. Grant

The cycle of good rational acceptance of valuable information has surfaced in such a way that I am compelled to devote this edition of "Beyond The Walls" to my latest personal experience. As many of you who have been following what I believe is an extraordinary journey—thanks in great part to SMART Recovery®—the empirical information I altruistically share is truly born out of the desire to tell you the benefits of a changed perspective which is really what our organization is all about.

The tools and techniques used in SMART Recovery® provide finely tuned and easily applied instruments for dealing with self-abuse with substances and related self-defeating/destructive beliefs. Which is very good! However, I cannot underscore enough the even greater elation I derived from training administrative, clinical and operational personnel on the basic mechanics of REBT (Rational Emotive Behavioral Therapy). Having had the opportunity to observe "before REBT" and "after REBT," in my own life, I can deliver to other people, through me—not from me—clarity of understanding.

I found that irrational human behavior can be vivid even when cloaked behind a veil of, "I'm okay and you need help", as opposed to criminal errors in thinking or obvious, addictive, distorted, irrational—and undisputed—thinking. Perhaps I'm biased by having handled constructively circumstances that are at the very least non-preferred. Yet, the results after the three-hour session revealed that disputation—in other words—a thorough examination of what the Administration believed about its staff, to what the clinical team believes about its residents (clients or customers), or what interdepartmental colleagues, created a rent in the efficacy of rational communication.

To that end I would like to applaud the very base concept found in the acronym SMART Recovery®. This is because it is the Management of one-Self, and it is the often arduous, yet in most cases rewarding, results that come from training which fortifies the journey of recovery from self-defeating beliefs as well as discovery of our intuitive healthy self-care. Moreover, as one who works within the so-called belly of the beast when it comes to addictive behavior and errors in thinking, the vibrations that reverberate through encouraging disputation among the myriad of people, whose jobs call for the separation of peoples' behavior from who they truly are, it is my contention that we would all be wise to look "Beyond The Walls" of our own psychological constructs and do a detailed disputation of ourselves. After all…You cannot work it in another if you are not working it in yourself!

Positively Speaking: If you don't celebrate yourself responsibly, it is likely that you will eventually tolerate being the responsibility of another. Perhaps your management will default to the even more irrational part of yourself that you would most prefer to leave disengaged. The choice is yours.

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U.S. 8th Circuit Court of Appeals Rules: Requiring Sex Offender to Recite Serenity Prayer May Violate Establishment Clause

by Steve McCullough, Certified Paralegal

James Munson, an Arkansas prisoner, filed this action against the Arkansas Department of Correction (ADC) Director Larry Norris and Assistant Director Ray Hobbs; Tucker Unit Warden David White; Post Prison Transfer Board (PPTB) Chairman R. Brownlee and Member John Felts; and Reduction of Sexual Victimization Program (RSVP) Director Max Mobley, Coordinator Roy Dunlop, counselor Phyllis Smith, and Dr. Stephen Clark.

Munson alleged that he was granted parole in June 2000 with the stipulation that he first complete the RSVP, a one-year sex offenders' class. He began the program in January 2001, but was removed from it in September 2001. While in the program, he refused to admit to certain charges that the prosecuting attorney had included on an information sheet, claiming that requiring him to do so violated his Fifth Amendment right against self incrimination. He further alleged that counselor Smith told him that she "disapproved of Mr. Munson's interracial marriage" and would use her power as a counselor to remove him from the RSVP. Munson also claimed that, in violation of his First Amendment rights, he had been required to recite a prayer known as "the Serenity Prayer", a requirement approved by ADC Director Norris, Assistant Director Hobbs, RSVP Director Mobley, Coordinator Dunlop, Dr. Clark, counselor Smith, and Warden White.

Munson moved for appointment of counsel, but his motion was denied and he was forced to proceed pro se. The district court then held a pretrial evidentiary hearing, at which Munson was the only witness. He became eligible for parole in May 2000, but the PPTB told him that he must first complete the RSVP, because he had been convicted of a sex crime. Prior to starting the RSVP, Munson was shown the prosecutor's report of the incident for which Munson was convicted, and he was told that he had to admit to everything in the report or he would not be permitted to complete the RSVP. Munson refused to make the requested admissions because the report contained a false statement. In addition, at the RSVP meetings, Mr. Munson objected to being required to recite the Serenity Prayer, as he did not wish to use the word God. "The record shows," the Court wrote, "this prayer was modeled on the Alcoholics Anonymous (AA) Twelve Steps and repeatedly referred to God."

"This decision by the United States 8th Circuit Court of Appeals is very significant, because the 8th Circuit now becomes the fourth United States Circuit Court of Appeals to hold that plaintiffs state sustainable causes of action when they allege government coercion to attend 'meetings' in which 12 Step tenets are espoused."

Munson was told that if he did not say the prayer, he would be expelled from the program. When Mr. Munson skipped the prayer, he was placed on extra work detail. Two weeks later, Coordinator Dunlop and a Ms. Clinton told Munson that all the RSVP therapists and counselors had voted to remove him from the program. In a letter to the PPTB, a Dr. Gamble and Coordinator Dunlop explained that Munson had been discharged from the RSVP for "failing to make sufficient progress."

The district court held against Munson as follows:

1) Mr. Munson had no constitutional right to be conditionally released before the expiration of his valid sentence and, thus, the PPTB's demand that he complete the requirements of the RSVP program did not violate his Fifth Amendment rights. (The Fifth Amendment, among other things, is supposed to protect Americans from self incrimination.)

