

ADOLESCENT SUBSTANCE USE AND ABUSE

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FOR MY DAUGHTER MEARS

Some of you who will read my thesis that portrays some part of my life's story and a great deal of Mears' life story may question why a Father would compose a document of this nature? After sound consideration, Mears and I determined two points. One, this is our story. And two, we believe that by telling our story we might provide some hope, guidance and light to kids and their families who travel the same path.

-Finn Green

THE DROWNED CHILDREN

You see, they have no judgement.
So it is natural that they should drown,
first the ice taking them in
and then, all winter, their wool scarves
floating behind them as they sink
until at last they are quiet.
And the pond lifts them in its manifold dark arms.

But death must come to them differently,
so close to the beginning.
As though they had always been
blind and weightless. Therefore
the rest is dreamed, the lamp,
the good white cloth that covered the table,
their bodies.

And yet they hear the names they used
like lures slipping over the pond:
What are you waiting for
come home, come home, lost
in the waters, blue and permanent.

-Louise Glück

INTRODUCTION

We were interested in the question of the relationship between the author and the subject. Why did the author choose this topic? What was the meaning of this story or issue in the writer's life? But this is a new style of social science: Most of us have been educated away from this mode of expression and find it hard to speak in this voice.

-Ruthellen Josselson, The Narrative Study of Lives, 1993

Many children are walking on thin ice, drowning, sinking and becoming quiet. Drugs and alcohol can take in our most precious and valuable resource: a subtle foe stalks our children. Children and young adults are not renewable resources. Each child, each life is special and meaningful, yet sometimes children vanish in the icy, dark water. Thin ice easily fools children, leading some to death. Drug and alcohol usage fools children, leading many to early graves. Some people may say that talk of early death and the grave borders on being scare tactics...they are correct. People need to be scared—they need to know that drugs and alcohol kill our children.

Drug addiction and alcoholism are chronic diseases that affect not only the individual sufferer but also the lives of all those they touch. I have a personal involvement with this reality. In the beginning of my freshman year at the University of Kentucky my daughter Mears, then fifteen years old, broke her three-year partial silence with me: "I can't stop drinking when I start drinking. I need help." Finding the help that Mears requested became my primary focus. We did not seek out this reality; the reality found us and it constantly searches for sufferers. Mears' behavior for the previous two years did not appear normal or healthy. She had changed friends, become silent, distant,

non-cooperative, unloving, and apathetic about school and life in general, and acted as if she hated me.

Mears had been harmed by my behavior. As an irresponsible parent, I had given her many reasons not to trust me. Trust is an essential element in relationships. Relationships and lives suffer when the failure of trust is present. Her mother and I had been divorced for almost ten years. At the time when Mears broke her silence, I had been sober for six and a half years. My network of friends consisted of individuals who had similar life experiences as mine. Ann- a licensed clinical social worker, my counselor, and friend- knew where we could find help for Mears: Kids Helping Kids.

Kids Helping Kids (KHK) saved Mears from impending doom and possibly death, changing our lives forever. KHK is a long-term adolescent alcohol and drug rehabilitation program that also treats the adolescents' family members. The first Friday night that I went to KHK a man introduced himself to me, looked me in the eyes and said that "Kids Helping Kids will give your daughter her life back". An hour later, I learned that he and his family had sold their home in Georgia and moved to Ohio so that they could participate with his daughter in the KHK program. Shortly thereafter, I made a decision to do all that I could to help other families who face the same devastating situation. My senior thesis for the Gaines Seminar in the Humanities is an effort to support this decision.

As with most valuable interests, a plan of order and a set of guidelines prove beneficial; this interest deserves both. My thesis committee chairman, Dr. John Greenway of the University of Kentucky's Department of English and Honors Program, and committee members Dr. Joanna Badagliacco of the University of Kentucky's

Department of Sociology, and Dr. Sallie Prewitt of the University of Kentucky's Center for Drug and Alcohol Research, graciously provided both order and guidelines. Without their individual and combined wisdom, rational, and selfless support my effort would be both chaotic and fruitless.

I intend to construct a thesis that both quantifies and qualifies truths and realities relating to adolescents and substance use. I will begin by defining the problem and looking at its effects on a broad national spectrum that will narrow down to a state and local focus. These views will be bolstered by scientific and quantitative data. After establishing that, in fact, a problem exists I will then define some potential solutions, or, treatment variation and modality options. This effort will narrow to focus on KHK. Then a definition of a successful recovery will serve as an introduction for Mears' story. Her story will be told in the form of a qualitative narrative and written in the style of an interpretive biography.

First, my committee suggested an intense literature review that primarily focused on the methodology of interpretive biography and three fundamental categories regarding adolescents use of and potential addiction to alcohol and drugs: Sociological, Psychiatric and Biological. This review netted a substantial amount of salient data that has been synthesized and presented in the subsequent chapter. This chapter begins with the interpretive biography methodology and then provides scientific information on the definition and degrees of substance use, abuse and dependence, causal and risk factors, multiple diagnostic disorders, diagnostic methods, and quantitative data regarding epidemiology on the national, state and local levels. The information identifies a crisis for many adolescent substance users.

Chapters two and three cover information identifying different treatment modalities and variations for adolescents. In chapter two a literature review examines information on the available treatments on a broad, national spectrum. In the following chapter, I will narrow the focus on treatment down to KHK. At the time of this writing, I have observed the normal routine of operations at KHK for over three years. I sketch an outline that describes the KHK program. This chapter touches on the manner of treatment administered by KHK and received by its adolescent clients and their family members. Also, in this chapter the program's history, formulazation, mission statement, and Board of Directors, Administrators and personnel will be reviewed.

The chapter prior to the conclusion gives a voice to Mears' life story. This chapter takes the form of qualitative narrative in the style of interpretive biography. This mode of expression, though difficult, enables the espousal of essential truths about being human; few matters are more important. I believe that you will find Mears' story worth telling and hearing. "The story tells us in a meaningful way what life itself is about...life has an implicit meaning, which is made explicit in stories" (Josselson and Lieblich, 5,6). I hold to the hope that our collective voice will both be heard and helpful.

In addition to the factual gifts that I am Mears' father and that I have witnessed much of her life, I collected the information from Mears for her story on audiotape during three separate sessions. Each of the three sessions followed the interpretive biographical interview method practiced by Norman K. Denzin. I asked Mears to tell me about her experiences with alcohol and drugs: what her life was like, what happened, and what her life is like now. The first of these scheduled sessions took place in a conference room at KHK, where Mears then worked as a Senior Staff Counselor. The following week,

Mears recorded the second session while alone in her apartment. These two recordings were transcribed in their entirety. For a basis of discussions, I provided my committee members with copies of the transcriptions. The discussions helped me to formulate a guideline for the third and final session with Mears. The third session, a conversation between Mears and me, took place a month later in her apartment. I also had this conversation transcribed in its entirety. The three transcriptions are in the appendix.

It is my hope that our story will touch the lives and hearts of at least one family who currently struggles with the devastating reality that many children and families fall as prey to substance use and abuse. I believe that you will see a child who not only has been saved from slipping through the ice, but you will also meet someone who now understands the dangers of drugs and alcohol. I also hope to use this thesis as a tool to explore the feasibility of providing other communities with facilities that treat adolescents and their families who are affected by adolescent substance use and abuse.

Please do not misinterpret me. I do not believe, as a general rule, that alcohol or legal prescription drugs are harmful to society as a whole. However, I do believe that there exists a certain group of individuals who not only harm themselves but also harm others when they use drugs or alcohol. It is this group of individuals who I wish to help. Actually, I hope to help this group of individuals, so that they may help themselves. I believe in my mind and know in my heart that every child deserves freedom from the bondage of drugs and alcohol.

CHAPTER ONE

LITERATURE REVIEW

Interpretive Biography Methodology

In this essay I will speak in the first person, in spite of some conventional wisdom that suggests “handbooks” are more detached summaries of general knowledge.

–Louis M. Smith, Strategies of Qualitative Narrative, 1998

Qualitative research is a complex area of inquiry consisting of multiple layers and numerous variations of methodological frameworks. In his Qualitative Inquiry and Research Design, John W. Creswell divides qualitative research into five categories: Biography (use of sociological interpretive approach); phenomenology (use of psychological approach); grounded theory (use of sociological approach); ethnography (use of anthropological and sociological approach), and case study (use of evaluation approach). Creswell also identifies five philosophical assumptions that researchers consider while designing their qualitative study. These five assumptions are the nature of reality (the ontological assumption); the relationship between the researcher and that being researched (the epistemological assumption); the role of values (the axiological assumption); the language of the research (the rhetorical assumption), and the process of research (the methodological assumption). Each of these assumptions answers a particular question, which in turn indicates the researcher’s perspective or worldview.

According to Norman K. Denzin and Yvonna S. Lincoln in their Strategies of Qualitative Inquiry, qualitative and quantitative research differ in five basic ways: uses of positivism, acceptance of postmodern sensibilities, capturing the individual’s point of

view, examining the constraints of everyday life, and securing rich descriptions.

Creswell believes that “quantitative researchers work with a few variables and many cases, whereas qualitative researchers rely on a few cases and many variables” (Creswell, 15,16). Be the differences as they may, both quantitative and qualitative researchers “think they know something about society worth telling to others” (Becker, 1986, 122). I believe that qualitative research provides the best form and opportunity to define and express our story.

