

# The PREVENTION CONNECTION

NEWSLETTER

## Mind, Body, Spirit: An Overview

—David Young

**O**ver the past 25 years, interest in the role of spirituality, religion and faith in health, healing and wholeness has increased among health professionals, clergy, faith communities and the general public. In 1996, *TIME* magazine's cover feature was entitled *Faith and Healing: Can Spirituality Promote Health? Doctors Are Finding Some Surprising Evidence*. In 2003, the cover story of *Newsweek* magazine was *God and Health: Is Religion Good Medicine? Why Science Is Starting to Believe*.

The interplay between the Mind, the Body and the Spirit (MBS) has held interest for humankind since the beginning of recorded history. The close link between religion and medicine was well established in many ancient healing traditions and artifacts from the Predynastic period (6,000-5,000 BC) in Egypt indicate that mental and physical illnesses were not only treated as indistinguishable, but viewed in terms of their associations with evil spirits and/or demon possession. Egyptian,

Assyrian and Persian hieroglyphics, pictographs and cuneiform writings depicted the ancient healing art of laying on of hands. Religious orders were responsible for caring for the sick and infirm, for certification of physicians and for establishing the shelters that were the forerunners of our hospitals. The first hospital was established by a religious order in 372, and was intended to treat the sick, the poor and those with leprosy.

Bacteria was discovered in 1676 and the germ theory of disease came about in the 1870s, advancing western medicine on a strong science-based path. Any notion of

a connection between the mind and the body was perceived as superstition. Thus, in the early years, as medical science developed and matured, the two major healing traditions—medicine and religion—diverged into different paths to healing and wholeness.

Animal-based research in the 1920s and human research in the 1950s and 1960s, which linked stress with physical ailments, ran counter to medical dogma. A pioneer in mind-body research during the 1960s, Herbert Benson, MD, coined the term *relaxation response* to describe a state in

which blood pressure was lowered and heart rate, breathing rate and metabolic rate were decreased as a result of simple mental focusing or meditation. More studies were published showing that certain diseases worsened in the face of depression, that meditative techniques had health-enhancing effects, and mind-body medicine became an emerging field in the 1970s and 1980s. The Mind/Body Medical Institute was founded in 1988 at Massachusetts General Hospital in Boston with a mission of *promoting worldwide health and well*

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***This overview traces the exploration of the relationship among mind, body and spirit in association with health, healing and wholeness, moves to a consideration of the research on these topics, and concludes with comments on emerging findings and potential applications to prevention.***

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## Mind, Body, Spirit

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*being through the study and advancement of mind/body medicine, including the relaxation response and belief systems.*

Recognizing the importance of the MBS movement, the US Congress established the Office of Alternative Medicine (OAM) in 1991. This was a forerunner to the National Center of Complementary and Alternative Medicine (CAM) at the National Institutes of Health (NIH). Today, mind-body medicine has developed into a broad spectrum of interventions and techniques involving the brain, mind, body and behavior, including but not limited to meditation, prayer, journaling, autosuggestion, visualization, hypnosis, art, music and dance therapies. In 2007, American adults spent \$33.9 billion out-of-pocket on purchases of CAM products, classes and materials, and made 354 million visits to CAM practitioners.

The role of *spirit* in the MBS relationship has been a topic of controversy among health professionals, faith leaders and researchers for years. Many definitions have been proposed for *spirit*, *spiritual* and *spirituality*. Suffice it to say that the spiritual realm is less tangible than the physical, temporal and material world. Spirituality, or matters of the spirit, is personal, individualistic, subjective, relational and invariably based on faith, belief and trust.

***“Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual’s search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another.”***

**—The Association of American Medical Colleges**

The role of spirituality in health (and sickness) experienced a renewed level of interest beginning in the 1980s. The Robert Wood Johnson Foundation funded the *Faith In Action* (FIA) initiative in 1983 to encourage volunteerism as a strategy for meeting the needs of chronically ill people. The following year, Reverend Dr. Granger Westberg, PhD (a minister, hospital chaplain and medical school professor with a

passion for holistic health care), established the first institutionally-based parish nurse program. Two key spinoffs of the early parish nurse movement were the establishment of the International Parish Nurse Resource Center in 1985 and the founding of the Health Ministries Association (HMA) in 1989. The HMA—people of faith working together for healthier communities—was established as a multi-faith organization acknowledging that all faith traditions have a commitment to health, healing, hope and wholeness. By 1997, the American Nurses Association (ANA) recognized parish nursing as a new specialty practice and in collaboration with the HMA, developed and co-published the *Scope and Standards of Parish Nurse Practice* in 1998.

In recent years, the interest in investigating the interrelationships of MBS and the impact on health status and health outcomes has mushroomed. Harold Koenig, MD is a Master of Health Sciences (MHS), a national and international leader in the field and founding Co-Director of the Center for Spirituality, Theology and Health at Duke University Medical Center. Koenig is one of the most prolific researchers and writers on the topic of religion, spirituality and health. Dr. Koenig reviewed original research published in medical and health-related journals to find that as many as 3,000 quantitative studies have examined relationships between religion/spirituality and health; the majority reported positive links.

A national poll of US adults (1996) revealed that 4/5 believe that spirituality can help people recover from disease and 2/3 believe that physicians should talk to patients about their faith. A majority of today’s medical

students are offered courses on the MBS connection as part of their curriculum. In 1992, less than three percent of medical schools offered courses on religion, spirituality and medicine; today, more than 70 percent of the medical schools in the US and Canada have such courses. Increasing numbers of practicing physicians are

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taking spiritual history in concert with a medical history and incorporating prayer as part of their therapeutic modalities.

The rise in interest in MBS integration in science and medicine has not been without controversy. Many question the professional and ethical wisdom behind making spirituality a component of medical practice. In 2006, Richard P. Sloan, PhD, professor of behavioral medicine at Columbia University, published a comprehensive and provocative examination of the emerging reunification of religion and medicine entitled, *Blind Faith: the Unholy Alliance of Religion and Medicine*. Dr. Sloan does not dispute the fact that religion/spirituality can bring a sense of comfort in times of adversity, but he finds no compelling evidence showing the cure of any ailment due to the association of religion and health.

Engaging science and medicine in the MBS triad has produced a number of interesting spinoffs. One is the emerging field of *neurotheology*—the study of the ways in which brain chemistry and structure affect religious beliefs and feelings. Another area links controlled, empirical studies that demonstrate the effects of forgiveness (and lack of forgiveness) on physiology, health and disease. The combination of Americans' fact-paced, technology-driven lifestyle, economic decline, job losses, house foreclosures and homelessness has produced an unprecedented level of stress with adverse outcomes on mental, emotional, physical and spiritual health. Uncontrolled stress can lead to a number of unhealthy behaviors, including excessive consumption of food, alcohol, tobacco and drugs. Experts report that from 75-90 percent of visits to physicians today are related to the stress associated with adverse events, including divorce, death of a loved one, disease, depression, conflict, broken relationships and lack of forgiveness. Compounding this stress is the fact that many of today's working adults are caring for aging parents and/or displaced grandchildren. According to Dr. Koenig, religious involvement may help reduce stress, minimize depression and enhance quality of life—and is related to lower rates of alcohol and drug abuse, less crime and delinquency, fewer risk behaviors, healthier

lifestyles, better physical health, lower use of health care services, better coping mechanisms and faster recovery from illnesses.

As noted throughout this overview, a growing number of emerging national and regional organizations are dedicated to the view that the mind, body and spirit are closely interconnected and interdependent, each of equal importance in overall health, all along the continuum from prevention to treatment. All across North America, there is a growing interest in holistic health care modalities as they are incorporated into mainline medical care. Human history alone demonstrates the validity of the growing convergence of MBS within western medicine, as we move toward more integrated approaches designed to create and sustain conditions that reduce risk and promote safety, personal responsibility and well-being. A better understanding of the interplay of the MBS complex and how it manifests in physical ailments will aid in establishing more effective prevention and intervention strategies.

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The information, statements, views and opinions contained in this article are those of the author and not of any institution, organization, agency or other entity. For more information, visit [www.hmassoc.org/](http://www.hmassoc.org/)

### Selected References:

1. Benson H, Stark, H. 1996. Timeless Healing: The Power and Biology of Belief. New York, NY: Scribner.
2. Dossey L. 1993. Healing Words: The Power of Prayer and the Practice of Medicine. New York, NY: HarperCollins Publishers.
3. Koenig HG, McCullough ME, Larson DB. 2001. Handbook of Religion and Health. New York, NY: Oxford University Press.
4. Koenig HG. 2008. Medicine, Religion and Health: Where Science and Spirituality Meet. West Conshohocken, PA: Templeton Foundation Press.
5. Sloan R. 2006. Blind Faith: The Unholy Alliance of Religion and Medicine. New York, NY: St. Martin's Press.

### Selected Resources/Web Sites:

1. Benson-Henry Institute for Mind Body Medicine  
[www.massgeneral.org/bhi/](http://www.massgeneral.org/bhi/)
2. The George Washington Institute for Spirituality and Health  
[www.gwish.org/](http://www.gwish.org/)
3. Center for Spirituality, Theology and Health  
[www.spiritualityandhealth.duke.edu/](http://www.spiritualityandhealth.duke.edu/)
4. Health Ministries Association  
[www.hmassoc.org](http://www.hmassoc.org)
5. International Parish Nurse Resource Center  
[ipnrc.parishnurses.org/](http://ipnrc.parishnurses.org/)

### Benchmarks of the MBS Movement

- 1983—*Faith in Action* initiative funded by the Robert Wood Johnson Foundation
- 1984—First institutionally-based Parish Nurse program established
- 1988—The Mind/Body Medical Institute (M/MBI) established
- 1989—The Health Ministries Association (HMA) founded
- 1990—*Healing and Wholeness: The Church's Role in Health*, World Council of Churches.
- 1991—Office of Alternative Medicine (OAM) established within NIH
- 1993—Interfaith Health Program (IHP) established, Carter Center, Emory University
- 1998—National Center for Complementary and Alternative Medicine (NCCAM) established at NIH
- 1998—*Scope and Standards of Parish Nurse Practice* co-published by the ANA and HMA
- 2001—*Handbook of Religion and Health* by H. Koenig, M. McCullough & D. Larson published
- 2005—*Faith Community Nursing: Scope and Standards of Practice* co-published by the ANA and HMA

# CASA Montana

—Ellen M. Bush, Executive Director, CASA of Montana

—CASA volunteers believe that children deserve every chance to grow up in a safe, nurturing home.

**CASA of Montana is looking for volunteers. For more information about the program in your area, contact local CASA programs.**

Anaconda GAL Program  
3rd Judicial District  
(406) 563-7972  
Email: [dcuny@anacondapca.org](mailto:dcuny@anacondapca.org)  
[www.anacondagal.org](http://www.anacondagal.org)

Yellowstone CASA  
13th Judicial District (Havre)  
(406) 259-1233  
Email: [yellowstonecasa@imt.net](mailto:yellowstonecasa@imt.net)  
[www.yellowstonecasa.org](http://www.yellowstonecasa.org)

Gallatin County CASA/GAL  
Program, Inc.  
18th Judicial District  
(406) 582-2051  
Email: [guardian@gallatin.mt.gov](mailto:guardian@gallatin.mt.gov)

Front Range CASA/GAL, Inc. (Conrad)  
9th Judicial District  
(406) 576-7041  
Email: [frontrangepcasa@3rivers.net](mailto:frontrangepcasa@3rivers.net)

5th Judicial District Voice for Children,  
Inc. (Beaverhead, Jefferson and  
Madison counties)  
(406) 925-1405  
Email: [casa-gal@hotmail.com](mailto:casa-gal@hotmail.com)

CASA-CAN: Children's Advocate  
Network (Great Falls)  
8th Judicial District  
[jpylarcasa@gtfalls.com](mailto:jpylarcasa@gtfalls.com)  
(406) 454-6738  
[www.casacan.org](http://www.casacan.org)

Bitterroot CASA (Hamilton)  
(406) 961-4535  
Email: [bttrcasa@msn.com](mailto:bttrcasa@msn.com)  
[www.bitterrootcasa.org](http://www.bitterrootcasa.org)

**S**taci,\* an articulate and poised young woman, spoke at the *Leadership Summit for the Protection of Children* in June. Staci is a 17-year-old high school student who shared her life story and history of abuse with a group of strangers at the Summit. The fact that those strangers were judges, lawyers, social workers and Court Appointed Special Advocates (CASA) staff trying to make the system work better for foster children didn't make it any easier.