2) Munson's Fourteenth Amendment claim was unsupported, because only one counselor criticized his interracial marriage and all of the counselors decided to remove him from the program. (The Fourteenth Amendment, among other things, is supposed to guarantee Americans due process of law before denying them life, liberty or property.)

3) Munson's First Amendment rights were not violated by the RSVP prayer requirement, because he had not been written up or removed from the program because of his refusal to pray but, rather, his "fail(ure) to make sufficient progress." (The First Amendment, among other things, is supposed to guarantee that government not establish a religion).

The district court accordingly dismissed all counts of Mr. Munson's complaint with prejudice. Munson filed this appeal to the United States 8th Circuit Court of Appeals.

In the case of *Munson V. Norris*, 435 F.3d 877 (8th Cir. 2006), the 8th Circuit Court of Appeals upheld the district court's denial of Munson's Fifth Amendment claim, finding that "RSVP and ADC officials were not responsible for the parole condition (that inmates convicted of a sex offense had to complete the RSVP) and had no power to remove it." The 8th Circuit Court of Appeals also upheld the district court's denial of Munson's Fourteenth Amendment claim, finding that "Only Counselor Smith expressed disapproval of Munson's interracial marriage, and all RSVP therapists and counselors voted to remove Mr. Munson from the program." However, the district court's

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dismissal of Munson's First Amendment claim was reversed, and the 8th Circuit Court of Appeals remanded the matter back to the district court with specific instructions to "decide whether requiring Mr. Munson at the RSVP meetings to recite the Serenity Prayer was in violation of the Establishment Clause (of the First Amendment to the U.S. Constitution)."

The U.S. 8th Circuit went on to provide the district court with some guidance on the question by citing the following precedent:

"[S]ee, e.g., *Warner v. Orange County Dep't of Prob*., 115 F.3d 1068, 1075-76 (2d Cir. 1996) (county government agency violated Establishment Clause by conditioning plaintiff's criminal probation on his participation in AA; noting considerations would have been different had plaintiff been offered reasonable choice of therapy providers so that he was not compelled by state's judicial power to enter religious program); *Kerr v. Farrey*, 95 F.3d 472, 479-80 (7th Cir. 1996) (prison violated Establishment Clause by requiring attendance at Narcotics Anonymous meetings, which used "God" in its treatment approach, where refusal to attend could negatively impact inmate's security-risk rating and consideration for parole); *Griffin v. Coughlin*, 88 N.Y.2d 674, 649 N.Y.S.2d 903, 673 N.E.2d 98, 101-05 (1996) (conditioning desirable privilege—family visitation—on prisoner's participation in religious program that incorporated AA doctrine, without alternative, was violation of Establishment Clause), cert. denied, 519 U.S. 1054, 117 S.Ct. 681, 136 L.Ed.2d 607 (1997)"; *Munson* @ 880 - 881.

This decision by the United States 8th Circuit Court of Appeals is very significant, because the 8th Circuit now becomes the fourth United States Circuit Court of Appeals to hold that plaintiffs state sustainable causes of action when they allege government coercion to attend meetings in which 12 Step tenets are espoused. By adopting existing precedent, the 8th Circuit now joins the 2nd Circuit, *Warner v. Orange County Dep't of Prob*., 115 F.3d 1068 (2d Cir. 1996); the 3rd Circuit, *Rauser v. Horn*, 241 F.3d 330 (3rd Cir. 2001); and the 7th Circuit, *Kerr v. Farrey*, 95 F.3d 472 (7th Cir. 1996), in holding that government coercion to attend meetings in which 12-Step doctrine is embraced constitutes an impermissible requirement to participate in religious exercise unless non-religious alternatives are practically provided. None of the U.S. Circuit Courts of Appeal has ruled otherwise.

The decision of the 8th Circuit panel was unanimous. Counsel who represented the Appellee was Renae Ford Malone, Assistant Attorney General, of Little Rock, Arkansas. Also appearing on the brief for the Appellee was Mike Beebe. The Appellant, James R. Munson, Jr., of Newport, Arkansas, represented himself.

Decisions by the United States 2nd Circuit Court of Appeals are mandatory authority over federal courts located within the states of New York, Connecticut and Vermont. Decisions by the United States 3rd Circuit Court of Appeals are mandatory authority over federal courts located within the states of Pennsylvania, New Jersey and Delaware as well as federal courts located within the territories of the U.S. Virgin Islands. Decisions by the United States 7th Circuit Court of Appeals are mandatory authority over federal courts located within the states of Illinois, Indiana and Wisconsin. Decisions by the United States 8th Circuit Court of Appeals are mandatory authority over federal courts located within the states of North Dakota, South Dakota, Minnesota, Iowa, Nebraska, Missouri and Arkansas.

Please note: It is extremely important for the reader to understand that this column is not intended to impart any kind of legal advice. Anyone contemplating decisions or actions based in whole or in part upon perception of his or her legal position is strongly urged to seek and follow the advice of a competent and experienced attorney.

Editor's note: That makes a total of sixteen states covered by the First Amendment of the Constitution. The Solid South has been cracked, but what happened to the West?

3-Minute REBT

by Philip Tate, PhD

Author of ***Alcohol: How To Give It Up and Be Glad You Did,*** **1996, See Sharp Press, Tucson, AZ.**

Dr. Tate's 3-Minute REBT will be back next issue…stay tuned!

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