In its own right, qualitative research represents a field of inquiry, in that

Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiries that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting (Creswell, 15).

The qualitative researcher employs a spectrum of empirical materials to describe the phenomenon in question by defining the routine and problematic periods, epiphanies, and meanings in individuals’ lives (Creswell, 16). These methods include but are not limited to biography, case study, introspective, personal experience, interview, life story, observational, interactional, and visual texts. I deployed a cross-section of these interconnected methods in an effort to present a clear and better view of the subject matter.

The combination of these multiple methods and perspectives represents a strategy to add depth, breadth, and exactness to our story, for

Qualitative research is endlessly creative and interpretive. The researcher does not just leave the field with mountains of empirical materials and then easily write up his or her findings. Qualitative interpretations are constructed (Denzin and Lincoln, 30).

The qualitative method outlined by Creswell seems suitable for my project because it helps to create a holistic view of our story. I first created a text consisting of field notes and documents from the field, primarily audiotapes, transcriptions, personal diary entries, memories and letters. I made notes based on this data. I then re-created these notes as a working interpretive document. This vital segment of the process proved to be both confusing and difficult. Creswell recommends “that one engage in a small pilot qualitative project to see whether he or she is at ease with the ambiguity and decision process involved in the study (16). The lines blurred in my small pilot project. “Tedious” accurately describes the process I experienced while crafting the qualitative narrative in the hybrid style of two specific types of interpretive biography.

Before identifying these specific styles of interpretive biography, I think it useful to provide a broad yet brief aside that examines the history and variant methods of biography. According to Denzin, the biographical method, which has a documented history beginning in the 1920s, experienced a basic rebirth and newfound use by sociologists and scholars in the late 1980s. However, in 1959, C. Wright Mills supported the biographical style and argued that

the sociological imagination enables us to grasp history and biography and the relations between the two within society. No social study that does not come back to the problems of biography, of history and of their intersections within a society has completed its intellectual journey (Denzin, 9).

Biography represents a vital and necessary intellectual component in the construction of the history of society. There are two broad variations of a biography: a classical objective approach and an interpretive approach. Both variations, however, are a study of *an individual* and his or her experiences as found in archival materials and documents or

told to the researcher. Denzin defines the biographical method as the “studied use and collection of life documents, or *documents of life* (Plummer, 1983; p.13), which describe turning-point moments in individuals’ lives” (Denzin, 7). In a classical biography,

the researcher uses statements about theory, concerns with validity and criticism of documents and materials, and the formulation of distinct hypotheses, all drawn from the perspective of the researcher (Creswell, 50).

Creswell claims that interpretive biography challenges each style of classical biography: the broad forms; biographical study, autobiography, life history, and oral history; and the specific biography. In his Interpretive Biography, Denzin states that “the classic stance pits the sociologist against the subject; it turns the subject into an object of the study” (52). Creswell labels interpretive biography as “Denzin’s approach to biography” (Creswell, 48). Denzin has applied his interpretive biography approach to the study of adult alcoholics, and I will apply Denzin’s approach to the study of adolescents and their usage of alcohol and drugs.

Interpretive biographies depict an individual’s experiences and can express their introspective knowledge, in turn, helping other individuals who experience similar circumstances by creating a window for them to look through. According to Denzin, interpretive biography formats oftentimes take one of three forms: “(1) from the subject’s point of view, (2) subject-produced biographies, and (3) making sense of an individual’s life” (Denzin, 58-59). For the purpose of my thesis, I have crossed forms one and three into a hybrid. Form one, “from the subject’s point of view,” argues that the best understanding of a culture comes from seeing its impact

on the individual lives of family members. It works outward from a social collectivity, typically a family, to the larger social structure which shapes the lives of the members of the culture.

Such documents can then be used as platforms for the expression of political positions (Denzin, 59).

The welfare of our children's lives is political. A bi-partisan statement that addresses the reality of children adversely affected by alcohol and substance use can be well voiced and heard through an interpretive biography. The underlying culture-of-adolescent substance usage will be anything but vague when giving Mears' story a voice. Her story **is not** unique. Mears' experience epitomizes that of thousands of individuals within a certain segment of the adolescent culture.

Form three, "making sense of an individual's life" stands on a foundation with two supporting infrastructures: (A) that the author finds a part of themselves in the subject, and (B) "that all life histories have their origins in early childhood" (Denzin, 64-65). Denzin defines yet another layer of these methods as the "Progressive-Regressive Method"

In order to study these meaning structures, I listened to the self-stories alcoholics told one another around the A.A. meeting tables. From these stories, I worked back in biographical time to discover how the individual first became a drinker, then an alcoholic drinker, and then a recovering alcoholic who no longer drank. The author employed a variant of Sartre's (1963, pp. 85-166) progressive-regressive method which begins with a key event in a subject's life and then works forward and backward from that event. In my study, forward progression began with the individual's participation in A.A. and admission of his or her alcoholism. I listened to these individuals as they began to discuss their past life experiences. I worked backward, identifying how the person got to A.A. in the first place (Denzin; p. 67).

A synthesis of Denzin's forms one and three creates an ideal hybrid interpretive biography method for our story. Mears' perspective not only represents her position but also depicts the point of view for thousands of children. Making sense of her life is

paramount to the lives of others. By finding a part of myself in Mears' life stories, realizing that my struggle with alcohol and drugs has its origin in my childhood, I too can relate with the lives of adolescents whom are and have been stalked by this reality. This hybrid form of qualitative research methods provides a sound methodological framework to approach the biographical narrative and its interpretation.

After determining that the above-described framework best suited this purpose I asked Mears to record her life story, as it relates to alcohol and drug usage, on audio-tape. These tapes were then transcribed in their entirety. I both listened to the tapes and read the transcripts numerous times in an effort to identify, what I considered as, vital points, crucial experiences, and Mears' epiphanies. After identifying these aspects of her story, I began to match them with some of the more salient reference points typically characterized with adolescent substance use and abuse. I identified and considered the salient reference points from two sources: one, the following literature review on adolescent substance use and abuse; and two, the poignant stories that I heard told by both children and their family members at Kids Helping Kids. I began to locate each of these points on a chronological line that served as an elastic outline for Mears' story.

The elastic outline proved quite useful as I integrated entries from my personal diary, snippets of personal letters, segments from contracts, and personal memories into Mears' recorded story. There were three basic outline categories in which I positioned this data: What Mears' Life was Like, What Happened? A Turning Point Of Time, and What Mears' Life is Like Now. I then wrote the interpretive biography of Mears' life in chronological order.

Sociological, Biological, and Psychiatric Literature Review Preface

Addiction is an actual illness. When we see somebody with a physical impairment we have compassion and some tolerance for what they have to go through. When we have a person who has a physical abnormality that's hidden away in the brain, we jump to judgement very quickly. People say 'Why can't they control their use of drugs?' They don't realize that there's actually something organically wrong. There's no doubt that addiction is a treatable and preventable illness

-Dr. Darryl Inaba, Uppers, Downers, All Arounders, 2000

Adolescent substance use and abuse exists, whether you believe it or not. One objective of my thesis is to provide a review that synthesizes and defines some aspects of the sociological, biological, and psychiatric elements of adolescent substance use, abuse and dependence. I conducted an extensive literature search using several journal article databases, including PsycInfo, Medline, and Current Contents. Articles included were limited to studies performed after 1987. Studies and surveys on adolescents and substances were reviewed with the focus on examining the degrees of substance use, abuse and dependence, the epidemiology, causal and risk factors, multiple diagnostic disorders, and diagnostic methods. The terms "substances" or "drugs" can include alcohol, marijuana, cocaine, heroin, inhalants, and numerous other illicit drugs including prescription drugs improperly obtained or used. I hope that this information helps to define and to quantify the problem that confronts our children and us.

First, it is necessary to address several problematic areas that exist when gathering and analyzing survey data of this nature. A prevalent problem exists with adolescent substance use survey data because "many users lie about or minimize their use of drugs

even when assured that the survey is confidential” (Uppers, Downers, All Arounders UDAA, 326). Even more problematic is the reality that a majority of the surveys are taken from school populations, omitting the entire adolescent dropout population. Speculation and empirical data exist (outside the scope of this review) that the dropout population may well represent the most concentrated group of adolescent substance abusers and dependents. If this speculation is accurate, the statistics reviewed underestimate the actual percentage of adolescent substance abusers. Fundamentally, for this review, the varying methodologies, samplings, and definitions of abuse employed by these studies represent the primary difficulties with synthesizing the survey data: “abuse means different things for different people and for different drugs” (UDAA, 326). However, the following section attempts to synthesize data primarily from four sources in order to determine some of the differences between adolescent substance use, abuse, and dependence.

Adolescent Substance Use, Abuse, and Dependence

Substances are widely used by adolescents as a means of excitement, consolation, rebellion, independence, and as an effort to belong to a peer group, or as a symbol of social or even sexual maturity. Substance use by adolescents follows certain patterns. Generally, adolescents begin substance use with coffee, tobacco and alcohol, substances legal for adults, with the onset of drinking alcohol usually occurring between the ages of 10 and 13. If adolescents continue, marijuana likely becomes their next drug. Cocaine, hallucinogens, inhalants and black-market prescription medications are used next.