She talked openly about abuse by her father and then by her stepfather, as well as her mother's inability to be an effective parent. "I hope I can overcome a lot of bad people in my life," she says. "If I didn't have these guys in my life (her CASA volunteer and other adults) I could honestly say I would be dead, really messed up on drugs or be pregnant."

After Staci spoke, she hugged all of the adults who were supporting her from the audience—her CASA, her Child Protective Services worker and her foster parents. Many of us came away impressed and inspired by her story. Now other people will see and hear her story on a new DVD about CASA.

## What is CASA?

CASA is an acronym for *Court Appointed Special Advocate*. In 1977, concerned over making decisions about abused and neglected children's lives without sufficient information, a Seattle judge conceived the idea of using trained community volunteers to speak for the best interests of these children in court. This pilot program was so successful that judges across the country began using citizen advocates. In 1990, the U.S. Congress passed the *Victims of Child Abuse Act*, which encouraged the expansion of CASA. Today there are more than 950 CASA programs in operation across the country; more than

68,842 volunteers donate over 5.8 million hours.

CASA Montana is structured to meet the needs of abused and neglected children through the work of trained volunteers. Fifteen local non-profit groups work together for the welfare of Montana's children to provide them with voices, hope and futures. Court Appointed Special Advocates are community volunteers appointed by judges and trained by local program directors to speak up, in

court, for abused and neglected children who have been removed from their homes through no fault of their own. Most of these children are in temporary foster care and group

homes, so CASAs often become the only constant in these children's lives.

With information provided by CASA volunteers, judges can make more informed decisions as to what is best for each child. These volunteers are often appointed as a Guardian Ad Litem (GAL) for a child. CASA/GAL volunteers review records, gather information, and talk to everyone involved - parents, teachers, foster parents, therapists, and of course, the child. From this information, they present recommendations to the judge as to what is best for the child.

CASA of Montana is a network of 15 local CASA/GAL offices. These programs

**CASA volunteers play a critical role in a foster child's life, as Staci reminded the Summit attendees.**

**In 2008, CASA volunteers served over 20,000 hours on behalf of more than 900 Montana children, about 60 percent of the 1,500 who were in out-of-home care.**

provide trained volunteers as advocates to children in about 60 percent of the abuse/neglect cases in the

state. At this point, more than 450 volunteers in Montana are advocating for nearly 900 children in 40 counties around the state.

Telling the CASA story is not easy. Many times CASA kids must remain nameless and faceless. Staci's story helped

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## CASA Montana

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those involved with CASA to put a face on the young people who need advocates. Staci reminded us of all the young people aging out of foster care and how much they need support and a continuing voice for advocacy.

Federal law requires a Guardian Ad Litem in each dependency case, but court funding covers only about a third of the costs of providing these services through the CASA lay advocate programs. The 15 local CASA programs are challenged to recruit, fundraise and write grants. These programs do an impressive job with limited resources. All of them operate on less than \$1 million a year. In 2008, volunteers donated almost 20,000 hours of time. That volunteer time is worth more than \$1 million, if valued at the \$60 an hour paid to an attorney if a CASA volunteer is not available.

CASA of Montana provides network services for local programs, assisting with program training, education and state outreach. CASA of Montana works collaboratively with court programs, child and family services, local programs, public defenders and attorneys. The June *Leadership Summit* brought together almost 200 people to work collaboratively at the local level to improve the system for our children.

***A CASA volunteer provides a carefully researched background of the child and family in order to help the judge make a sound decision about the child's future. Each case is unique. The CASA GAL (Guardian Ad Litem) helps the judge determine whether it is in the child's best interests to stay in foster care, be returned to the parent(s), or released for permanent adoption. To prepare a recommendation to the court, the GAL talks with the child, parents, family members, social workers, school personnel, health providers, and others familiar with the child's situation and background.***

CASA volunteers gather information from Child Protective Services, foster parents, schools, therapists, resource officers and other service providers to provide a report to the court. These volunteers are hard working, committed people who

often hold a full time job. Their job is to advocate for the best interest of the child.

Each volunteer must complete a 30-hour National CASA training program before beginning service. Each volunteer goes through a background check and interview before joining the training class. Local CASA programs train volunteers in their community, involving local experts, judges and service providers.

CASA volunteers are ordinary people who are committed to doing what is best for children. CASAs come from all walks of life, with diverse professional, educational, and ethnic backgrounds. Over 50 percent work full-time. The common denominator is a sincere concern for the well-being of children. CASA volunteers are thoroughly trained in courtroom procedure, social services, the juvenile justice system and the special needs of abused and neglected children. CASA GALs advocate for children during complex legal proceedings, help explain the reasons their cases are before the court, the roles of the judge, attorneys, and social workers, as well as what is happening in court. CASAs also encourage children to express their opinions and hopes, while remaining objective observers.

CASA volunteers usually handle only one or two cases at a time, which allows them to identify pieces of the puzzle that may not be obvious to others. The volunteer may notice learning difficulties or find specific resources that can help a specific child. They can encourage the child's parents to work on the court treatment plan developed by the Child Protection Services worker. Through careful listening and consistent contacts with the family, CASA volunteers may also learn about a relative who is interested in the child if parental rights are terminated.

—Ellen M. Bush is the Executive Director of CASA of Montana. For more information, see [www.casagal.org](http://www.casagal.org) or call 866-863-2272.

*\*The name has been changed.*

### CASA programs cont'd

CASA of Hill County  
12th Judicial District (Havre)  
(406) 265-6743 ext.135  
Email: [casa@hrdc4.org](mailto:casa@hrdc4.org)

CASA-Advocates for Kids (Helena)  
1st Judicial District  
(406) 457-0797  
Email: [bcollins-casa@qwestoffice.net](mailto:bcollins-casa@qwestoffice.net)  
[www.helenacasa.org](http://www.helenacasa.org)

CASA for Kids (Kalispell)  
11th Judicial District  
(406) 755-7208  
Email: [casafvmt@centurytel.net](mailto:casafvmt@centurytel.net)  
[www.flatheadcasa.org/](http://www.flatheadcasa.org/)

Sixth Judicial District CASA (Livingston)  
(406) 222-4904  
Email: [ann@casajd6.org](mailto:ann@casajd6.org)  
[www.casajd6.org](http://www.casajd6.org)

Prairie CASA/GAL (Malta)  
(406) 390-3550  
[spk4kids@yahoo.com](mailto:spk4kids@yahoo.com)

Eastern Montana CASA/GAL (Miles City)  
7th and 16th Judicial Districts  
(406) 234-2354  
Email: [casagal@midrivers.com](mailto:casagal@midrivers.com)

CASA of Missoula, Inc.  
4th Judicial District  
(406) 542-1208  
Email: [casamissoula@gmail.com](mailto:casamissoula@gmail.com)  
[www.casamissoula.org](http://www.casamissoula.org)

CASA of Lake County (Polson for Lake and Sanders (not in Sanders))  
(406) 883-0158  
Email: [dianer@cskt.org](mailto:dianer@cskt.org)

# The Vicki Column

—Ho-lis-tic (*adjective*): Relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts <*holistic* medicine attempts to treat both the mind and the body>.

—Merriam-Webster Online

## Montana's Network of Care for Behavioral Health

*This new web site is a terrific resource for individuals, families and agencies with concerns about with behavioral health issues. It provides information about behavioral health services, laws, and related news, as well as communication tools and other features.*

*Regardless of where you begin your search for assistance with behavioral health issues, the Network of Care helps you find what you need—it helps ensure that there is “No Wrong Door” for those who need services. There is also an “emergency services” link that provides contact numbers for Montana’s crisis centers.*

*This is an exceptionally user friendly and comprehensive tool that offers a wealth of resources. It is provided by the Montana Department of Public Health and Human Services Addictive and Mental Disorders Division. Check it out: this is one you don’t want to miss!*

— <http://montana.networkofcare.org/mh/home/index.cfm>

Perhaps the theme of *Mind, Body, Spirit* can best be compared to the field of holistic / integrative medicine, which operates under the belief that healing includes the body, mind, emotions and the spirit. Rather than looking for a quick, discrete fix of a certain problem, this belief system incorporates prevention and wellness through the correction of core imbalances, and by addressing contributing factors.

Prevention is all about systems-level thinking. One of the articles in this newsletter talks about research into the long-term effects of ACEs: Adverse Childhood Experiences. This research tells us that the more adverse experiences a person encounters in childhood (e.g., physical, emotional or sexual abuse, physical or emotional neglect or such occurrences as the death or imprisonment of a parent, witnessing the abuse of a parent or substance abuse in the home), the more likely it is that subsequent adulthood will include adverse outcomes, including chemical abuse/dependency and mental illness as well as physical maladies, including cancer and heart disease. Someone who experiences four or more ACEs during childhood can be thousands of times more likely to suffer adverse outcomes during adulthood. It appears to be that simple: harm the spirit, mind and body of the child, and the adult s/he becomes will suffer the consequences. This has tremendous implications for prevention. Families, communities—and on an even broader scale, our earth—must be treated as systems. Core issues must be addressed *before* they snowball, rather than waiting until something has really gone south and then try to address it. Ultimately, prevention is more cost effective, more humane, easier all the way around.

I just read *The Last Child in the Woods: Saving Our Children from Nature Deficit Disorder*. It says that today’s children spend far less time outdoors than their parents and grandparents did, for a variety of reasons. The book discussed the link between children’s alienation from nature and attention-deficit hyperactivity disorder, stress, depression, anxiety and childhood obesity. These connections may seem somewhat tenuous, but the social and physical isolation rising from electronic recreation is far different than the natural relationship-building inherent in fort-building, hiking, fishing or exploring the woods.

Today’s children do not have as much opportunity to engage in unstructured imaginative play or exploration. The structure of childhood today is often born of fear and of our own isolation within neighborhoods. It can also stem from the frantic pace of multiple calendars within the family.

My husband and I recently had to make a difficult decision. Our youngest child wanted to start walking home from school. We know that Helena is a safe place, but fear lingers that *something could happen*. He could dart into traffic, encounter bullies, get hurt. On the other hand, we worried about limiting him, keeping him from important childhood experiences . . . unstructured time, alone or with friends, poking along and exploring new routes home from school, taking time to stop and examine a caterpillar or watch a squirrel. We weighed the threat of danger against potential loss. Ultimately, we opted to let him walk. So far, it’s working out well. He’s happier: he’s a naturally busy boy, and it’s hard for him to sit still in a classroom all day long. Now he gets to exercise after school. He really *needs* that 20 minutes of wiggle time.

Some projections indicate that for the first time ever, children will have shorter and unhealthier lives than their parents had. Trends seem to underline this, as indicated in Melanie Reynolds’ article, *What Do Sidewalks Have to Do With Public Health?* Since 1977, walking trips have decreased by 40 percent while motor vehicle trips have grown by 90 percent. Concurrently, since 1979, obesity-related annual hospital costs for children have tripled. We also know that more children and adults than ever before have been diagnosed with depression, anxiety disorders, stress-related illnesses and more.

For now, I plan to carefully weigh the implications of my decisions before I automatically say “no,” realizing that small decisions, small changes can have big implications. The decisions to allow walking to school or building a tree fort will eventually be superseded by driving, dating, travel and more. I just hope for the wisdom to remember that these decisions ultimately have a bearing on the body, the mind, the emotions and the spirit.

Vicki

# Notes from the Edge

Staci\*: *The Story of a CASA Kid*

**G**rowing up, my living situation was not like the Brady Bunch. In fact, it was about as different as it could be. The trouble was, my parents wanted a carefree lifestyle, one that didn't provide room for taking good care of children. Eventually, we left my father. We fled to the mountains and lived in a tent on a reservoir. It was the best time of my life. We were together, we cared about each other, and, for the first time, I felt safe. Then we went to see my grandparents and my mother met "Sam."

Sam and my mom fell in love. We packed up our tent and moved in with a complete stranger. Sam seemed okay at first, a little on the gruff side, but we knew he loved my mom. After four months, he started drinking and he started hitting us. Sam also believed that kids had to *earn* the right to eat. If we worked, we got to eat. So we worked. We fenced Sam's land, cleaned the barn and cleaned the house. And the hitting continued. One day, Sam asked me to get him hamburger. I dropped it on my way across the lawn. He backhanded me. I snapped. I slapped him across the face. He backhanded me so hard that I landed on the floor, and then he started kicking me. I fought back. I picked up a hockey stick and swung with all my strength. I hit Sam three times before my mom put me in a choke hold to keep me from killing him. I immediately passed out.