However, variations have been found for some samples: for example, 25% of a sample of 944 serious drug abusers in

Manhattan reported never using alcohol (Golub and Johnson, 1994). Sex differences have been found in the general population; for males, progression to illicit drug use was dependent on prior use of alcohol, whereas for females either cigarette or alcohol use was a “significant condition” for progression to marijuana (Kandel et al., 1992) (Weinberg et al., 253).

Adolescent substance use exists as a continuum of behavior. The spectrum of behavior begins with experimentation and sporadic use that may lead to a chronic, severe dependence with life threatening consequences increasing as progression continues. The progression of substance abuse from the heightened potential for use to dependence can be described by five stages. Particular behavioral signs and manifestations can be recognized in each stage.

Stage 0: Preabuse or Curiosity Stage

Stage 0 describes the adolescent with an increased potential for substance abuse. The primary practitioner who identifies an adolescent in stage 0 is in a key position to offer primary prevention strategies. This increased potential for substance abuse stems from the combination of genetic susceptibility, personality traits, family influence, and environmental factors.

Stage 1: Experimental Stage (Learning the Euphoria)

Adolescents in stage 1 have already made a decision to “try” drugs and begun learning the drug induced mood swing or euphoria. Drugs most commonly used at this stage are tobacco, alcohol, and marijuana, the so-called gateway drugs. Stage 1 drug use is confined to social situations, on weekends, in the company of others, and when others supply the drugs. There are few behavioral changes other than “avoidance lying” as interest in peer pressure from the drug-using world comes into conflict with the values and beliefs of the nondrug world (Muramoto et al., 144).

Some systemic research indicates that “the majority of adolescents who use substances do not progress to abuse or dependence” (Weinberg et al., 253). Additional research supports that “much of the alcohol and other drug use in high schools is experimental,

social, or habitual with bouts of abuse” (UDAA, 327). Professionals commonly define the nature of engagement in stage 1 as adolescent substance use (ASU). ASU appears to primarily be “a function of social and peer factors” (Weinberg et al., 254).

Advancement into stage 2 and stage 3 represents what professionals commonly define as adolescent substance use disorder (ASUD). ASUD “appears more related to biological and psychological processes” than does ASU (Weinberg et al., 254). ASUDs commonly co-occur with multiple diagnostic disorders including psychiatric disorders such as conduct disorder (CD), attention-deficit-hyperactivity disorder (ADHD), affective disorders, and anxiety disorders. The severity of the ASUDs may be impacted by these multiple diagnostic disorders. Multiple diagnostic disorders may impair the adolescent’s ability to engage in substance treatment. Therefore, it is necessary to assess for disorders that commonly co-occur with ASUD (Deas et al., 232-233). Multiple diagnostic disorders are examined in more detail in a following section. ASUD surveys focus on both frequency of and quantity of use of multiple substances, typically targeting use within the past 30 days. ASUD commonly applies to “persons consuming five or more drinks on each of five or more occasions in the past thirty days” (Weinberg et al., 254). ASUD can be defined when describing,

Stage 2, Early Regular Use (Seeking the Euphoria)

The adolescent now actively seeks the drug-induced mood swing. Use is no longer confined to a social context but is increasingly situational, as the adolescent seeks relief from everyday stress. Use is more frequent and sometimes solitary, regular on weekends, and occasionally weekdays. The stage 2 user no longer relies on drugs offered by others but now has his or her own supply. The range of drugs used expands to include stimulants, sedatives, and inhalants in addition to alcohol, tobacco, and marijuana. Stage 2 signs and symptoms are subtle

at first but most obvious in late stage 2. Signs include changes in dress, decline in personal hygiene, deterioration in school performance, loss of previous interest in extra curricular activities, and less interest in “straight” friends. The stage 2 adolescent exhibits more mood swings, engages in regular lying and “conning” as she or he increasingly leads a dual life between the mores and values of family, society, and the drug world.

Stage 3, Late Regular Use (Preoccupation With the Euphoria)

“Getting high” becomes the main goal of the stage 3 adolescent’s life, and daily activities are planned around opportunities to use. The user experiences “down times,” with marked dysphoria or withdrawal symptoms when not using. The adolescent may begin to question his or her control over drugs, experiences depression, and may even contemplate suicide. With the increasing frequency of use, the irritability, apathy, guilt, shame, and anxiety worsen, leading to more drug use, often with more powerful agents, to control these unpleasant feelings. The “harder” drugs are used daily, frequently alone as well as with others. Behavioral problems and family conflicts worsen as the adolescent lies, fails in school, or has legal problems resulting from the cost of maintaining a drug habit. There is growing retreat into the drug-using world, drug-seeking behavior is obvious, and self-destructive and risk-taking behaviors, including overdosing increase (Muramoto et al. 144-146).

Progressing from stage 3, heightened ASUD, into dependence oftentimes can be identified by patterns of use; however, many studies designed for adult diagnosis rely on symptoms of withdrawal to identify dependence. Although empirical evidence is sparse, it is widely held that adolescents may show symptoms of use and abuse but usually do not exhibit symptoms of dependence in the form of tolerance or withdrawal as identified in adults.

Adolescents may demonstrate symptoms of dependence that include physical, cognitive and psychological disturbances, first of all mood related reactions, but the DSM-IV (as well as its predecessor, DSM-III-R) criteria for withdrawal from specific substances do not appear to sufficiently describe the withdrawal symptoms in adolescents (Segal et al., 194).

Most assessment instruments like the DSM-IV (American Psychiatric Association, 1994) and its predecessor, DSM-III-R (American Psychiatric Association, 1987) were originally formatted for adult diagnostic purposes. However, in the past decade modifications applied to DSM-IV diagnostic criteria may help clinicians distinguish relatively “normal” adolescent experimentation with substances from more serious problematic use that calls for treatment intervention (Deas et al., 232).

Adolescent withdrawal symptoms do not uniformly fit alcohol or a single substance withdrawal process, as initially and primarily identified in adults. It has been reported that between 70% and 98% of adolescents in treatment for substance abuse were users of multiple substances, or polysubstance abusers (Muramoto et al., 148). Whether or not adolescents experience withdrawal as a result of participating in stage 4, adolescents experience heightened needs to use and other characteristics.

Stage 4, End Stage or “Burn Out”

The stage 4 adolescent now needs drugs just to feel normal and to avoid the profound and nearly constant dysphoria. Depression, guilt, shame, and other remorse may be overwhelming, and suicidal ideation becomes more common. The user turns to more potent agents, using them in larger amounts. Drug use is nearly constant, as the user becomes less selective, using any and all drugs available, and obtaining them by whatever means necessary. Increasing physical and mental deterioration becomes obvious. The user often drops out of school and engages in more risk-taking and self-destructive behaviors. Family relations are severely disrupted, and the user may have been expelled from the home. Paranoia, angry outbursts, and aggression are common. Overdosing occurs more regularly, in addition to blackouts, amnesia, and flashbacks. Physical symptoms such as cough, fatigue, malaise, and problems related to malnutrition become chronic. (Muramoto et al., 144-146)

The symptoms identified above by stage 4 address active adolescent dependence and do not address the symptoms of withdrawal that are normally identified in adults with substance dependence.

In actuality, clear withdrawal symptoms appear only after several years of abuse; for instance, the alcohol withdrawal syndrome requires 6-8 years of drinking. Due to a shorter experience of substance use in adolescence some criteria of adult dependence cannot be seen in this age cohort (Segal et al., 194).

Classic symptoms of dependence found in adults such as extremely high tolerance to cocaine and or heroin, or a marked decrease in tolerance to alcohol, blackouts and a noticeable change in drinking behavior are also infrequently seen in adolescents.

Regardless, adolescents who are unable to discontinue heightened substance abuse and experience serious behavior, like psychosocial and medical disturbances, can be classified as chemically dependent despite the absence of some symptoms of adult substance dependence, primarily withdrawal characteristics (Segal et al., 194).

The ways in which adolescents parallel or differ from adults in the development and expression of substance use disorders raises a matter of importance and scientific interest: adolescents are not adults. For example, after the first exposure to alcohol adolescents commenced regular drinking—defined as drinking at least once a month for six months or more—more than three years earlier than adults. Shortly thereafter adolescents began to pick up signs of dependence. Adolescents acquired their initial dependence symptom at an average of seven months compared to nearly three years for adults, and tended to qualify for a dependence diagnosis within about one and one half years of beginning drinking, whereas adults averaged nearly eight years. Adults drink more often; however, adolescents drink almost as much in terms of quantity per occasion

(Deas et al., 233-234). Adolescence is the primary risk period for the initiation of substance use; those who have not experimented with either licit or illicit drugs by age 21 are unlikely to do so thereafter (Segal et al., 196).

Epidemiology

During the past thirty years unlawful drug use by American adolescents changed from an “extremely deviant phenomenon to an epidemic situation” (Segal et al., 194). Unfortunately, ASU can lead to disastrous consequences, critical accidents, disability, and even death. In fact, drug and alcohol related accidents are the leading cause of disability in adolescents (Muramoto et al., 141). The Fayette County Coroner reports that over seventy children and young adults, under twenty-one years of age, died in Fayette County during the 1990’s due drug and alcohol usage.

Recent surveys indicate a sharp increase in ASU beginning in the early 1990s. In 1994, it was reported that four million teenagers, 20% of all adolescents between 12 and 17, drank alcohol on a regular basis. In 1995, the Carnegie Council on Adolescent Development reported that between 1991 to 1994 the tobacco smoking rate among eighth graders increased 30%, while 66% of those surveyed said that they had tried alcohol; and 28% admitted they had been drunk at least once. Almost twenty percent of the eighth graders surveyed admitted to using inhalants. According to the National Institute of Drug Abuse, between 1992 and 1993 marijuana use increased from 7.2 to 9.2% of eighth graders, 15.2 to 19.2% of tenth graders and from 21.9 to 26% in the twelfth grade (Segal et al., 195). The 1996 Monitoring the Future Study found that 4.9% of high school seniors admit to daily marijuana use over the past thirty days. An ASU survey of U.S. High School Seniors performed in 1999 indicates that 51% used alcohol, 23.1% used

marijuana, 4.5% used amphetamines, 2.6% used cocaine, 2.0 % used inhalants, and 0.5% used heroin within the previous 30-day period. Seventy percent of teenage suicides involve alcohol or drugs; 50% of date rapes involve use by either the victim and/or the rapist, and 40% of adolescent drownings involve alcohol (UDAA 327). Adolescents do not need to be using substances in a manner more severe than stage 1 to suffer these consequences. They can merely be experimenting.

According to the National Arrestee Drug Abuse Monitoring Program, in 1998 over half of male juvenile arrestees tested positive for one or more illegal substances. These are conservative statistics considering that the authorities did not test for alcohol. Security on Campus reports that 90% of national university campus crime involves alcohol or drugs and that 70% of these crimes are student on student crimes.

The annual national negative economic impact attributable to ASU and ASUD is estimated at more than 58 billion dollars (e.g., 36 billion in violent crime, 18 billion in traffic accidents) (UDAA, 328).

Causal and Risk Factors

Many professionals consider alcoholism as a family disease. “Familial predisposition to alcoholism has firmly been established. Children of alcoholics run a four times higher risk of alcohol abuse than children of non-alcoholic parents” (Segal et al., 199). These children still have a higher likelihood of becoming substance dependent even when adopted by non-alcoholic parents. Although genetic disposition is postulated, no single gene has been identified or is thought to account for the tendencies toward ASUD. How these familial risk factors exert themselves remains under study; besides

genetics, possibilities include parenting styles, family stress, child victimization, other biological contributors and the interaction among these factors (Weinberg et al., 255). In one study, 57% of ASUD cases reported frequent family violence (Muramoto et al., 150).

In some cases the family no longer serves as a protective cell that provides stable nurturing. Some “young persons often suffer from a sense of not belonging. ‘No longer a child and not yet an adult, he often feels that he is an outsider and that no one needs or wants him.’ In an attempt to reach out, the adolescent seeks friends and new experiences” (Segal et al., 200). Recent studies indicate a number of conditions put adolescents at greater risk of ASU and ASUD. A significant correlation between ASUD, antisocial behavior and delinquency exists. These conditions and risks include: schools that have no policies, detection procedures, or referral services for users; few alternative activities; low self-esteem; being caught in the juvenile justice system; living in poverty; dropping out of school; and getting pregnant (UDAA, 328).

America is a country trying to dismiss all the troubles of its teenagers, states the report of the Carnegie Council on Adolescent Development. The Ethical vacuum, produced by a declining role of family values, is filled with the rock music and heavy metal pseudo-philosophy, glorifying ‘fun’ and violence. Alcohol, drugs and promiscuous sex provide the young people with several defective techniques to escape from identity problems, frustrations, disappointments, emptiness, boredom and lack of meaning of life. Ethnicity as well as imitation of adult behavior, curiosity, a rebellion against age-related restrictions and taboos have also been cited as the factors (Segal et al., 200).

By age 12, those children who feel that they are significant participants in and valued by their families seem to be less prone to ASU or ASUD in the future. Likewise, by age 12, children who can articulate their personal position concerning abstention from drugs, alcohol, and sex seem less likely to develop ASU or ASUD in the future. Young people

who feel that they matter and have a position in their community seem less likely to use substances (UDAA, 329).

Multiple Diagnostic Disorders

Alcohol and drugs weaken immune systems responses, increasing probability and severity of additional physical illness (Segal et al., 202). Alcohol abuse, by either an adult or an adolescent, alters metabolism and affects the internal organs, particularly the liver, the central nervous system, cognitive and emotional functioning. Intravenous drug use is frequently associated with HIV infection, hepatitis and endocarditis within the adolescent population. Prolonged use of inhalants causes irreversible neuropsychological damage.

Studies on multiple diagnostic disorders in adolescents have significantly increased since the late 1980's. When one disorder is proven to precede another, co-occurrence does not imply causality and cannot be used for clinical prediction. ASUDs have a high co-occurrence rate with behavioral and psychiatric disorders. Studies found significant rates of comorbidity of ASUD and depression, anxiety, eating disorders, and particularly disruptive behavior disorders (Weinberg et al., 256). In 1991, the Diagnostic Interview Schedule for Children tested 547 adolescents, aged 12 through 18 years, a clinical population in either residential treatment or special education programs. The study found conduct disorder (CD) and depression associated with ASUD, and the highest rate of ASUD in those with both disorders. In 1992, 226 adolescents, aged 12 through 18 years, were administered the Schedule for Affective Disorders and Schizophrenia for School Aged Children (K-SADS) during the fourth week of their stays

in substance abuse facilities; 82% had Axis I disorder, and 75% of those had more than one disorder. Predominantly, 61% suffered mood disorder, 54% suffered CD, and 43% manifested anxiety disorder. Also in 1992, 156 adolescents, aged 13 through 18 years, were administered the K-SADS which indicated dual diagnosis of ASUD and CD in 71%, major depression in 31%, and both in 14%. For those with major depression the studies found it typically secondary to ASUD (Weinberg et al., 256).

“The statistical relationship between ASUD and ADHD appears to be largely due to the association of each with CD. However there may be other subgroups of ADHD populations who tend toward ASUD comorbidity” like those affected by ADHD into adulthood or with social skills defects (Weinberg et al., 256). ADHD may “play a causal role in the development of alcohol related neurocognitive symptoms” (Segal et al., 203).

Substance abuse adversely affects psychosocial maturity of adolescents, compromises their school performance, contributes to low achievement and increases the rates of school dropouts. Substance abuse interrupts normal psychosocial functioning, decreases social support, diminishes participation in age appropriate activities, produces anxiety, tension, and lowers self-esteem. And on a fundamental level, substance induced psychosocial disorders interfere with basic eating and sleeping patterns (Segal et al., 202).

Diagnostic Methods

Behavioral characteristics, family assessment, physical findings and complaints, laboratory tests, and psychiatric examinations are methods available to diagnose ASU or ASUD. Clinically, an in-depth drug use history and psychiatric and physical examinations are the mainstay for diagnosis and treatment planning (Weinberg et al.,

257). However, reliance on the physical examination alone will miss the majority of ASUD cases (Muramoto et al., 149).

Behavioral findings are usually “the first indication that a teenager is abusing substances and can [be] present in any of the various realms of functioning in an adolescent’s life” (Muramoto et al., 148). Some of the indications that substance use may be problematic for the adolescent are: mood swings; depression, isolation, suicidal ideation; fights and violent outbursts; rebellious, paranoid attitude or behavior; changes in circle of friends, older friends; decline in school performance; change in sleep patterns with excessive sleeping; decline in personal hygiene; loss of interest in extracurricular activities or hobbies; selling possessions or apparent ability to buy more items; change in dress, including substance related motifs; drug paraphernalia; and legal problems. These indicators may or may not be related to substance abuse; however, they should be considered serious enough to investigate. Watching for behavioral changes from the norm to recurrent abnormal behavior helps to monitor these indicators (Muramoto et al., 148-149).

Assessing an adolescent’s family proves essential in the evaluation of his or her suspected substance use. Kids Helping Kids believes that assessing and treating the family members proves essential in the treatment of adolescent substance use. There are a number of familial factors that have been correlated with ASU and ASUD:

Relative lack of parental supervision, with less involvement, less control, and less familial goal-directed behavior; weak parent-child mutual attachment; conflicted parent-child relationship; intrafamilial tension, conflicts in adolescence; tolerance of deviant, illegal, or unconventional behavior by parents or siblings; parental or sibling aggression, unconventionality, or social isolation; parental psychopathology, poverty; parental divorce, death or abandonment (Muramoto et al., 150).

ASU and ASUD may be a reflection of other serious familial issues like violence or sexual abuse. ASU and ASUD place tremendous stress on non-using family members and signs of physical and mental strain may be evident with them.

There are numerous common physical findings and complaints that indicate ASU or ASUD. A medical history that includes minor trauma, fractures, motor vehicle accidents, and sexually transmitted diseases may reveal clues to ASU or ASUD. Generally speaking, weight loss or drastic weight changes, somnolence or insomnia are findings noted in substance-abusing adolescents. Other physical descriptions include: acute or chronic sore throat, inflamed or swollen uvula, red eyes or conjunctivitis, chronic cough or congestion, hypertension, nausea or vomiting, diarrhea, anorexia, sexually transmitted diseases, menstrual irregularities and delay in secondary sexual characteristics. Visual indicators include singed eyebrows from crack pipes, needle tracks resulting from IV drug use, and scars and burns from self-mutilation (Muramoto et al., 149).