A month later, he and my mom broke up. My mom quickly found a new boyfriend who was even worse. This guy led a wild party life. He loved having a place where his friends could come to party, and he loved to party with his new family. Everyone was drinking, including my little sister. My mother and this man were totally out of control. And then one night while my mother was gone, he raped me. When my mother got home, I told her what had happened, but she accused me of seducing him. I left that night. I was 14. Right after that, my mom shipped my sister out to live with my grandparents.

—When you have a bad start, it usually drags you off track. What people don't realize is that it is possible to get back on the right path. It takes a lot of effort, a lot of help and self-determination, but it can be done.

Eventually, my mother's boyfriend left her. After that, she begged me to come back and take care of her, so I moved back in. For the first time, I confided in a girlfriend, told her why I hadn't been to school for several months. I will always be thankful that she told her mother, who called the police. The next day the police came, with social workers. After that, I stayed with an aunt for a while, then moved into a group home, and finally, I was put in the same foster home where my sister was living.

I transferred to my new school with solid Fs, and landed in a home where I was treated as if I was 15, with age-appropriate rules and expectations. My foster parents had young kids when I moved in with them, and by watching, I learned a lot about what it means to be real parents. I've also realized how much my parents missed. With my foster parents' help, I've gotten my grades up to Bs, and I'm doing all of the things I've always missed out on.

I'm lucky. Ever since I got out, I've been surrounded by a support system. I have learned to trust, and have realized that adults can actually be on my side. I have had a wonderful CASA worker, a social worker who's stood by me, and wonderful foster parents who have pushed and loved me as if I were their own. I've had people I can confide in and people who have believed in me. And I thank every single one of them for never giving up on me. I have already gone farther than I ever thought possible, and now I plan to go even further. I plan to go to college, become a social worker and eventually give back some of what I have been given.

\*The name has been changed to protect the privacy of this very brave girl.

## What is post-traumatic stress disorder (PTSD)?

*PTSD can be a debilitating condition that occurs after exposure to a terrifying event or ordeal during which physical harm occurred or was threatened.*

*Traumatic events that can trigger PTSD include violent personal assaults such as rape or mugging, natural or human-caused disasters, accidents or combat.*

*Many people with PTSD repeatedly re-experience the ordeal in the form of flashbacks, memories, nightmares or frightening thoughts, especially when exposed to events or objects that remind them of the trauma. Anniversaries of the event can also trigger symptoms. People with PTSD can experience emotional numbness, sleep disturbances, depression, anxiety, irritability, or outbursts of anger. Feelings of intense guilt (called survivor guilt) are also common, particularly if others did not survive the traumatic event.*

*Most people who are exposed to a traumatic, stressful event have some symptoms of PTSD in the days and weeks following the event, but the symptoms generally disappear. But about 8 percent of men and 20 percent of women go on to develop PTSD, and roughly 30 percent of these develop a chronic, persistent or long-lasting form.*

*Source: National Institute of Mental Health; LINK "<http://www.nimh.nih.gov/health/>" [www.nimh.nih.gov/health/](http://www.nimh.nih.gov/health/)*

# Progress to Peace

—Jill Hoxmeier

**E**

valuating success in prevention is difficult. Over the last year working with a dating violence prevention program, I've frequently redefined "progress." That isn't to say I've lowered standards out of frustration or shied away from defeat. Quite the contrary: the more I learn about teen relationships—the intricacies of dating violence—the better I understand what a difference we're capable of making.

The Violence Free Crisis Line created the PEACE Project (Peers Educating and Advocating for Changing Expectations) in 1999. The program prides itself on following a *for youth, by youth* model in which high school students create and execute an agenda that is facilitated by a program coordinator. As that coordinator, my enthusiasm and appreciation is renewed every time I meet with my 15 peer educators . . . every time I witness their passion and articulation in making presentations . . . and every time they confide in me, asking what to do to help a friend in an abusive relationship.

This last school year, we spoke to more than 800 middle and high school students in Flathead Valley. We educate on characteristics of healthy and unhealthy relationships; realistic and unrealistic expectations of a partner; the specific behaviors of power and control used by abusers; how gender stereotypes and inequality contribute to dating violence; and what can be done to help a friend who is in an unhealthy relationship. We also combat myths of sexual assault and rape, often arousing active discussion and allowing students to voice their opinions and challenge one another. Engaging students opens the doors to changing attitudes. In this job, change and progress go hand in hand.

Perhaps the most rewarding part of presentations for the volunteers comes when they read the students' evaluations. Presenters are continually commended by their peers for being "not preachy" and non-judgmental. They've also been complimented on their ability to

## What is dating violence?

*Dating violence is controlling, abusive, and aggressive behavior in a romantic relationship. It occurs in both heterosexual and homosexual relationships and can include verbal, emotional, physical, or sexual abuse or a combination of these behaviors.*

— One of five teens in a serious relationship reports having been hit, slapped, or pushed by a partner.

— About one in 10 (9%) teens has been verbally or physically abused by a boyfriend or girlfriend who was drunk or high.

— Teens identifying as gay, lesbian, and bisexual are as likely to experience violence in same-sex dating relationships as youths involved in opposite sex dating.

— Many studies indicate that as a dating relationship becomes more serious, the potential for and nature of violent behavior also escalates.

Source: Teen Dating Violence Fact Sheet: [www.ncvc.org](http://www.ncvc.org)

***" . . . I have found out a lot about relationships . . . how some of mine in the past weren't healthy . . . I figured out that the relationship I was in was not a healthy one and it was okay to break up . . . I also just like PEACE because it's more than just a group that gets together and gives presentations; we are all friends and we are all there to help each other . . . in my school, after we gave PEACE presentations, it must have hit some people because there were girls walking around with more respect for themselves and figuring out that they deserve better . . . "***

**—Ariel, a Columbia Falls High School sophomore**

8

get other students to rethink their beliefs on gender roles, appropriate behaviors, double standards and expectations. Getting teens to rethink beliefs—in a fun, non-confrontational way—shows tremendous success in the volunteers' ability to present information. What I've found to be an even better indicator of progress is how we've started the dialogue, one that just doesn't happen in regular school curriculum. Not only are teens *talking* about dating violence and rape, they want to know more. Jaws drop at the mention of statistics, and my volunteers get pulled aside in school by students to talk more. Whether in girls' room chatter or checking out our MySpace blog, teens yearn to talk about what's going on in their relationships. To give time and attention to their relationships is to validate them and say, "Yes, your relationship matters and it's important you're safe and healthy."

Success also occurs on another level. Though PEACE volunteers present our message to hundreds of their peers throughout the year, throughout that year, the volunteers meet every month, continuing their own education and building relationships with one another. This interaction is really valuable. At the end of the day, I have 12 committed, engaged young ladies who are passionate about educating on relationship violence. That's 12 people who really understand the signs of abusive relationships and aren't afraid to speak out to their peers or to help friends who might be experiencing the violence.

Success comes in a variety of packages. The PEACE Project is successful in keeping its volunteers engaged and in disseminating its message. The curriculum is continually updated to meet the ever-changing needs of volunteers. The program appeals to teens' desire to make a difference for their peers on a subject they can get excited about. The message is one of advocacy, encouragement and, most importantly, empowerment. I'd call that success by any measure.

—Jill Hoxmeier is the PEACE Project Coordinator for the Violence Free Crisis Line in Kalispell, Montana. She can be reached at

# The Soul of Prevention: *Spirit, Science and Action*

—Jeff Linkenbach, Ph.D.

**T**he *Soul of Prevention* is authentic leadership, which means daring to be real with ourselves, and joining in the process of transformation within the communities we serve. Authentic leadership is not just about showing up. It has everything to do with the quality of *how* we show up and work with communities. We must be willing to be vulnerable leaders who model growth in our own lives, in part as a way of best serving communities. It is through trust that we are able to build and maintain coalitions, enlist support for policy changes and secure the resources needed to build the capacity needed for our work to succeed.

*The Science of the Positive* (Linkenbach, 2005) embraces this philosophy and has identified that community prevention leadership must proceed in order of the three realms of:

- 1) Spirit first;
- 2) then Science;
- 3) into Action.

This concept has been one of the cornerstones of individual change. One of the great psychological pioneers, Dr. Carl G. Jung, discovered for himself and then instructed his students about the importance of putting spirit first before engaging in science and action. He instructed them by saying, “Learn and practice your theories as best as you can, but always remember to lay them aside when we touch the miracle of the living human soul.” This injunction would serve us well in community health settings as well.

Sadly, there is often an anti-mystical quality to prevention practice. It need not be so. As our work in community prevention has expanded from focusing on the individual to the environment, the needs for personal and community transformation only increase. Spirit after all, is not restricted and contained within the boxes of logic models.

Some leaders in the prevention field passionately define differences between the prevention and treatment communities,

when in reality there is only one field with a continuum of offerings. Each point on the prevention-intervention continuum has much to offer the other. The life altering experiences, for example, of those who have been touched by the gift of recovery from chemical dependency know deep in the core of their beings that a spiritual transformation is tantamount to sustainability. Science and action are embraced as playing critical roles in recovery as bodies detoxify and brains rewire with new cognitive-behavioral structuring. Yet as any person who has walked through the abyss of addiction will tell you, the epicenter of sobriety rests in the process of surrendering into something greater than self—a spiritual transformation, if you will. This focus and process at the level of community is one and the same. We must recognize *Spirit* first, then *Science*, into *Action*.

I have been working with one of our projects on the Navajo Nation. It brings me peace to know that we will begin our work by first honoring Spirit with a blessing ceremony, before moving on to spend the next two days speaking big, sterile-sounding words like *cultural competence* and *regression analysis*. When my feet touch the red earth of Shiprock, Arizona, I plan to pause, and remember the story of a lesson learned from other health researchers standing in the red dirt of the Australian outback.

The story is told that after days of engaging in ethnographic research, the researchers were challenged by their perceived barriers to help the community. Perhaps they, as often happens, labeled the community as resistant or in denial. I do not doubt that they had learned and practiced their theories well, but they were stuck about how to best proceed. Paradoxically, being stuck might be one of the most misunderstood conditions of community leader readiness, because it is at these times that we are humbly ready to listen to the wisdom of community.

As with all archetypal journeys, guides will appear for us when we need them in our prevention journeys as well. This time, the guide appeared in the form of an Australian Aboriginal woman, named Lily

Walker. After patiently enduring days of their technical assistance, she challenged the researchers by saying, “If you are here to help me, then you are wasting your time. But, if you have come because your liberation is bound up in mine, then let us begin.” Valverde (1991).

Let us begin to look deeply and understand that our personal transformation and effectiveness as leaders is entwined within the communities we serve. After two decades of research and practice, *The Science of the Positive* continues to hear from the communities we serve that our work must progress in the order of Spirit first, then Science, into Action. Perhaps if he were here today, Dr. Jung would witness the ways in which we are still learning and practicing our theories as best as we can, and appreciate us when we dare lay them aside as we touch the miracle of the living community soul.

—Dr. Jeffrey W. Linkenbach is a senior research scientist and Director of the National MOST Of Us Institute, in the Department of Health & Human Development at Montana State University. His latest book is *Seed of Fire, Roots of Hope: Inspiration for the Courageous Leader*. Jeff can be reached at [jwl@montana.edu](mailto:jwl@montana.edu)

**“Learn and practice your theories as best you can, but always remember to lay them aside when we touch the miracle of the living human soul.”**

—Carl Jung

# ACEs and the MAMTC

—Brenda Roche, Ph.D.

**T**

he Montana Board of Crime Control was awarded a targeted capacity expansion grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2005 that ended in 2008. Grant funds were used to support the Montana Adult Methamphetamine Treatment Coalition (MAMTC), which provided evidence-based methamphetamine treatment to adults in some of Montana's previously underserved rural and frontier counties through established providers—Butte-Silver Bow Chemical Dependency Services, Eastern Montana Community Mental Health Center in Miles City and the Fort Peck Reservation's Spotted Bull Treatment Center in Poplar.

The target population of methamphetamine-addicted adults lived within the pre-defined service areas. Participants were largely un- or underemployed and living on incomes below federal poverty levels. The population included a broad spectrum of pregnant women, adults with dependent children, families who had lost their children to the child welfare system, and men and women suffering from Post-Traumatic Stress Disorder (PTSD). Many had been involved with the criminal justice system; many more had co-occurring mental illnesses. Because of the significant dopamine depletion that rises from methamphetamine abuse, when a user first presents for treatment, mood disorders are common barriers that must be recognized and addressed.