Routine laboratory tests will miss most cases of ASU and even ASUD. Urine drug screening proves the most useful test to confirm drug use. A routine drug test does not test for all types of drugs and the length of time that a drug test will indicate positive after an adolescent's last use varies with the properties of that drug: 1 through 3 days for heroin, amphetamine and cocaine, and up to 30 days after chronic marijuana use (Muramoto et al., 150 and Weinberg et al., 257). Excluding the determination of blood alcohol levels, urine samples are more sensitive than serum tests. Urine drug screen results can be particularly effective in approaching an adolescent who denies drug use

(Muramoto et al., 150). Hair, saliva, and sweat analyses represent promising laboratory alternatives (Weinberg et al., 257).

Prior to the early 1990s, a fundamental issue existed with self-report screens and psychiatric diagnostic instruments used for analyzing adolescent substance abuse: they were developed for adults and did not consider differences in drinking and drug use patterns between the two age groups. Thus, research has been directed toward modifying diagnostic instruments designed for adults and designing new instruments solely for adolescents. Studies identify limitations with both instruments, “the most cited being that adolescents, like adults, often underreport their drug use” (Winters et al., 1992: Weinberg et al., 257). The self-report screens can be self-administered, take a short time to complete, and are rapidly interpreted and scored. These screens attempt to identify whether the individual qualifies either in ASU or ASUD categories and they also query information on nine related areas. The psychiatric diagnostic instruments are administered during either semi-structured or structured interviews and provide comprehensive assessment of substance use, substance use patterns, psychosocial factors, some include a Lie-scale or Tendency-to-Fake scale, and referral information. These tests can provide salient data that can help to determine the most effective treatment modality for the adolescent.

CHAPTER TWO

TREATMENT

Beating addiction requires every tool on the table – medication, counseling, social support, family support – and keeping up the fight when you’re losing...treatment is not a war but a long, slow siege

-Newsweek, February 2001

In the previous chapter, I identified some magnitude of the adolescent substance use and abuse problem. In this section, I identify, to some extent, a solution available for this dire problem. I conducted an extensive literature search using several journal article databases, including PsycInfo, Medline, and Current Contents. Studies and surveys were reviewed with the focus on examining the types of treatment variations and modalities available for adolescents and their families suffering from substance abuse. For the purpose of this review I identify two distinct categories of adolescent treatment: “variations” refers to the length and physical operations (ex. long-term residential) whereas “modalities” refers to the types of therapy administered (ex. family-based and multi-systemic interventions).

Screening and Assessment of Adolescent Substance Use and Abuse

In the fall of 2000, The Journal of the American Academy of Child and Adolescent Psychiatry reported that regional studies revealed “that seven to ten percent of adolescents are in need of treatment” for ASU and ASUD (1324-1326). Only a small segment of this population—usually those with severe substance use disorders, co-morbid disorders, or legal problems—receive treatment. The National Institute of Drug Abuse and National Institute on Alcohol Abuse and Alcoholism reports that 115,000

adolescents are treated each year in the United States for substance abuse. A majority of this population remains untreated for various reasons: simple unawareness or complicated denial that the problem exists, the ineffectiveness of screening and assessment methods, limited resources, inadequate age-appropriate programs, and a broad failure to reach a consensus on preferred treatment strategies. The process of presenting individuals for treatment, treating, and evaluating the treatment of adolescents with ASU and ASUD lags far behind that which exists for the adult population.

Presenting adolescents for treatment typically involves a screening and or an assessment process. These processes gather data concerning multiple variables relating to the individual. Most clinical investigators and professionals agree that treatment modalities should embrace empirically validated techniques, “even if these techniques are borrowed from adult substance abuse literature...however, the treatments must take into account the developmental issues and problems characteristic of adolescents” (Kaminer, 147). The previous chapter’s literature review identifies a complexity of problems that commonly co-exist among this adolescent population. These problems are not limited to unsafe sexual behavior, delinquent and aggressive behavior, familial and relational issues, and mental health problems. Some professionals believe that

the ideal screening procedure should entail a single instrument that is holistic. Screening is distinct from assessment. The purpose of screening is to identify individuals who may be at risk for a particular problem and to rule out those who are not. A comprehensive assessment needs to be conducted to determine whether and what type of intervention is appropriate. This two-stage process of screening and assessment can conserve limited medical resources while increasing the likelihood of detecting serious problems (Harrison et al., 132).

The negative aspects of multidimensional or holistic screening approach are their length and time required for administration. Several holistic instruments have been developed, among them are, the Juvenile Wellness and Health Survey, the Drug Use Screening Inventory-Revised, the Problem-Oriented Screening Instrument for Teenagers, and the Youth Self Report. These screenings take anywhere from 20 to 40 minutes and have 76 to 159 items that they address (Harrison et al., 132). There are shorter screening methods that fail to address more than one or two problematic areas. Therefore, many holistic instruments are too long for application and the instruments that meet the brevity test fail to address the broad range of potential problems that the adolescent may possess.

The basic premise of screening and assessment is to identify the problems of the adolescent possesses and in turn match the adolescent with the most appropriate treatment modality. However, Project MATCH, an extensive investigation of numerous adolescent treatment facilities that employ various modalities of treatment (cognitive-behavioral therapy, motivational enhancement therapy, psychopathology therapeutic intervention, and twelve-step methods) found no evidence that matching is a viable treatment strategy (Kaminer, 147). With the limited number of treatment facilities available to adolescent sufferers, even if properly matched, the patient may not have the option of switching or being referred to a particular program. Therefore, the American Society of Addiction Medicine endorses that

rather than focusing on matching a patient with a particular program, it may be more beneficial to match the patient's problems with targeted services within the program that meet his or her needs (Kaminer, 148).

At this point, I must mention the difference between the individual's "needs" and the individual's "wants". It is my belief, and experience, that there is a great disparity

between these two characteristics as they relate to an individual's abilities to succeed in any effort, particularly substance abuse treatment efforts. An adolescent may desperately need treatment for substance use or abuse but the real variable remains—does the adolescent want treatment for his or her problem?

There may be many factors that can affect an adolescent's desire to participate in a treatment program. Some of these pretreatment factors may help to predict the individual's completion of a substance abuse treatment program. What are some of the factors that may indicate an adolescent's desire to participate in and to complete a treatment program? A study of 132 consecutively admitted adolescents to the CHOICES program in Halifax, Nova Scotia began with a battery of standardized questionnaires that addressed demographic information, substance abuse history, psychopathology, self-esteem, family relationship problems, and peer relationship problems and may provide some incite to this query. The mean age of the adolescents was 16.4. The median socioeconomic ranking of the subjects was 35 (the median for Canadians is 39). There were 93 male and 39 female subjects. Seventy-four, or fifty-eight percent, of the adolescents completed the program. "Using discriminant function analysis, five pre-treatment measures were found to predict treatment completion in male subjects," including greater severity of alcohol-related problems; greater usage of substances other than alcohol, marijuana, and nicotine; higher degree of internalizing problems, and lower self-esteem. Significant predictors for completion by female subjects were not found (Blood and Cornwall, 14). These results indicate a correlation, among the male subjects, between the severity of the problem and the completion of treatment, in turn increasing the likelihood of recovery. Perhaps, that is to say, unfortunately, that the male

adolescents who stand a greater opportunity of treatment completion must experience a greater severity of pre-treatment problems. Whether or not an individual adolescent wants treatment may well rely on their awareness of the severity of their problem(s).

Variations and Modalities of Adolescent Treatment

In the Spring 2001 issue of The American Journal on Addictions (178-189) Deborah Deas, M.D., M.P.H. and Suzanne E. Thomas Ph.D. report that “although several treatments for adolescents with substance abuse are available, there are few well-controlled studies in the extant literature that compare these treatments for efficacy”. Deas and Thomas reviewed data encompassing twenty years that focused on five main treatment modalities: “family based and multi-systemic interventions, behavioral therapy, cognitive behavioral therapy, pharmacotherapy, and twelve step approaches” (178). Their report data prior to 1993 rested on R. Catalano’s review of the then extant literature that indicated three conclusions:

(1) some treatment is better than no treatment, (2) post-treatment relapse rates were high in adolescents, and (3) there was little evidence to suggest that one treatment modality was more efficacious than another, but since so few controlled studies were available to address this issue, Catalano reported that conclusive statements were premature (179).

Based on the conclusion of Deas and Thomas, not much has changed since Catalano’s 1993 report, the exiguous evidence makes it difficult to conclude that one treatment modality for adolescent substance use and abuse is more effective than another.

Catalano, Deas and Thomas represent a consensus of investigators who believe that reviews of clinical trials conducted over the past 25 years indicate on a broad basis “that little is known about the effectiveness of the various treatments for this population”

(Kaminer, 147). Relevant studies fail to utilize validated outcome measures. There is a great scarcity of unbiased quantitative outcome data from adolescent treatment facilities.