A growing body of scientific research suggests that chronic use of stimulants affects dopaminergic neurons in limbic reward system structures. Researchers have also found evidence of changes in the structure and function of brain neurons after chronic stimulant use. Some propose that the changes come from dopamine depletion, changes in neurotransmitter receptors or other structures, or changes in other brain messenger pathways. As a result, the treatment needs of individuals addicted to methamphetamine are unique, complicated and significant.

According to the National Institute on Drug Abuse: Methamphetamine and Addiction, the most effective therapies for

methamphetamine addiction are behavioral. For example, the Matrix Model, a comprehensive behavioral treatment approach that combines behavioral therapy, family education, individual counseling, 12-Step support, drug testing and encouragement for nondrug-related activities, has been shown to be effective in reducing methamphetamine abuse. Contingency management interventions, which provide tangible incentives in exchange for engaging in treatment and maintaining abstinence, have also been effective.

Researchers have identified as many as 72 social risk factors for substance abuse and dependence (Leshner, 1998). These include poverty, racism, social dysfunction, dysfunctional families, poor education and substance-abusing peers. Risk factors influence the initial decision to use substances. Substance use subsequently modifies mood, perception and the emotional state, all of which are modulated through the brain. For these reasons, substance abuse and addiction must be understood as more than social problems or poor choices. Addiction is a chronic brain disease that causes compulsive drug seeking and use despite harmful consequences. Interestingly, drug abuse leads to physical changes in the structure and function of the brain.

According to *The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead*, a growing body of research indicates that childhood trauma is a significant risk factor for the development of adult substance abuse disorders. Research reveals that traumatic childhood experiences can lead to a higher risk of adult alcohol or substance addiction. Adult survivors of childhood physical, emotional, or sexual abuse are not only at increased risk for addiction, but likely to suffer from other physical and mental health disorders, including depression, heart disease and obesity.

The Adverse Childhood Experiences (ACE) Study was carried out in Kaiser Permanente's Department of Preventive Medicine in San Diego. Twenty-six thousand (26,000) consecutive adults coming through the Department were asked if they would participate in a study to demonstrate how childhood events affect adult health

*A report prepared for Montana's Office of the Attorney General put the 2008 price tag of methamphetamine abuse at more than \$200 million. While this has declined since 2005 from a high of more than \$300 million, it still reflects an appreciable cost burden to the State of Montana. Calculated into this cost were methamphetamine-related crime (\$80 million), work-related productivity losses (\$65 million), health-care related expenses (\$48.8 million) and treatment (\$6 million). Other costs—measurable and immeasurable—were incurred as well. In 2008 alone, it cost Montana \$11.9 million for foster care for children removed from homes where methamphetamine had preempted their parents' ability to provide safe care. The total price in terms of pain, loss and community disruption cannot be calculated.*

*Source: The Economic Cost of Methamphetamine Use in Montana. February 2009. Montana Department of Justice: A Report Prepared for the Attorney General. [www.montanameth.org](http://www.montanameth.org)*

## ACEs and the MAMTC

*Continued from Page 10*

status: 71 percent (18,000 volunteers) agreed to participate.

Volunteers were asked about eight categories of childhood abuse and household dysfunction. The abuse categories were: recurrent physical abuse, recurrent emotional abuse and sexual abuse. The five categories of household dysfunction were: growing up in a household where someone was in prison; where the mother was treated violently; with an alcoholic or a drug user; where someone was chronically depressed, mentally ill, or suicidal; and where at least one biological parent was lost to the patient during childhood, regardless of cause. An individual exposed to none of the categories had an ACE Score of 0; an individual exposed to any four had an ACE Score of 4. In addition, a prospective arm of the Study is following the cohort for at least 5 years to compare distant childhood experiences against current emergency room use, doctor office visits, medication costs, hospitalization and death.

The ACE Study revealed an epidemiological correlation between the ACE Score and likelihood of later becoming an IV drug user. For example, a male child with an ACE Score of 6 has a 4,600 percent increase in the likelihood of later becoming an IV drug user as compared to a male child with an ACE Score of 0. In addition to these examples, many other measures of adult health were found to have a strong, graded relationship to what happened in childhood: heart disease, fractures, diabetes, obesity, unintended pregnancy, sexually transmitted diseases and alcoholism were all more frequent.

The main outcomes measured were self-reported use of illicit drugs, including initiation during 3 age categories: 14 or younger, 15 to 18, or as an adult aged 19 or older. The study revealed that each Adverse Childhood Experience (ACE) increased the likelihood for early initiation of illicit drug use by two to four times. The ACE score also had a strong graded relationship to initiation of drug use in all three age categories as well as to drug use problems, drug addiction and parental drug use. Compared with people who had no ACEs, people with five or more were seven to ten times more likely to report illicit drug use problems, addiction to illicit drugs and parental drug use.

MAMTC clients were invited to complete an optional intake questionnaire designed to provide data; 135 of MAMTC participants agreed. The results of that questionnaire strongly suggest that these individuals experienced highly disproportionate rates of childhood trauma.

- 69.7% had been a witness to domestic violence as a child;
- 66.7% indicated their parents were divorced or separated;
- 56.9% had been emotionally abused as a child;
- 45.4% had been physically abused as a child;
- 42% had been abandoned by one or more parents;
- 36.3% had Post Traumatic Stress Syndrome (PTSD);
- 33.1% had been sexually abused as a child; and
- 30.5% had been sexually abused by a non-relative.

In total, between 2005 and the end of June 2008, the MAMTC engaged 144 recovering methamphetamine addicts. The outcomes included a decline in engagement in a variety of risk behaviors, improved abstinence from the use of alcohol and illegal drugs, stabilized housing and relationships. As of 10/31/08, 55.6 percent of 144 MAMTC clients had remained in the program for longer than 121 days. Just 6.9 percent remained in the program for fewer than 30 days.

These findings are important because they are very positive. This project will inform treatment practices and improve programming for adults addicted to methamphetamine here in Montana. Perhaps even more importantly, they provide a clear path and real hope. Fortunately, treatment approaches that provide strategies for addressing co-occurring medical, psychiatric and social problems can lead to sustained recovery. The strategies employed by the MAMTC project work and can help counteract the effects of addiction.

—*Brenda K. Roche, Ph.D., of Arrowhead Psychological and Behavioral Services, LLC served as the Principal Investigator for the MAMTC project. For more information, contact the Montana Board of Crime Control, or visit their website at [www.mbcc.mt.gov](http://www.mbcc.mt.gov).*

***The study revealed that each Adverse Childhood Experience (ACE) increased the likelihood for early initiation of illicit drug use by two to four times. Compared with people who had no ACEs, people with five or more were seven to ten times more likely to report illicit drug use problems, addiction to illicit drugs and parental drug use.***

For more information, read:

- *The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead.* [www.norlien.org/publications/GoldintoLead.pdf](http://www.norlien.org/publications/GoldintoLead.pdf)
- *Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study.* Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, Anda RF. National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Division of Adult and Community Health, Atlanta, Georgia. [www.ncbi.nlm.nih.gov/pubmed/12612237?dopt=Abstract](http://www.ncbi.nlm.nih.gov/pubmed/12612237?dopt=Abstract)

# Prison Paws for Humanity

—Sherri Downing

**S**

—“These are living beings . . . not something you put on a shelf at five on Friday.” —Deb Bouwkamp

## Psychiatric Service Dogs

*Traditional service dogs assist owners by performing physical tasks such as guiding, retrieving and pulling. Psychiatric service dogs can also help with physical tasks, but can also be trained to interrupt dissociative episodes, provide timely medication reminders, and create safe personal boundaries for their owners. These dogs also perform therapeutic functions such as barking or nudging handlers who suffer from panic disorders in order to alert them to oncoming panic attacks, and can help ease dizziness by bracing or leaning against handlers.*

*The dogs may exhibit uncharacteristic behavior, such as pacing, staring or vocalizing, to alert the owner to an incipient episode. This can help the owner better manage or subvert the episode using cognitive skills, risk reduction behaviors, or medication.*

*Alerting behaviors help the client develop insight, which can mean the difference between functioning and nonfunctioning.*

Source: [www.samhsa.gov/SAMHSA\\_News/VolumeXVI\\_2/text\\_only/article19txt.htm](http://www.samhsa.gov/SAMHSA_News/VolumeXVI_2/text_only/article19txt.htm)

Shayla is a gangly brindle Boxer with a white patch that covers her nose, chest and front paws. She has overly large, goofy-looking ears and a puzzled look. By the time Shayla reached us, she was 14 months old and had already been through four homes. While she was in her first home, her leg was mangled by a car. Her owner took her to the vet to be put down, but Shayla was lucky. The veterinarian saw her potential. He put a steel rod in her leg and gave her time to heal. Eventually, he found another home for her. Unfortunately, most of Shayla’s time there was spent locked in an airline crate. At some point, the landlord noticed her and gave her owners the rest of the week to find her a new home.

My son and his wife heard about this dog and offered to take her, despite the fact that they already had two high-energy dogs, a brand new baby and a six-year-old daughter. The first time they saw her, Shayla was racing up the sidewalk on her hind legs, front feet waving above ground as a large man skidded behind her, running to keep up at the end of the leash. Shayla was already barking, her deep *whoo-hoo-hoo* echoing through the neighborhood. She bounced into my son’s house and up on his couch, bounced off again, then ran through the house in wild circles. She settled down

after a day of romping with their other dogs. Shortly after that, I offered to take her home with me, hoping that she’d inspire my own rather chubby Boxer, Elsa Mae, to get a little exercise.

Not long before Shayla came along, I had been to the Montana Women’s Prison

*Prison Paws for Humanity*. I learned that the program is going into its sixth year, but that it started with a single telephone call.

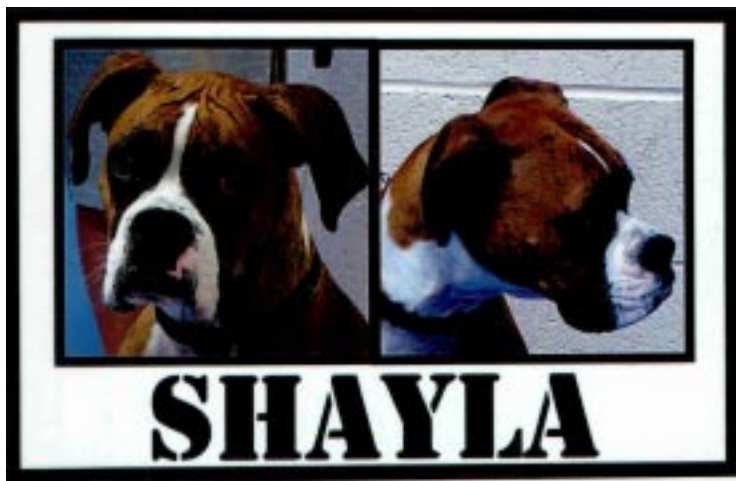
Deb Bouwkamp, a local service dog trainer, had seen *Cell Dogs* on Animal Planet. The segment showcased a program for unadoptable dogs that were matched up with prisoners. The prisoners were responsible for the dogs 24 hours a day, seven days a week. They learned how to train and rehabilitate dogs, which could then be adopted out to good homes. The show talked about the way the dogs helped inmates transform their lives. Prison violence went down, prisoners learned to love and care for another being, and gained skills they could use once they left prison.

Deb knew it could be a win-win proposition for some of the women at MWP. She was so excited that she called one of her acquaintances, Warden Jo Acton, to share her idea. That single phone call would eventually change hundreds of lives—canine and human. Within ten days, Prison Paws for Humanity was in place.

Deb Bouwkamp has served as Program Director from the beginning. They started with ten rescue dogs from the local animal shelter. Many of the dogs who land in Prison Paws, like Shayla, are throwaways, strays or dogs rescued from abusive or neglectful homes. Many would have been put down if not for this last-ditch effort to socialize them. Now, six years into the program, they’ve had up to 38 dogs at one time.

When Shayla landed with us, I realized how little anyone had tried to teach her, and knew I didn’t have the skills needed to teach her to become a good pet. I got in touch with Deb Bouwkamp and asked if I could enroll Shayla. Luckily, they had room. After she’d been with them for about two months, I went to get her, and had the opportunity to interview Deb and the two young women who had worked most closely with Shayla. While we talked, Shayla lounged on the floor between the two of them.