My intent is not to determine the efficacy, or order thereof, of adolescent treatment modalities and variations. My intent is to provide a description of the basic variations and modalities that treat adolescents and their families for substance use and abuse disorders. I arrived at this decision because I agree, at this time, with Catalano “some treatment is better than no treatment.” If any type modality or variation saves one child’s life, then, in my opinion, it’s effective.

The essential assumption of family-based and multi-systemic interventions is that both the community and family help to create the conditions related to adolescent drug use and abuse. Consequently, parent-child relationships and social environments can aid the adolescent in recovery. The adolescent is viewed in the circumstances of the family, peer, community, and school surroundings, in which the dynamics of those relationships affect and influence the adolescent’s thoughts, perceptions, and behaviors. Some of these perceptions can lead to deviant or destructive behavior patterns, including substance use. Dysfunctional relationships within any of these systems may lead the adolescent towards problem behavior, so the therapies postulate that treatment should involve individuals from the contributing relationships. The family therapy model utilizes the “functional family therapy method” (Deas and Thomas, 179-180). This method includes establishing clear and consistent communications, positive re-labeling, and creating an environment that fosters hope, trust, responsibility, and self-esteem. There are separate group therapy sessions for parents and relatives, as well as therapy sessions for the adolescent client and their family members.

Behavioral therapy is a treatment approach based on the fundamentals of “operant and classical conditioning” (Deas and Thomas, 180). The essential assumption is that substance use and abuse behaviors are actually learned in one’s environment. The main elements of behavioral therapy are “functional analysis, skills training, and relapse prevention” (Deas and Thomas, 180). Initially, therapy identifies the behaviors that “promote substance use and provision of skills that disrupt the behavioral cycle” (Deas and Thomas, 180). These stimuli, either internal or external, both trigger and help to maintain substance use. The adolescents are provided with skills training to strengthen problematic areas defined in the functional analysis. This training helps the adolescent to manage situations that lead to relapse. Areas of common focus are “assertiveness training, drink/drug refusal skills, relaxation techniques, self-control, stress management, and social skills” (Deas and Thomas, 180). Many adolescent treatment facilities rely on elements of behavioral therapy.

Cognitive-behavioral therapy (CBT) expands the principles of behavioral therapy to recognize the influences of information processing, social learning, and stage of development aspects. CBT stresses the interactions between cognitive, behavioral, social, and developmental factors to promote individual behavioral changes and changes in his or her perceptions. CBT posits that substance use is functionally related to the individual’s problems that are influenced by cognitive and social factors. Like behavior therapy, CBT targets high-risk situations and perceptions and then emphasizes developing and maintaining the skills to deal with these high-risk areas. The goal of CBT is to help the individual recognize and, if possible, avoid the situations that lead to

substance use, while coping with the behavioral triggers associated with these threatening situations.

The FDA has approved several drugs that are used for the treatment of drug and alcohol addiction by adults, “including opiate antagonists (for prevention of relapse) and benzodiazepines (for treating withdrawal symptoms)” (Deas and Thomas, 184).

Pharmacological intervention therapy for adolescent substance abuse is gaining both scientific attention and controversy. The controversy centers on test results that indicate that “psychotropics used for depressive disorders in adolescents are not significantly better than placebo” (Deas and Thomas, 184). As of spring 2001, there are only two controlled trials of pharmacological interventions that target substance use in adolescents. Pharmacological interventions of adolescents typically address the co-morbid disorders associated with substance use disorder, not ASUD itself.

Twelve-step interventions are oftentimes implemented as an adjunct treatment in many programs that practice family-based and multi-systemic, behavioral, and cognitive-behavioral approaches. Twelve step programs, like Alcoholics Anonymous and Narcotics Anonymous, believe that substance dependence is a chronic and progressive illness. Twelve step philosophy may be briefly described by dividing the steps into three sections, each step and section offers a specific purpose. Section one, the first three steps ask the participant to accept that they have permanently lost control over their usage of alcohol and drugs and suggest reliance on a spiritual higher power. Section two, steps four through nine propose that the individual makes a personal inventory, admit to their wrongs and to make amends to those whom they have harmed. Section three, steps ten through twelve suggest that the individual, while maintaining a spiritual connection to a

higher power, resolutely help others who suffer from dependence on alcohol and drugs (Alcoholics Anonymous, 58-71). In summary: trust a spiritual higher power, clean your side of the street, and help others. The twelve steps are usually not modified for application by adolescents. Adolescent only twelve step groups are available at some treatment facilities (Deas and Thomas, 184-185). Alcoholics Anonymous meetings for both homogeneous and heterogeneous age groups are offered nationwide.

There are numerous variations of facilities that administer the above five modalities to adolescents and their family members. Recent and separate study results directly contradict each other on whether or not most adolescents attend homogeneous or heterogeneous age group variation facilities. One study published in 1993 states that “Most adolescent substance abusers are placed in a homogeneous treatment center” (Marshall and Marshall, 200). However, a more recent study completed in 1999 claims that large-scale multisite studies of adolescent substance abuse have been performed primarily “within the context of studies on adults, due largely to the lack of treatment programs designed specifically for adolescents” (Rounds-Bryant, Kristiansen, and Hubbard, 575). Hypothetically, this may be attributable to the correlation between the increase of adolescent substance abuse in this six-year period and a consequent failure to build and implement homogeneous adolescent facilities, simple rule of supply and demand. Variations include hospital and non-hospital facilities, religious centers and non-religious centers, long-term residential and long-term non-residential, and short-term residential and short-term non-residential or outpatient treatment. The duration of the short-term variations ranges between several days and four to six months. Long-term variation duration ranges between six months to several years, to a lifetime.

CHAPTER THREE

KIDS HELPING KIDS

...like their motto, 'If your kid is lost, then one of our kids will find them.' That's what they say and that's what happens. That's Kids Helping Kids. It's not like diplomas helping kids, or some clinical woman. I mean they play a big part, like Michelle played a big part in my program and in my treatment but if she would've been the only person I would have dealt with I wouldn't have been sober still...I wouldn't have made it.

-Mears Green, March 2002

KHK both changes and saves the lives of children. I disavow any claim or effort to fully describe the KHK program model. A claim of this nature would be both false and futile for the only way to provide a complete depiction of the KHK program is by actually experiencing it in person on an ongoing basis. I only sketch an outline that describes the program as it relates to its aspects or the participation by the KHK staff, kids, and parents.

History and Personnel

Kids Helping Kids (KHK), located in Milford, Ohio, is a unique long-term, day treatment, multi-modality, adolescent drug and alcohol rehabilitation program. Several factors attribute to KHK's uniqueness. Utmost, however, it's not called Kids Helping Kids for nothing. New adolescent clients, or "newcomers," are immediately placed under the guidance of program peers who have progressed to a point of earning the responsibility of helping others. KHK also employs their own program graduates, or "seventh-steppers," as Staff Counselors whose responsibility is to help current KHK clients through rehabilitation. KHK administers a hybrid treatment that synthesizes the

family-based and multi-systemic, behavioral therapy, cognitive-behavioral therapy, and twelve step intervention modalities. Parents and families are involved in many aspects of treatment, including the provision of nighttime housing for the adolescent clients. In this section, I describe these above notable factors in detail and provide information on KHK's history (KHK history provided by Executive Director Penny Walker), philosophy, personnel, and quantified data.

The late 1970's marked an alarming increase of substance use and abuse by American adolescents. In 1979, a study revealed that there were no beds in Cincinnati, Ohio rehabilitation facilities or hospitals for adolescents suffering from alcohol and chemical dependency. One evening, people packed a Northern Kentucky High School gymnasium to listen to George Ross talk about STRAIGHT, an adolescent drug and alcohol rehabilitation program based in Florida. Within months, more than sixty families from the Cincinnati area had admitted their children into the STRAIGHT program.

STRAIGHT required that family members attend meetings in Florida on a monthly basis, and if not their child would be dismissed from the program. This requirement prompted a proposal from the Cincinnati parents to STRAIGHT: open a STRAIGHT facility in Ohio. Although STRAIGHT had plans on going national, they initially declined the request. Some parents wanted to continue lobbying STRAIGHT while others wanted to start a new rehabilitation program. The two schools of thought split the Cincinnati contingent. In 1981, both STRAIGHT and KHK opened facilities in the Cincinnati area, STRAIGHT in Milford, Ohio and KHK in Northern Kentucky.

The two organizations experienced some nature of competition in the early years. In 1982, First Lady Nancy Reagan attended a STRAIGHT fund-raising event in Ohio that

helped STRAIGHT net two million dollars in solicitations that year. STRAIGHT bought a land-tract and constructed a state of the art facility, specifically designed for adolescent rehab. The KHK Board of Directors hired STRAIGHT's George Ross to oversee KHK's operation. At times, STRAIGHT would be treating nearly two hundred adolescent clients while KHK might treat a dozen or so. However, as many things do, things changed. Ross remained with KHK for only a few years when Penny Walker replaced him as Executive Director. By 1986, STRAIGHT found it necessary to close the doors on their facilities, including the one in Milford, Ohio. The STRAIGHT facility in Milford, Ohio remained unoccupied and in foreclosure for seven years until KHK purchased it in 1993. The acquisition negotiations with the court system began in July and ended in September 1993. KHK held their first meeting in the renovated facility in November 1993 and continue to operate there today.