Ryan, one of Shayla’s trainers, told me that she had come into MWP without self-esteem or confidence in herself. She says



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(MWP) in Billings to teach a class. Our training team got a tour and I saw, firsthand, some of the impressive work going on there. One outstanding program was

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## Prison Paws for Humanity

Continued from Page 12

that being part of Prison Paws has made a huge difference in the way she sees herself and the way she interacts with the world. “I am a new person because of this program. Before, I was always in trouble, in and out of solitary confinement, fighting with people. I still had a criminal way of thinking. But we’d always had pets when I was growing up, so I thought it would be worth a shot to apply for the program.” Since participants must have a record of good behavior, Ryan made the effort to change her ways and was accepted.

The first dog Ryan trained was a golden lab that she named *Hunter*. Ryan says she came to love the dog so much that when it came time to find him a home, her parents came to get him. The dog is still there, waiting for the day that Ryan can join him. “Being with the dogs makes it safe to feel something. The dogs have helped me learn how to trust. I’ll be able to move from bonding with these animals to mending my relationships. This has given me the chance to make the changes that will allow me to maintain sobriety when I get home.” She paused for a moment. “We do habilitation so that these dogs can become family pets or service dogs. Being able to give something back has turned my life around.”

Director Bouwkamp says that isn’t unusual. She says that the women who come into the prison are often angry, hurt, and unable to trust. The Prison Paws Program makes it safe for them to let go of those feelings. “This program makes a difference . . . for the dogs, for the women who learn the skills to train them, and for the families who eventually adopt the dogs.”

Jessi was the other trainer who worked with Shayla. Usually, a dog will be assigned to just one trainer, but Shayla was transferred to a second woman halfway through her stay. Sometimes the most important thing is finding the right “fit” between personalities . . . canine and human. Though Ryan was wonderful with Shayla, after all this dog had been through, she was particularly difficult to train. Deb thought a midcourse change might help.

Jessi, the other young woman who worked with Shayla, confided, “It’s funny. When I was outside, I never bonded with animals. I was scared of them, but I got right into this program. The first four months, I felt incompetent, insecure . . . but I stayed. Working with the dogs has helped me maintain stability. I have learned a lot. I have such a sense of accomplishment when we send these dogs home with new skills.”

Jessi went on to say that she’s gained a sense of responsibility, of respect and of compassion since she came into the program. Working with the dogs has meant that she has had to put the animals’ needs first. It has already made a difference in the way she interacts with her three young children, and she believes that will lead to an improved ability to parent when she goes home.

Many of the dogs who come into the Prison Paws Program have been rescued from animal shelters or have come in by way of Animal Control. When the shelter has a dog that may be euthanized, they contact the program. If there’s room, the dog gets a chance.

Being successful in the Prison Paws program takes a lot of work. During the 30-day obedience training, the dogs learn basic commands like *sit* and *stay*; by the end, they are in control on the leash. By the end of the advanced class, they are in control off of the leash. The women working with them learn, too. They learn responsibility, patience and communication skills. At the end, a dog who could have been euthanized gains the skills to be a good pet. The women grow and gain self-esteem because they’d had a chance to accomplish something lasting,

something important. In the end, perhaps what makes this program work so well is that by training the dogs, people learn skills that will bring them success for the rest of their lives, in the process, forming bonds that heal the spirit.

—For more information, contact Deb Bouwkamp at 406-247-5162.

***“It makes us feel good when we’re able to save the dogs, though of course, not all of them can be rehabilitated. We’ve got a couple right now we’re working hard with. Hopefully we can get them to the point where they’ll be ready for a good home.”***

—Jessi

### Service Dogs for Children with Autism

*People with Autism Spectrum Disorders may experience difficulty recognizing and processing subtle social cues in facial expression, body language, inflection, and intonation which results in confusion in learning how to recognize and exhibit expressions of emotions, but not the feelings of those emotions.*

*When a person with Autism is trying to process twenty simultaneous stimuli, it can take time to get down the list to the really important information. A trained service dog can signal the person of an important event, such as the phone or doorbell ringing. The dog’s signal reminds the handler to drop all other processing and focus on the sound indicated by the dog. Autism service dogs can also be trained to guide a confused handler from an over-stimulating situation, or to find a specific person, perhaps a caregiver, when the handler is over-stimulated. In some cases when a person with Autism is over-stimulated, pressure can be very calming, and the dog can also be trained to apply the pressure.*

For more information:  
[www.servicedogcentral.org/content/node/233](http://www.servicedogcentral.org/content/node/233)

***One comment on Shayla’s “obedience score card” was, “This dog definitely has trust issues, but she loves me and I love her and we’ll get through her stubbornness together.”***

# Equine Assisted Wellness

—Gordon Birch and Cory Reich Ph D.

—What horses need to hear from us is what many of us would like to hear from ourselves, and each other. They need us to have a calm, focused assurance. They need us to be consistent. They need us to be assertive yet non-threatening. They need us to be strong and compassionate. In short, horses need us to be our best selves. —Chris Irwin, *Horses Don't Lie*

**A**

ddiction is a brain disease. The last decade has characterized an unprecedented watershed of research and advancing medical technology. As a result, we have been able to begin penetrating the mysteries of the brain. The neuroscientific research has identified the neuropathology and neuroadaptive effects that together characterize the disease of addiction.

Findings have further identified that the disease of addiction begins as dysregulation of the hedonic system of the brain (e.g. the ability to perceive pleasure). This dysregulation has a direct effect on the individual ability to mediate stress. Neuroadaptive changes affect the addict's ability to properly perceive or experience pleasure while reducing the coping skills required to mediate the effects of stress. The disease progresses to a point where the ability to self-regulate and exercise will be deeply impaired. Brain scans demonstrate that the executive control of the frontal cortex is compromised, and that the mid-brain begins dictating craving and choice. In other words, the disease of addiction evolves to a point where it disables the ability to exercise choice.

Additionally, addiction affects the brain systems that regulate learning, memory, emotions and motivation. In an addicted brain, these translate to what appears to be maladaptive behavior. The stigma associated with the disease of addiction is plagued with the false attributions of defective moral character and personality defects. Although five decades of research argue the validity of these suppositions, many still treat addiction with moral contempt and imprisonment.

With the biological conditions that characterize the disease of addiction better understood, we are beginning to contextualize the initiation, persistence, and recovery processes of addiction. The research underscores the nature of stress and its role in stress-response diseases, in this case, addiction.

Specific stressors, and the ways in which these stressors correlate with onset, main-

tenance and recovery, are unique to the individual. Stress signatures take place within the context of meaning intrinsic to the individual. Additional factors that play into stress include social context, social position, genetics, life experience and developmental stage.

Through the years, addiction has been treated using an acute care model, even though addiction is characterized as a "chronically relapsing disorder." Treating addiction requires a disease management approach that takes place over the course of a lifetime. Like any chronic disease (e.g., diabetes), addiction requires an acute phase of treatment (e.g., medical detox and stabilization) during which patients are stabilized, physical healing takes place, and people have the opportunity to gather the tools to manage the disease. Treatment is typically residential and can last for a period of 30 to 90 days, depending on the individual. This, however, is just the beginning.

Every component of recovery requires knowledge of the human condition characterized by a *will to meaning* and its link to wellness and/or disease. Because the disease of addictions hijacks the healthy brain systems that would normally regulate behavior, *meaning seeking* and *meaning making* coupled with a lack of coping skills can challenge fulfillment. Equine-assisted wellness techniques provide an

effective hedonic rehabilitation approach within a relational context that is easily transferable to other areas of life. Experiential opportunities assist in healing and restoring a life of meaning.

*Equine assisted personal development* provides those who are in recovery the opportunity to gain experience with horses, experience designed to promote self-awareness and relational growth. The human-horse process teaches participants about themselves within a relational context,

helps them become aware of behavioral patterns and to better understand the dynamics of healthy relationships.

Horses live in the here and now. They live in a moment of judgment based on communication and relational trust. They respond immediately

***Experiential learning teaches us that principles are just principles until we practice them into reality. Horses teach the dance of good communication. They are tough and steadfast partners. They don't judge. They don't forget. Their feedback is immediate and honest.***

based upon the way participants communicate with them. Horses help make participants aware of their emotional state because they respond to the way the participants choose "to be." In working with the horses, participants gain insight into their own feelings, behaviors and mixed messages.

Equine Assisted Personal Development occurs in individual and a group setting with a maximum of 12 participants. Sessions are facilitated by a licensed professional and a trained equine-assisted horseman and life coach. The process involves establishing a relationship with a horse on the ground and evolves into nurturing that relationship. Activities include *joining up* with the horse, grooming, lunging, Natural Horsemanship training and group exercises. Professional facilitators observe the interactions between the horse and the participant, and ask questions based on what is being revealed through the relationship. At the end of each session, participants have time to process the experience and consider the relevance within context of their lives.

Experiential learning (Equine Assisted Personal Development / Learning) programs are founded on the belief that change must include direct experience in the processes of growth. All change has some

***Continued on Page 15***

## Equine Assisted Wellness

*Continued from Page 14*

form of experience at base, but experiential learning demands that the learner be as close as possible to that base of origin. Experiential learning often requires problem solving, curiosity and inquiry. It is sometimes loosely defined as *learning by doing, combined with reflection*. It is active rather than passive, requiring the learner to be self-motivated and responsible for learning and the teacher to be responsible to, and not for, the learner. Like experiential learning, Equine Assisted Personal Development focuses on placing clients in activities that challenge dysfunctional behaviors and reward functional change.

Horses have a unique capacity to influence people. Through the development of the person-horse bond, horsemanship instruction and equine care, people have the opportunity to participate in a transformative intrapersonal process. In order to benefit the person and the horse, the relationship requires constancy of attention, time in, responsiveness, assertiveness, communication and relationship skills. Each of these components has been recognized as an active ingredient required for secure attachments.

We are often asked, “*Why horses? Why not other animals?*” Horses are large and powerful, so their size alone provides a natural opportunity to overcome fear and develop confidence. Accomplishing a task involving the horse creates confidence and provides opportunities to experience and formulate life metaphors that translate well when dealing with life’s other intimidating and challenging circumstances.

Horses are also like humans in that they are social animals. They have defined roles within their herds and would rather be with their peers. They have distinct personalities, attitudes and moods. An approach that seems to work with one horse does not necessarily work with another. At times, they can seem stubborn and defiant. They like to have fun. In other words, horses provide vast opportunities for metaphorical learning. Using metaphors, in discussion or activity, is an effective technique when working with individuals or groups struggling to gain self-efficacy.

In an era when immediate gratification seems to be the norm, horses require people to be engaged physically and

mentally. Half measures and partial commitment fail completely. Maturity has been termed the capacity to be assigned a task, or assign a task to yourself, and see it through without being monitored. Equine Wellness is, at its essence, the maturing process between a person and a horse. Skills and attitudes acquired during this process are transferable and portable.

Most importantly, horses have the ability to exactly mirror human body language. The lesson to be learned is that if people change themselves, horses respond differently. Horses are honest, which makes them especially powerful mirrors into our own psyche, allowing them to serve as accurate messengers of self-knowledge. Horses immediately sense and respond to negative emotions and behaviors. This forces students to be accountable for their emotions, and to recognize the effects that their emotions and behaviors can have on others.

Unlike humans, horses have no hidden agenda or conflicting feelings. Horses do not respond positively to faulty forms of communication (such as manipulation, bullying, or passive/aggressive behavior) that many students have become accustomed to using. To be successful with a horse, controlled and effective body language is essential, which forces participants to be aware of their methods of communication and to problem solve when these methods don’t produce the desired results.

Horses also model the importance of fun. They require us to focus and to practice our theories. Horses teach the dance of good communication. What works one time may need adjustment; creativity and bravery are in needed to repair miscommunication. The horse instinctively mirrors what we need to see in ourselves by magnifying problem areas. Our work demonstrates compelling evidence that horses are masterful teachers in family dynamics, social rules, discipline, nurturing, respect and trust.