As Executive Director, Penny Walker guides a complete staff of relevant personnel resources. The staff currently includes but is not limited to Program and Clinical Director Michele Hoehn, M.A., C.C.D.C. III-E, a fully accredited Clinical Staff and Coordinator, a Medical Director, a Nurse Practitioner, a Staff Psychiatrist, a Consulting Psychologist, an Educational Coordinator, and a fully operative Executive Staff. KHK's Board of Directors currently consists of twenty members and is supported by an Advisory Board and an Honorary Board that includes four Congressmen and a Senator. I am forever indebted to and thankful for these people.

Philosophy, Assessment, Admissions and Host Homes

KHK is for kids between the ages of thirteen and twenty-one. KHK's philosophy supports a belief that

chemical dependency is a disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. We further believe that, with adolescents, chemical abuse is characterized by developmental arrest or deterioration which may be viewed in stages with characteristic physical, psychological, and social symptoms.

As a result of chemical abuse, the adolescent may experience inadequacies of personality, impairment of cognitive functioning, diminished motivation, interpersonal and social conflicts, emotional blocking and regression, and causal disregard for behavior consequences (www.kidshelpingkids.com).

The KHK philosophy identifies areas of concern that are addressed by basic treatment modalities including family based, multi-systemic, behavioral and cognitive-behavioral interventions. KHK helps adolescents to learn how to apply a set of principles that will better enable them to manage their behavioral and emotional responses to life's situations. A KHK goal is to return the adolescent client "to a healthy productive lifestyle" (www.kidshelpingkids.com). How does KHK get the opportunity to give these kids a chance to live a healthy productive lifestyle?

I doubt that many kids, if any, wake up, or come to, one morning and say, "I want to go to a long-term drug rehab." For example, in our situation, that's not what Mears did. She only asked for help ("only" implies no shortcoming on her part, whatsoever). Furthermore, she told me later that if she had known that "KHK was the kind of help you were going to get me, I wouldn't have asked." The pattern of Mears' sad and destructive behavior had been increasing in both regularity and severity for some time. Making the decision to send Mears to KHK did not come easy. My first visit to KHK occurred

eighteen months prior to the time when her mother Cere and I took Mears there in February 1999.

In the fall of 1997, KHK Program Director Scott Stacey and Admissions Director Pat Burfitt personally interviewed me to discuss the nature of the problem. They did briefly describe KHK's program; however, they focused on the problem, not on treatment. I began to both see and accept certain things while I verbalized my perception of the problem to them. I accepted then that Mears, who was not quite fourteen, had definitely been using alcohol and drugs. I also accepted that my previous behavior had been an example for Mears, not a good or responsible example either. For several years, Mears had watched me either trying to force solutions to problems or to altogether avoid life situations by drinking alcohol. I accepted that I needed help being a responsible parent. Scott Stacey and Pat Burfitt helped me to ascertain the nature of the problem and to realize that potentially I could be both a part of the problem and the solution. Mears, her mother and I were floating in ice-laden water. As I left, Scott said, "I'll see you later." He could not have been more correct, thankfully.

The next time I contacted KHK, I spoke to Pat Burfitt on the telephone Monday, February 22nd, 1999, and we made arrangements for Mears' admission to KHK. Pat remembered my previous visit to KHK and said we could bring Mears there anytime. Cere and I would take her to KHK the next morning, unbeknownst to Mears. Although I knew that we were being loving, responsible parents, I experienced a great deal of emotional pain and mental confusion with this decision and admissions process. When we arrived at KHK two kids took Mears off to our right behind a set of doors and Pat led Cere and me into a nearby room. Pat explained that

Mears is on the other side of this wall with four kids from the program and she, by now, has probably figured out a few things. The other kids will have told her that they have been here for ten months, seven months, fourteen months and eleven months and are here because of drug and alcohol abuse. Mears will be given the choice of telling you good-bye with the condition of being cordial, or not telling you good-bye.

We were only beginning to experience what Pat continued to explain—the nature and extent of the program. From Pat, I heard well-explained information about the KHK Open Meetings on Friday nights; however, I did not understand much of what Pat verbalized until experiencing the numerous situations that she depicted. For example, I understood what Pat told us earlier about it being Mears' choice to tell us good-bye only when Christopher, one of the kids on the other side of the wall, came into the room and said, "Mears wants to say good-bye." I had never been glad to say good-bye to Mears; in an odd way, a sense of relief engulfed me. She remained seated when her mother and I walked into the room. Cere told her "I love you Sweet-Pea" and Mears responded, "I know that." The three of us were crying. Glancing at me, Mears said, "Toodles" and I leaned over and held her face in my hands and kissed the top of her head. After a moment, Mears slightly recoiled. I let her go and left the room. By leaving Mears there, her mother and I had become parents of a KHK first phase newcomer client.

KHK recognizes two types of families, in-town or out-of-town families. Families who live within a fifty-mile radius of KHK are considered as in-town and families who live outside of that radius are out-of-town families—we were an out-of town family. That meant that Mears would be staying overnight with "oldcomer," in-town families or "Host Homes." An oldcomer kid and their family have advanced to at least the second phase.

Newcomer kids are supervised by oldcomers during their stay at night. The hosting family makes house rules and it is the responsibility of the oldcomers to assure these rules are followed. These host families provide a critical part of each client's treatment, by providing a positive role model and adult perspective as each kid works through their issues (www.kidshelpingkids.com).

In addition to being role models, the host families provide breakfast and dinner as well as daily transportation to and from KHK for numerous kids. These families help to change and save the lives of children. During the admissions process, KHK clearly defines the differing roles and responsibilities of in-town and out-of-town families.

Program Description, Open, Group and Aftercare Meetings

There are six phases that KHK adolescent clients and family members participate in, given that the client completes the program. Kids must satisfy specific requirements of each phase prior to advancing to a subsequent phase. KHK also requires that the adolescent client spend a minimum number of days in each phase.

First phase newcomer clients have few, if any privileges. Some privileges that are immediately removed are speaking without being spoken to, independently moving about, speaking to family members, wearing certain clothes, going home, going to school, talking on the telephone, listening to music, and watching television. KHK also teaches that being responsible is a privilege; for example, first-phase kids earn the privilege of helping to clean the facility. These privileges are bestowed or restored based on the individual's behavior, compliance to KHK rules, and consequent advancement through the phases. First phase kids spend ten and one half-hours per day focused on and participating in their treatment program.

Kids continually both introspectively examine and discuss their history of alcohol and substance use with clinicians, peer counselors and oldcomers prior to earning privileges like talk-time. “Talk-time,” a first-phase privilege, is a fifteen-minute monitored conversation with their parents or guardians that takes place after open meetings on Friday nights. Kids generally experience two or three talk-times, at a minimum, prior to advancing to the second phase. Second phase clients have earned the privilege of going home on the weekends with their family. Third phase clients return to school, taking classes at schools in Milford, and may work part-time for businesses in Milford. Fourth phase clients may talk on the phone, listen to music, watch television, and are gradually re-integrated into their home communities. Fifth phase clients have all privileges restored, even driving and visiting friends without being in the presence of parents or guardians. If a kid fails to comply with certain KHK guidelines they may be either not allowed to advance through the phases, or may in fact be “set-back” to first phase. Parents, guardians, and family members of KHK adolescent clients advance or regress through the phases as their kid does.

Parents, guardians, and family members attend two separate meetings held on Friday nights. Group meetings last ninety minutes and are held prior to the Open Meetings that may last several hours. Monday night meetings are offered for siblings.

KHK holds Open Meeting in a room the size of a junior high school gymnasium. Seating arrangements ceremonially identify four distinct groups. Kids are divided into girl and boy groups and face the parents who are divided by being parents of either a boy or girl client. Parents and family members of girl clients sit directly opposite of the boy clients and family members of boy clients sit directly opposite of the girl clients. In other

words, parents and family members sit in a diagonal quadrant to their kid. The primary purpose for this aspect of the seating arrangement is to reduce attempted eye contact and potential manipulation of the family member by their newcomer child. Newcomer kids sit in the front rows of their respective sections and parents of newcomers sit in the back rows of their respective sections. As the kid advances through the phases they move back in the rows, eventually to stand in the back row. The parents, on the other hand, move to the front of their respective section as their child advances through the phases, eventually ending up on the front row as a parent of a fifth phase kid or a seventh-stepper. The seating method produces an effective nuance.

I have both a clear memory of and notes about our first KHK Open Meeting on February 26, 1999. The kids were in place as the parents filed into the room and found their seats. That night there were less than twenty girl and close to thirty boy clients. KHK personnel introduced themselves, then monitored and led the meeting. Next each newcomer kid stood and introduced him or herself. When someone handed Mears the microphone she stood and said,

I'm Mears Green and I'm sixteen years old. I've been here for three days. My drug list is alcohol, marijuana, cocaine, and mushrooms. I've used for three years. I've learned the first five steps, and my goal is to learn them all. A time from my past is Christmas and I went to my Grandmother's high on cocaine and had been drinking...just so I could be with my family. I was in the bathroom that night swallowing down pills with alcohol. I'm really ashamed of that.