—Gordon Birch and Cory Reich  
*work with the Pretty Shield Foundation. Equine Assisted Personal Development is one of many services offered by the Pretty Shield Foundation (PSF), a 501(c)(3) serving the needs of Native American children, adults and families throughout the United States. For more information, contact the Pretty Shield Foundation at 406-855-4646 or by e-mail at psf@180com.net*

## Experiential Learning

*Experiential learning is predicated on the belief that change occurs when people are placed outside positions of comfort (e.g., homeostasis, acquiescence) and into states of dissonance. In these states, participants are challenged by the adaptations necessary to reach equilibrium. Several elements are inherent to this process.*

1. *The learner is a participant rather than a spectator in learning.*
2. *Learning activities require personal motivation in the form of energy, involvement and responsibility.*
3. *The learning activity is real and meaningful in terms of natural consequences.*
4. *Reflection is a critical element of the learning process.*
5. *Learning must have present and future relevance for the learner and the society in which s/he is a member.*

***What the horse truly asks of us is that we be fully alive, awake and present. To genuinely find the freedom that the horse symbolized takes hard work, determination, honesty, and self-awareness. The reward is reclamation of the self, an enhanced life, and healthier relationships.***

—Johann Wolfgang Goethe

# Food as Obsession

—Mona L. Sumner



hen food and eating behaviors become obsessions, the physical and emotional consequences are severe, even deadly. Those who have eating disorders, such as anorexia nervosa and bulimia, suffer from the medical complications of starvation, binge eating and purging.

For too many women, the good life has become the pursuit of thinness. Thin is in and thin has become the cultural standard for the ideal woman. The message is on the air waves and in all forms of media. Teens are continually confronted with media messages and models who represent beauty as thinness. Even now, the latest health news seems obsessed with obesity and overweight children. Vulnerable females struggling with self-image interpret such messages self-destructively.

In this decade more than at any other period in history, women can achieve their definition of the ideal self because barriers to employment and academic advancement have been vastly reduced. Even so, the incidence of anorexia and bulimia has exploded in the last twenty years. It is estimated that women are eight to ten times more likely to suffer from an eating disorder than men are. It is also estimated that on average, thirty percent of the enrollees in weight reduction programs suffer from binge eating disorders. Prior to that, less than 0.5 percent of women were found to have anorexia or bulimia.

Whether anorexic, bulimic or a binge eating disorder, food is *not* the real underlying issue. Food is the tool by which the eating disordered woman seeks to control her internal and external environments because for these women, life feels out of control. As we have studied our patients at Rimrock Foundation and learned about the dynamics of their disorders, we have come to understand that at the heart of the eating disorder lies anxiety for which there may be multiple sources, depending upon individual circumstances. The patient has learned to manage or reduce anxiety through food-related rituals and behaviors and comes to experience a sense of control from these rituals. For our teenage girls, an eating disorder is often an expression of the struggle she is experiencing with

adolescent developmental milestones and unrealistic expectations.

No one theory explains the onset of an eating disorder. It is important to dispel the myth that all anorectic girls are struggling with the Karen Carpenter Syndrome, for example, as they struggle to achieve perfection. Increasingly our patients are highly diverse—from those who have lost their voices in the family system and are overwhelmed by familial pressures and expectations to those who are actively abusing substances and acting out their dysfunction.

It is crucial that we educate those who have the most responsibility for our young women—parents, teachers and coaches—about these illnesses and how they can play an active role in preventing them. When a teen hears a parent, teacher, coach or some other role model comment, however well intentioned, that she could lose a few pounds, the message she hears is, “I am fat and unattractive.” Coaches, in particular, need to be aware of the meaning of weight among young women and to refrain from becoming part of the problem. Around age 14, most girls are extremely vulnerable in areas that concern their weight and body image as they confront the developmental task of separating/emancipating and giving up childhood. Our twenty-something eating disordered patients are usually struggling with overachieving, trying to meet unrealistic parental or self expectations for performance in an adult world they have not yet mastered. Still others are seeking a way to feel in control in a family system that is out of control.

Prevention is optimum, but early intervention is also critical. The earlier an eating disorder is treated, the better the outcome. By the time an eating disorder has been practiced by an adult female aged 35 or older, recovery becomes far more elusive. And by then, the disorder has taken an enormous physical and emotional toll.

—Mona L. Sumner, MHA, ACATA, is the Chief Operations Officer for Rimrock Foundation. For more information, or to learn more about eating disorders, visit the Rimrock website and download their factsheets at [www.rimrock.org](http://www.rimrock.org).

## DO YOU . . .

- feel that others pressure you to be thin?
  - feel guilty about what you eat?
- feel that your weight is one of the only things you can control?
  - feel you've become isolated from family and friends?
  - prefer to eat alone?
  - use food as a comfort?
- consume large amounts of food in a brief amount of time?
  - feel fat despite others telling you that you're not?
  - ever exercise excessively?
  - ever induce vomiting after eating or drinking?
- count all the hidden calories or grams of fat in each bite of food?
  - often feel depressed and unhappy with yourself?
    - diet excessively?
    - use laxatives, diet pills, or diuretics each week?
- weigh yourself several times each day?
  - eat when you're lonely, anxious, depressed or nervous?
  - think you might have an eating disorder?

If you answered yes to five or more of these questions, you may have an eating disorder. An eating disorder can be treated with therapy and hard work.

Source: [www.mtech.edu/student\\_life/counseling/eatingdisorder.htm](http://www.mtech.edu/student_life/counseling/eatingdisorder.htm)

# What do Sidewalks Have to Do With Public Health?

—Melanie Reynolds, MPH

—“There is a connection . . . between the fact that the urban sprawl we live with daily makes no room for sidewalks or bike paths and the fact that we are an overweight, heart disease-ridden society,”

—Richard J. Jackson, MD, MPH

**M**

any of us would be more active if we could safely walk, bike and play in our communities. Urban sprawl affects the built environment by reducing the quantity and quality of safe sidewalks, biking and hiking trails. When people live within walking distance of grocery stores, recreation sites, shopping, schools and their places of employment, they have healthier life styles and lower obesity and chronic disease rates. Healthy community design can benefit us in many important ways by promoting physical activity, improving air quality and lowering the risk of injuries. Good design also increases social connection and a sense of community, which are important protective factors for physical and mental health.

There is a direct correlation between obesity and incomplete streets in our cities and neighborhoods. Incomplete streets are those that lack sidewalks, crosswalks, bike paths, accessibility and safe routes to school and work for all types of transport. Cars have driven transportation design for many cities. According to the Robert Wood Johnson Foundation (RWJF), since 1977, walking trips have decreased by 40 percent whereas motor vehicle trips have increased by 90 percent. How has that impacted health? National healthcare costs related to low-level activity and obesity have increased to an estimated \$117 billion a year. Obesity increases the risk for many life-threatening illnesses including Type 2 Diabetes, heart disease, stroke, hypertension and cancer.

All across the country, urban planning and public health professionals are beginning to work together to create communities that improve the quality of life for all. In Helena, the Lewis and Clark City-

County Health Department is working to identify connections between the built environment, public health and physical activity. Through a grant from the Montana Nutrition and Physical Activity Program (MT-NAPA) at MSU-Bozeman, we have seed funding to work with community partners to increase awareness of how the built environment impacts public health. There is a lot of interest in healthy community planning in Helena. We have *Non-Motorized Transport* and *Reduction of Green-*

*house Gas Emission* task forces in our city government. City and county planners are working to develop and strengthen policies and guidelines that promote street connectivity, good sidewalks and bike paths in new developments. State workers are promot-

ing *Bike to Work Day*, and encouraging others to join in. The Centennial Bike/Walking Path will soon connect Helena from Spring Meadow Lake to East Helena. Schools and parents are advocating for safe routes to school to encourage more kids to walk or bike to school. The list goes on.

Often when we think about overall health, we think about not having a second brownie, limiting our French fry intake, or stepping on the elliptical for a power 30-minute workout. Public health works to improve environmental conditions and promote healthy behaviors. How and where we live, work, and play has a lot to do with how healthy we are. If there is a nice sidewalk and safe street crossings that connect your house to the school where your kids go, they are more likely to walk to school. Integrating activity into our daily lives and living in environments where that is easy to do so makes good health more accessible for all.

**National healthcare costs related to low activity levels, overweight and obesity have risen to an estimated \$117 billion. Of that, \$14 billion is related to childhood overweight and obesity. Obesity increases the risk for many other life-threatening illnesses including Type II diabetes, heart disease, stroke, hypertension and cancer.**

—Melanie Reynolds is the Health Officer at the Lewis and Clark City-County Health Department. The Health Department's mission is to improve and protect the health of all Lewis and Clark County residents.

For more information about community planning and health visit [www.cdc.gov/healthyplaces](http://www.cdc.gov/healthyplaces) or [www.completestreets.org](http://www.completestreets.org). For more information about the work the Lewis and Clark City County Health Department is doing on complete streets and obesity prevention, call Gail Beckner at 457-8924.

- In the United States today, one in four Americans is obese and at least half are overweight.
- 19% of Montanans have reported “no leisure time for physical activity” and 42% do not meet the recommendations for 30 minutes of daily moderate physical activity.
- Since 1979, obesity-related annual hospital costs for children have tripled.
- 70% of obese children are at serious risk for becoming obese adults. This percentage increases to 80% when the child has obese parents.
- Today, children and teenagers are driven to school, do not receive appropriate physical education during school hours, and spend, on average, 44.5 hours per week watching television and engaged with other electronic media.
- Soft drink consumption has more than doubled since 1971. The average teenage boy drinks two 12 ounce sodas per day, or more than 700 cans per year. The average teenage girl drinks 1.4 twelve ounce sodas per day or more than 500 cans per year.
- In 2005, 87% of those in Montana classified with Type II Diabetes were obese.

# The Economic Cost of Alcohol Abuse in Montana

—The true cost of alcohol abuse is likely higher than the \$510.6 million estimated in the report.



Alcohol is a product that many of us in Montana enjoy. In 2005, we collectively consumed 124.7 million shots of distilled spirits, 33.0 million glasses of wine and 279.6 million 12 oz. cans of beer (NIAAA, 2008). On a per capita basis, Montana ranks in the top half of states in alcohol consumption, with the 2003 consumption of 435 beers per adult higher than all but four other states nationwide. In fact, overall consumption of alcohol per person of drinking age in Montana has historically been 15 to 20 percent higher than the national average. When beer, wine and spirits consumption are converted to their ethanol alcohol equivalents, the data show that Montanans consumed just over 3 gallons of ethanol per person 21 years and older in 2005, almost 18 percent more than the national figure.

Buying and selling alcoholic drinks is big business in Montana, employing thousands in production, processing, marketing, distribution and retailing. Even so, alcohol consumption is causally linked to outcomes that none of us enjoy. These outcomes affect the drinker, and range from alcohol-induced illness and premature death, highway crashes due to alcohol impairment, to one's ability to earn a living. It doesn't stop there, because others are affected as well. Society pays a substantial price. And because alcohol use—and alcohol abuse—is higher than average in our state, that price is larger than it has to be. The abuse of alcohol in Montana levies a cost in terms of dollars spent by businesses, individuals and governments—as well as dollars lost to the economy because of outcomes due to alcohol—of more than half a billion dollars a year. These costs include money spent on treatment, medical care, the economy due to loss of life, costs to business, government and families due to lost productivity as well as the associated costs on crime and criminal behavior.

The purpose of the *Economic Cost of Alcohol Abuse in Montana* study was to develop and present information on how alcohol abuse impacts the collective economic welfare of all Montanans. The

report focused on economic loss because it provides a means of placing the problem of alcohol abuse in perspective with other priorities that compete for our attention and resources.

## Treatment

In 2005, 46 publicly and privately owned facilities providing substance abuse treatment in Montana responded to the National Survey of Substance Abuse Treatment Services (N-SSATS) conducted by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Of the respondents, 57 percent were privately owned nonprofit facilities. At the time the survey, 3,048 patients were receiving treatment, of whom 2,692 (88 percent) were being treated either solely or partially for substance abuse.

Admissions to these facilities over the year are reported to SAMHSA as part of its Treatment Episode Data Set (TEDS) project. In 2005, there were 6,689 admissions for alcohol abuse, exclusively or in combination with one or more drugs. Patients were predominantly male—more than 70 percent of those admitted for treatment in 2005 were men. Younger and middle-aged men are particularly overrepresented, with men aged 21-49 years of age accounting for half of the overall patient base.

## Medical Care

The cost of providing specialized medical care for ailments resulting from alcohol use in Montana is significant. The study estimated that in 2005, the costs to individuals, governments, hospitals and other health payers statewide was \$100.7 million. These include hospital costs (inpatient and outpatient/emergency room care), physicians charges, prescription drug costs and the costs of nursing home care.

There are several links between the abuse of alcohol and the onset of medical conditions requiring specialized treatment.

## Adolescent Suicide in Montana

— Suicide is the second leading cause of death for Montana youth ages 15-24.

— Only unintentional injuries such as car wrecks, drowning and fire kill more Montana youth than suicide does.

— This is not a new phenomenon. Montana has ranked in the top 5 states for the highest rates of youth suicide for the past several decades.

— Alcohol and drug impairment, a sense of hopelessness, and underlying mental illness all contribute to the high rate of youth suicide.

— In 2005, 25.6% of high school students in Montana reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. (YRBS/OPI)

— Well over half of all Montana high school students have used alcohol within the past 30 days.

— Montana follows the same pattern as most of the United States: females are more apt to attempt suicide, and males are more apt to complete suicide. This is because more females choose reversible means such as poison, and more males choose irreversible means such as firearms.

— It is estimated that the suicide-related medical costs in Montana for a single year total over \$6 million, lost future earnings tops \$19 million, and loss to quality of life is estimated at \$78 million.

For more information, visit

## The Economic Cost of Alcohol Abuse in Montana

*Continued from Page 18*

Some conditions requiring treatment, such as alcohol poisoning and fetal alcohol syndrome, are due solely to alcohol abuse. A wider range of conditions are *partially* attributable to alcohol use. To estimate inpatient costs, the study relied on Montana-specific hospital and national estimates of fractions of costs that could be attributed to alcohol. In 2006, 7,128 patients recorded in the COMPdatda database were discharged from Montana hospitals for conditions wholly or partially due to alcohol abuse, resulting in more than \$124 million of hospital charges. Many discharges were for conditions like pneumonia and hypertension that have relatively small alcohol-related cost components. Again using national research, the study estimated that 2,323 hospitalizations were due to alcohol abuse, resulting in hospital charges of just under \$34 million.

Total medical costs also included additional complications when heavy alcohol users were treated for non-alcohol related conditions. At least one study estimated that hospital stays were 38 percent longer for those with a co-morbid alcohol condition. The costs of outpatient services were also added for purposes of the study, as were Veterans Administration hospital charges. Adding these together comes to a total for Montana hospital expenditures due to alcohol to \$55.6 million.

### Mortality

According to the death certificates recorded in Montana in 2005, 314 deaths had alcohol-related underlying or contributing causes. Taking detailed individual information obtained from death certificates, the study computed lost earnings resulting from the excessive mortality to find that the present value of lost earnings to the Montana economy resulting from alcohol-induced deaths to be \$206 million.

In 2006, 108 people died in alcohol-related motor vehicle crashes in Montana. There has been little movement in this fatality total or injuries over the last 20 years.

***Alcohol-induced deaths were more likely to occur to men than women, and to occur at a younger age, on average (50.3 years for alcohol-induced death versus 73.6 years for the overall population).***

Fatalities are typically higher in more populated counties, but high fatality totals also occur in some rural counties.

The use of alcohol results in deaths beyond those noted in the report, through falls, drowning, fires and other mishaps. Yet from just two sources of data—death certificates, and motor vehicle crash reports—early death due to alcohol imposes a cost of \$312.2 million on the Montana economy each year.

### Morbidity

Alcohol consumption is associated with impairments that can affect ability to function and earn a living. Alcohol affects motor skills and decision-making ability, and heavy drinking can correlate with tardiness, absenteeism and productivity. The study estimated that about 27,000 (71%) of the roughly 39,000 heavy drinkers in Montana are employed. Applying national impairment estimates to average earnings provided estimates of earnings loss due to alcohol. These ranged from a low of \$79 per year for females aged 18-24 to more than \$4,500 per year for women aged 55-64. Cumulatively, the study estimated the productivity impacts to the Montana economy to be \$53.3 million. This did not include the impact on the economy of those engaged in non-market work (e.g., keeping homes, providing for families) that is likely to be similarly affected.

### Crime

Alcohol and illegal drugs are contributing factors in a substantial amount of crime. Certain categories of crimes are far more likely when the perpetrators are under the influence of alcohol. Obviously, driving while intoxicated, liquor law violations and public inebriation all, by definition, involve alcohol. Other crimes, such as felonious assault and homicide, can be partially attributable to alcohol. Crime translates into many kinds of costs, but the study estimated that for local jails and other corrections facilities where sentences were

comparatively shorter, approximately \$2.8 million could be attributable to alcohol use. Costs to the court systems were estimated at about \$10 million, additional

police protection was estimated at \$19.8 million, and cost for incarceration at state facilities due to alcohol abuse was estimated at \$16.5 million.

Several important cost categories were not captured by the report, but would contribute to the costs of crime due to alcohol. These include costs to victims (e.g., disability, foregone earnings, insurance and crime protection costs); foregone earnings by inmates; and costs to the criminal's families due to loss of parent.

Even with these omissions, the study found the cost of alcohol abuse to the Montana economy through its impact on crime to be substantial. Taken together, the extra costs borne by businesses, individuals and governments in Montana for police protection, courts and criminal justice system administration, and corrections amounted to \$49.1 million per year.

Finally, many costs of the tragedies resulting from alcohol cannot be easily quantified. These include fire, loss of function from alcohol-related injuries, and victim costs. The exclusion of these items makes it likely that the true cost of alcohol abuse is higher than the \$510.6 million annual price tag of alcohol to Montana.

Alcohol abuse is not a one-time cost to the Montana economy; it is an amount paid every single year. Moreover it is an economic cost that represents resources that could be freed for other productive uses.

—Gratefully excerpted from *The Economic Cost of Alcohol Abuse in Montana* by Patrick M. Barkey, July 2008. The report was done by the University of Montana Bureau of Business and Economic Research. For more information, visit: <http://www.bber.umt.edu/>.

# Teen Pregnancy in Montana

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Teen pregnancy rates are a primary indicator of adolescent health. Teen childbearing can impact the health and economic outcomes of the teen/parent and the child for years to come. The United States leads all other industrial countries in teen pregnancy, though levels of teen sexual activity are about the same. An estimated 82 percent of teen pregnancies are unintended, according to the 1995 study by the Institute of Medicine. Though Montana's teen pregnancy rates are lower than those of the nation as a whole, they extract a significant social and economic toll on Montana families and communities.

DPHHS publishes a report entitled *Trends in Teen Pregnancies and Their Outcomes*, highlighting state and county data, indicators, and best practices in an effort to build local communities' capacity towards teen pregnancy prevention. The

most recent edition, covering the years 1991-2005, was released in May 2008. The overall teen pregnancy rate remained relatively stable between 2002 and 2006, with slight increases in the number of births to older teens. However between 2005 and 2006, Montana's teen pregnancy rate increased 3.2 percent, the teen birth rate increased 9 percent and the teen abortion rate decreased 13 percent. Older teens represent about two-thirds of the teenage pregnancies statewide, while younger teen pregnancies comprise the final third. This is not consistent across racial boundaries, however: approximately 44 percent of births to American Indian teens are to younger teens. Teens are more likely than women 20 years of age or older to have late or no prenatal care, low birth weight babies and babies who die within the first year of life. Teen parents are likely to be less educated, have more children, have more non-marital births, and have more unintended births than women who postpone childbearing.

## Resources

More information about teen pregnancy in Montana as well as tips and science-based advice for prevention:

[www.dphhs.mt.gov/PHSD/Women-Health/famplan-index.shtml](http://www.dphhs.mt.gov/PHSD/Women-Health/famplan-index.shtml)

Montana DPHHS's *Trends in Teen Pregnancies and Their Outcomes* Report: [www.dphhs.mt.gov/PHSD/Women-Health/famplan-index-shtml](http://www.dphhs.mt.gov/PHSD/Women-Health/famplan-index-shtml).

Screen older teens using the AMA's *Guidelines for Adolescent Preventive Services (GAPS)*  
[www.teenpregnancy.org/resources/data/pdf/WhatHelps.pdf](http://www.teenpregnancy.org/resources/data/pdf/WhatHelps.pdf).

Screen younger teens for resiliency factors using *Bright Futures* tools  
[www.pediatricsinpractice.org](http://www.pediatricsinpractice.org).

### ***The younger the expectant mother, the less likely she is to access prenatal care.***

- ***In 2007, 46 percent of high school students reported having had sexual intercourse at least once. This number increases based on the students grade level, from 28 percent for 9<sup>th</sup> graders to 59 percent for 12<sup>th</sup> graders.***
- ***Two out of three reported using a condom during their last intercourse.***
- ***Montana students rank highest in the nation for alcohol or other drug use before sexual intercourse.***
- ***14 percent of Montana high school students have had sex with four or more partners in their lifetime.***
- ***In 2006, 1,675 teen pregnancies were reported, including 18 to girls under age 15.***
- ***In 2006, 33 percent of Montana teens who had a pregnancy indicated that they'd also had a previous pregnancy.***
- ***Half of Medicaid's costliest "High Cost Babies" in FY 1994 were to teens.***
- ***In 2006, 77 percent of Montana teen pregnancies resulted in live births, approximately 23 percent of teen pregnancies resulted in abortions, less than 1 percent in fetal death.***
- ***Non-marital births to teens represent 24.6 percent of non-marital births in Montana; the remaining 75.4 percent of non-marital births were to women 20 years or older.***
- ***The percentage of teen non-marital births (compared to all teen births) rose from 46 percent in 1981 to 85.6 percent in 2006.***

## Teen Pregnancy in Montana

*Continued from Page 20*

Gathering information on fathers is very difficult because only 71 percent of teenage mothers include information on the birth records about the father of the baby, compared to 92 percent of mothers between the ages of 20 and 44. In 2006, fathers were at least four years older than mothers for approximately 27 percent of the teen births in Montana. The age of the father is unknown for one in four births. Eighteen to nineteen year old teen mothers make up the majority of all teen pregnancies. Mothers in this age group are more likely to report their partner's name and age on the child's birth record (76 percent), compared to teen mothers aged 15-17 (61 percent) and teen mothers under age fifteen (34 percent).

Each teen pregnancy is unique, but more than 70 protective and risk factors

have been identified as factors that encourage or discourage behaviors that result in teen pregnancy. These factors fit into five areas: community, family, peer group, romantic partner, and individual. Families, healthcare providers, community members, and teens themselves all have a role in reducing teen pregnancy.

Approximately 80 percent of surveyed students report satisfaction with their relationships with their parents. That is a strong protective factor. Parents are advised to speak openly and often with their children, beginning at an early age. Children want to hear their parents' thoughts on sex, but typically do not want to initiate the conversations.

According to the *Montana Prevention Needs Assessment*, Montana students report improved overall attachment to their communities between 2002 and 2006. That can be another strong protective factor.

Communities can support STD and pregnancy prevention programs that delay sexual activity; decrease the number of sexual partners and the frequency of sex, increase communication about sex, pregnancy and their risks; increase condom and birth control use; reduce alcohol and drug use; and increase family communication about sex.

Providers can implement clinical protocols that provide confidential services to teens, provide education on condoms, contraception and partner negotiation; and encourage them to seek advice from parents or a trusted adult.

For more information, or to review Trends in Teen Pregnancies and Their Outcomes, visit [www.dphhs.mt.gov/PHSD/Women-Health/famplan-index.shtml](http://www.dphhs.mt.gov/PHSD/Women-Health/famplan-index.shtml)

## Suicide Prevention Toolkit



The Montana Department of Public Health and Human Services, with the assistance of the Suicide Prevention Resource Center (SPRC) and the Western Interstate Commission for Higher Education (WICHE), is offering a toolkit to primary care providers around the State of Montana in our efforts to reduce the incidence of suicide in our state.

Research shows that many people visit their primary care physicians for mental health problems. Studies also demonstrate that people who ultimately complete suicide have visited their primary care provider within a month prior to death. Primary care providers are uniquely positioned to provide care that reduces the number of suicides and the suffering it causes in our rural communities. Yet primary care providers receive little reimbursement, support and guidance for their suicide prevention efforts and face multiple systemic barriers, including inadequate local mental health services.

The Suicide Prevention Toolkit for Rural Primary Care Providers brings best

practices in suicide prevention to rural primary care and offers physicians, patients and rural communities tools and support.

Toolkit contents include:

- 1) Suicide prevention primer for providers
- 2) Tool for creating an office protocol regarding suicidal patients
- 3) Crisis response planning tools for at-risk patients
- 4) Suicidal patient treatment tracking log and user's guide
- 5) Suicide risk assessment pocket cards
- 6) Community education materials: suicide prevention posters,
- 7) Suicide prevention resource list for providers and steps toward hospitalizing patients.

The toolkit is available at no cost. For further information, please contact Karl Rosston, LCSW, Montana Suicide Prevention Coordinator, at (406) 444-3349 or by email at [krosston@mt.gov](mailto:krosston@mt.gov).

### Adolescent Suicide

*Montana has one of the highest rates of youth suicide in the nation. Over 65% of the suicides in Montana are by firearms, which is significantly higher than the national average. Karl Rosston, the Montana Suicide Prevention Coordinator is promoting a firearm safety program aimed at protecting and promoting the safe use of firearms, increasing awareness of the warning signs of suicide, and providing ways to talk with a person who is suicidal.*

*High quality combination locks have been distributed to a number of county health departments, which hand them out in various community settings including musical events, hunter safety courses, home health care visits and child care organizations. The target populations are families with children and unprotected firearms in the home. The program, in its second year, has been nationally recognized by the Suicide Prevention Resource Center.*

*For more information, call (406) 444-3349 or email [krosston@mt.gov](mailto:krosston@mt.gov).*

## Suicide is Preventable

### So what can you do?

#### Know the facts:

- Montana is in the top 5 in the nation for suicide and has been for the last 30 years
- 65% of completed suicides in Montana are by firearms.
- The warning signs include: depression, hopelessness, giving away possessions, isolating, drug/alcohol use, change in mood, drop in school / work performance, change in sleep/appetite, comments such as, "I'd be better off dead," or "I'm a burden to everyone."

#### What else can you do?

- Protect your firearm from theft or misuse.
- Keep your gun locked.

#### If you are concerned about someone:

- Ask, "Are you suicidal?"
- Don't leave the person alone, tell somebody else, offer hope, and get a commitment to get help.
- If you or a loved one are in crisis and want help, call the Montana Suicide Prevention Lifeline at 1-800-273-TALK (8255)

#### For more information:

- The Centers for Disease Control: [www.cdc.gov](http://www.cdc.gov)
- The Montana Youth Risk Behavior Survey: [www.opi.mt.gov](http://www.opi.mt.gov)
- Montana's Vital Statistics: [www.mt.gov](http://www.mt.gov)
- Suicide Prevention Resource Center: [www.sprc.org](http://www.sprc.org)
- The Montana Prevention Needs Assessment: [www.prevention.mt.gov/pna/](http://www.prevention.mt.gov/pna/)

# Strengthening Montana

—Governor Brian Schweitzer

**A**n ethic of service and giving back to others builds strong, vibrant communities. Through the Montana Commission on Community Service and the Office of Community Service, national and community service programs are thriving across our state.

Since inception in 1993, the Montana Commission on Community Service has grown to a highly recognized entity. Through the administering of the AmeriCorps national service program and other community partnerships, the agency seeks to expand service opportunities for all Montanans.

Between 2005 and 2007, 284,000 volunteers dedicated 35.3 million hours of service per year across Montana. The estimated annual economic contribution of these volunteer hours to our state is \$689 million. As a result of these efforts and the

work of thousands of dedicated volunteers, our state's U.S. ranking in volunteer rate has steadily increased from #13 in 2006 and #7 in 2007, to its current national ranking of #5 in 2008.

On April 21, 2009, President Obama signed the *Edward M. Kennedy Serve America Act* into law, authorizing a dramatic funding increase for AmeriCorps and other volunteer programs. This legislation also establishes a goal of expanding from 75,000 government-supported volunteers to 250,000. With this financial support and a national call to service, there are tremendous opportunities for all Americans to do their part to address unmet needs and help their country.

I believe that the most important thing anyone can do is lend a helping hand. In the coming year and beyond, we will continue to empower individuals to answer the call to service. It is this commitment to service that makes Montana such a great place to live.

## Serve Montana: the Governor's Office of Community Service

—“Our state has a long tradition of neighbors helping neighbors, and because of thousands of national service members and their partners, our communities are stronger.” —Governor Brian Schweitzer

**F**or the first time, the United States honored September 11 as a *National Day of Service and Remembrance*. The Governor's Office of Community Service asked Montanans to honor the heroes from that day by making a pledge to service. As of 3:30 p.m. on 9/14/09, 1,100 total hours of service had been pledged through the Serve Montana website in honor of 9/11.

If you haven't visited the *Serve Montana: Governor's Office of Community Service* lately, you're in for a treat. The revamped site is user-friendly, well-integrated, and provides information and a diverse range of volunteer opportunities, including the Montana Citizen Corps, Fire Ready Montana and AmeriCorps.

The most familiar of these programs is AmeriCorps, which provides volunteer opportunities throughout Montana. Links are offered to all of the Montana programs, including the Conservation Corps, Campus Corps, Literacy Support Corps/WORD,

Inc., Jobs for Montana Graduates Foundation and Montana Legal Services Association. There are also links to the four major AmeriCorps VISTA programs in Montana, as well as Senior Corps, and the Learn and Serve Program.

The Montana Citizen Corps was designed to engage individual volunteers through education, training and service. By harnessing this energy, the Citizen Corps to make communities safer, stronger, and better prepared to respond to public safety issues. Fire Ready Montana offers education about emergency preparedness in the face of wild fire, wildfire mitigation, insurance, volunteering and more.

—Jan Lombardi, formerly the Governor's Policy Advisor on Education, has been named as the Executive Director of Serve Montana. She can be reached at 406-444-2573 or [jlombardi@mt.gov](mailto:jlombardi@mt.gov).

# Just Ask Anna

Dear Anna:

*I am a disabled adult with limited income and a 13-year-old child who is having mental health problems. I will need financial help providing him with specialized care. Can you tell me what is available and where to start?*

Sincerely,  
Worried Dad

Dear Worried Dad:

I appreciate your concern and your desire to provide the specialized care your child needs. I'm glad you contacted me. I truly believe the Department of Public Health and Human Services is the place families should be able to turn to for help when they find themselves in extreme difficulty.

You are not alone. Based on the results of an extensive federal Maternal Child Health Bureau telephone survey of families with children, Montana had an estimated 27,853 children with special health care needs in 2006, up from an estimated 26,981 in 2001. Finding the right help is critical. Children who have special health care needs in Montana are more likely to be very poor, miss more school, and more likely to have inadequate or no health insurance than their peers in the U.S. as a whole.

Following are several resources that you could check on behalf of your child.

— The Healthy Montana Kids Plan (HMK) is a free or low-cost health insurance plan that provides health coverage to eligible Montana children up to age 19. The HMK Plan is a result of Initiative 155, which was passed by Montana voters and funded by the legislature. Children in families with income up to 250 percent of the federal poverty level (for example, \$55,125 for a family of four) may be eligible. Depending on the family's income, the Plan will enroll eligible children in either the HMK Plus coverage group, which was children's Medicaid or the HMK coverage group, which was the Children's Health Insurance Plan (CHIP). HMK Plan applications are available at Offices of Public Assistance, county health departments, health care facilities, WIC offices, Head Start facilities, Indian Health Services, and

many more community locations. Applications are also available by calling 1-877-KidsNow (877)-543-7669.

- State funded mental health services for children under age 18 are administered through the Children's Mental Health Bureau of the Disability Services Division of the DPHHS. The bureau manages services for children who have a serious emotional disturbance (SED). In order to qualify for this program, children must be eligible for the Healthy Montana Kids Plus (Medicaid) coverage group of the Healthy Montana Kids (HMK) Plan. To be eligible, children must meet certain income requirements and meet categorical requirements.
- The Children's Mental Health Bureau also manages a small program for children who have a serious emotional disturbance. The program is called the Children's Mental Health Service Plan. This plan is limited to low-income youth who are within 160 percent of the federal poverty guidelines and who are not eligible for either Healthy Montana Kids Plus (Medicaid) or the Healthy Montana Kids coverage group formerly known as CHIP. The Children's Mental Health Service Plan (CMHSP) provides community-based outpatient psychiatric services, medication management and psychotropic drug assistance. To apply, a parent or legal guardian should fill out an HMK application, indicating a need for mental health care, and submit it to the HMK Plan.
- Some Montana children with special health care needs may be eligible to receive services from the Children's Special Health Services (CSHS) Program of the Department of Public Health and Human Services. CSHS is located in the Family and Community Health Bureau. Due to funding limitations, CSHS cannot provide financial assistance for several conditions including mental health disorders or behavior problems, but CSHS staff can provide resource and referral information. For more information, call 800-762-9891 or email [cshs@mt.gov](mailto:cshs@mt.gov).

I hope this information will get you started on finding the help your child needs.

Best wishes,  
Anna

*Just Ask Anna* is a DPHHS Prevention Connection Newsletter column by Director Anna Whiting Sorrell. Articles will be focused on prevention and based on questions submitted through the DPHHS website [www.dphhs.mt.gov](http://www.dphhs.mt.gov).

For more information:

1. Apply for the Healthy Montana Kids Plan: [www.hmk.mt.gov](http://www.hmk.mt.gov).
2. Covering Kids & Families (a national program to enroll children and adults in low-cost or free health care coverage programs): [www.coveringkidsandfamilies.org/](http://www.coveringkidsandfamilies.org/)
3. GovBenefits.gov: A comprehensive benefit search for Montana: [www.govbenefits.gov/](http://www.govbenefits.gov/)
4. Montana Comprehensive Health Association is a program that offers individual health insurance policies to eligible Montanans considered uninsurable due to medical conditions: [www.mthealth.org/](http://www.mthealth.org/)
5. Partnership for Prescription Assistance: [www.pparxmt.org/](http://www.pparxmt.org/)
6. Montana DPHHS Public Assistance Programs: [www.dphhs.mt.gov/programs/services/publicassistanceprograms.shtml](http://www.dphhs.mt.gov/programs/services/publicassistanceprograms.shtml)
7. Free Health Clinic Finder: [www.pparx.org/prescription\\_assistance\\_programs/free\\_clinic\\_finder](http://www.pparx.org/prescription_assistance_programs/free_clinic_finder)
8. Listing of all statewide Offices of Public Assistance: [www.dphhs.mt.gov/contactus/human\\_communityservices.shtml](http://www.dphhs.mt.gov/contactus/human_communityservices.shtml)

The opinions expressed herein are not necessarily those of the Prevention Resource Center and the Addictive and Mental Disorders Division of the Montana Department of Public Health and Human Services.

The Prevention Resource Center and the Addictive and Mental Disorders Division of the Montana Department of Public Health and Human Services attempt to provide reasonable accommodations for any known disability that may interfere with a person participating in this service. Alternative accessible formats of this document will be provided upon request. For more information, call AMDD at (406) 444-3964 or the Prevention Resource Center at (406) 444-3484.

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## The Last Word

—Joan Cassidy



—Stress (noun): A physical, chemical, or emotional factor that causes bodily or mental tension and may be a factor in disease causation.

Ask a dozen people to define stress or to explain its causes and effects, and you will get at least a dozen answers, and yet the interaction of mind and body is never more evident than in the physical manifestations of stress. Abundant medical evidence reveals that chronic stress can trigger a wide variety of physical symptoms, reduce immunity, and contribute to maladies as serious as cancer, cardiovascular disease and high blood pressure. Skin conditions, such as hives and eczema, can be related to stress, and it is also thought to be a common cause of everyday aches, pains, and health problems, including headaches, diarrhea and sleep loss.

Stress rises from acute occurrences such as traumatic accidents, death or other emergencies, it can be a side effect of a serious illness or disease, or associated with the struggles of daily life, including traffic, arguments with family members and the

pressures of work. Long term stress can be debilitating, rising from such situations as racial discrimination, life-threatening illness or divorce. Change is also stressful, whether positive or negative, so that even happy events like getting married, taking a new job, moving into a new home or having a baby can trigger stress.

The body reacts to stress by secreting hormones (in the blood) and neurotransmitters (in the brain). Some alter food metabolism to provide for sufficient stores of fuel for the brain and muscles needed for the *fight or flight* response. In the brain, neurotransmitters trigger emotion (e.g., aggression or anxiety), which then prompt the person to act on the fight or flight response.

Stress has also been linked to an increased tendency to engage in unhealthy behaviors, including drinking more alcohol, using drugs, smoking or overeating.

According to the National Institute on Drug Abuse, persons who are drug-addicted, even after a successful period of abstinence, appear more likely to relapse after experiencing stressful events. Animal studies underline the role stress plays in drug abuse relapse. Additionally, there is some suggestion that addicts may be more sensitive to stress than their non-addicted peers, though it is unknown whether hypersensitivity existed prior to use (thus contributing to initiation), whether it resulted from the effects of drug abuse on the brain or whether it's a combination of the two.

Some of the most effective tools for dealing with stress include adequate sleep, eating right, physical activity, meditation, talking with friends, journaling, engaging in a hobby and/or getting professional help. Another excellent technique is to reach out and help others by volunteering, doing community service, or by doing something kind for a neighbor, family member or friend. It is the *antidotes* to stress that we can see the interrelation of mind, body and spirit.