Mears sat and wept. I wept also, knowing we had done the right thing. I lived this couplet numerous times. After all of the newcomer kids and one boy and one girl oldcomer finished their introductions, the monitor asked if there were any phase changes. Kids who had phase changes shouted them out, one by one, "Third Phase," "Third

Phase,” “Fifth Phase” and so on. At that time, I didn’t realize what those announcements meant.

KHK literature defines three purposes of Open Meeting as

1. To provide a therapeutic environment, where parents can identify the many ways they have been affected by their child’s chemical dependency, AND the feelings they each have about this.
2. To productively confront your child with the seriousness of his/her disease, by relating episodes from his/her drug-using past which vividly demonstrate an affect of family and others.
3. To provide a time and place to celebrate the progress you and your child are making toward recovery.

(KHK: Your Role as a Parent of KHK Handout).

KHK stresses that parents should verbally express their feelings and avoid lecturing their child at all. After the kids announced their phase changes, the parents and family members spoke beginning that night, as every Friday, with the parents of first phase kids. Mears stood when Cere and I stood. Mears wept. We all wept. Cere recalled to Mears the “night I had to help you into the car from the party at Fasig-Tipton when we were with _____ and _____. I love you.” And then, I told Mears

I’m so glad you are here. I believe that God will heal you. I don’t remember a specific incident from the past. But, I am so sorry for having hurt you and for neglecting my fatherly responsibilities to you. I love you.

Mears said, “I love you Mom, I love you Dad.” We all sat down and the kids chorused, “We love you Mears.” We continued to weep. We didn’t spend anytime alone that night with Mears. At the end of the meeting, Mears and the other newcomers were led out of the room by oldcomers who held onto the belt-loop of the newcomer. As I stated earlier, you can only understand the program model when you attend KHK on an ongoing and regular basis.

The purpose of the other group meetings is to focus on the family member's part in, or responsibility to, both the problem and the solution. Group meetings are designed to cover six separate areas and are identified by the titles of basics, group, coming home, fourth phase, fifth phase, and seventh-steppers or program aftercare.

Basics and group meetings introduce and educate family members on the fundamentals of alcohol and substance use or abuse, and treatment—specifically KHK's program model in terms of parent involvement. Parents are exposed to a set of principles and skills that may help them to better understand the basis of their thoughts and feelings so that they may more effectively communicate with their children. KHK makes many demands of parents because they believe that parents are critical to their child's success at KHK. KHK exposes parents to the Twelve Steps of Alcoholics Anonymous. AA's Twelve Steps are essential to the KHK program model. Parents learn how to write a "moral inventory" (MI), based on the suggestions found within and throughout AA's Twelve Steps. Parents only write a couple of these inventories, while the kids write inventories on a daily basis for their program's duration. These MIs include the recognition of three good points of the individual's character and a statement of five well-defined and achievable personal goals. Some people who are unfamiliar with the Twelve Steps find their introduction to the Steps similar to that of learning a new language. A vital factor of KHK's success rests on both the kids and their parents learning and using this Twelve-Step language.

Parents are instructed during "Coming Home" group meetings on how to prepare their homes for their child's return. Kids return to their homes for the weekends upon their advancement to the second phase. KHK provides and reviews an in-depth

instruction text on “Home Preparation” and a set of rules for parents to both refer to and follow. The instructions and rules include suggestions for sleeping arrangements, what to do with your child’s belongings, security requirements, fire safety, how and who to communicate with at KHK, and what to do in case your child runs away from home. In addition, the kids are familiarized with these instructions and are held accountable for their adherence and also for reporting any violation of the rules. Parents’ failure to comply with these guidelines can result in the kids being setback to lower phases.

As important, if not more so, during “Coming Home” meetings parents are versed on fundamental personal skills like how to establish a new relationship, how to commit to communicating, and learning the arts of both listening and talking to your child and other family members. For example, KHK identifies “Stumbling Blocks to Listening,” and claims that,

listening to your child can do nothing but good! Unfortunately, so many of your own thoughts can get in the way of really hearing what your child has to say. Common and negative thoughts that can crowd your mind are ‘I’ve heard this all before,’ ‘I think the child likes to hear himself/herself talk,’ and ‘When is this kid going to get the point?’ (KHK Preparation for Coming Home Handout).

As KHK does consistently well, after identifying problem areas they then identify and provide solutions to these common problems. KHK identifies skills to “The Art of Listening” that suggest parents

- Focus your listening by choosing to ignore negative thinking.
- Focus your listening by not thinking about what you want to say next.
- Focus your listening by not interrupting.
- Focus your listening to particularly “sensitive issues” by giving your child your complete attention.
- Focus your listening by use of eye contact.
(KHK Preparation for Coming Home)

Following these and other KHK suggestions helped me to establish and restore my side of the relationship with Mears.

Kids join their parents in Fourth Phase, Fifth Phase, and Program Aftercare meetings. All group meetings are led and monitored by KHK clinicians, kids, or former program parents who share their experiences with a particular program aspect.

Fourth phase meetings focus on discussing real life situations that the families are experiencing. The meetings provide not only a format to follow but also a safe environment for the kids, who occasionally bring up difficult subjects that relate to their relationships with family members. The impetus behind this safe environment may well stem from the presence of other recovering kids. The child both relates to peers and may well have previously discussed their situation with them. For the most part, there exists a general comradely atmosphere between the kids and parents. There are, however, heated discussions as well when people deal with problematic matters they deem of great importance. When these situations arise, the KHK clinician oftentimes provides sound guidance and several options to consider as solutions to the specific difficulties. These solutions may be presented in the forms of suggestions, instructions, or by merely sharing their own experiences. KHK attempts to provide their clients and family members with skills that are effective and vital in dealing with life's situations.

Fifth phase meetings are mainly devoted to assisting the kids and parents in discussing, drafting and agreeing on contractual issues for the program aftercare phase. This agreement "formalizes various decisions about family life that have been made between the parties while at Kids Helping Kids," and is executed by the parents, the adolescent, and KHK (KHK Seventh-Step Contract). The term of the contract is for six

months following the graduation of the adolescent from KHK. There is an optional renewal period of six months unless otherwise agreed to by the parties. The contract negotiations offer an opportune time for unspoken misunderstandings to arise. The contract details cover many areas including but not limited to time spent together as a family, the adolescent's responsibilities at home, curfew, advising parents of plans, school and work issues, structured leisure time, financial responsibilities, and automobile use. It also addresses arrangements for living outside of the home, support meetings or church activities, "druggie" friends and inappropriate places, and the consequences for failure to abide by contractual agreement. Not unusually, parents and kids experience great difficulties with these negotiations—we did not. We executed our contract during our last family meeting with our family counselor and clinician Michele Walton (now KHK's Program Director Michele Hoehn). We had had four or five family meetings with Michele during the eleven-month course of treatment. Graduations held during Open Meetings mark the end of the first five phases. Then the kids become Seventh-Steppers and are required to attend a six-month aftercare on a weekly basis, with monthly parental attendance required.

Aftercare proves to be the phase or period when most kids and family members experience great apathy, in turn potentially abandoning program responsibilities. Completing the first five phases requires a great deal of fortitude and commitment. The task may emotionally, physically, and mentally drain many participants. Possibly, a tendency exists to believe that by completing the first five phases that you have completed the KHK program. Aftercare proves to be when and where the rubber meets

the road. Kids and family members are no longer nurtured in the security that lends itself to them while in treatment. Once again, they are truly tested by real life.

Will they choose the new way, or the old way? Kids are asked to spend ten hours a week during aftercare at the program “participating in group sessions with clients and a two-hour Saturday support group for graduates” (www.kidshelpingkids.com). Meeting this commitment instills a sense of personal accomplishment and responsibility in addition the kids remain accountable to their peers. Each kid who continues to progress through aftercare earns additional program privileges. Kids must complete aftercare in order to work as KHK counselors.

CHAPTER FOUR

ONE GIRL'S STORY

I've lost a lot of friends to drugs and alcohol. Two friends of mine shot themselves. One friend of mine died in a drunk driving accident and the driver was his best friend, and he's sitting in jail right now for manslaughter. And I don't, I don't want to be in the newspapers for something like that. I don't want to be remembered for that. Even if I'm not remembered for anything spectacular, I definitely don't want it to be because of that.

-Mears Green, February 2002

When you're talking about recovery what does success mean?

Mears does not want her life to end as a result of drinking alcohol or using drugs. She believes that she cannot successfully drink alcohol or use non-prescribed, mind-altering drugs. Some professionals believe that most adolescents who drink, drink alcoholically. Further, these professionals theorize that many of these adolescents who drink alcoholically do not possess the additional characteristics which are necessary in every alcoholic or addict—they don't have the disease. Many individuals, young and old, can cease drinking given a sufficient reason. But what about the individual who is an addict or a chronic alcoholic as described by William D. Silkworth M.D.? These types develop what Silkworth describes as the "phenomenon of craving."

This phenomenon, as we have suggested, may be the manifestation of an allergy, which differentiates these people, and sets them apart as a distinct entity. It has never been, by any treatment with which we are familiar, permanently eradicated. The only relief we have to suggest is entire abstinence (Alcoholics Anonymous, xxviii).

If Silkworth is correct, and the phenomenon of craving has never been permanently eradicated then the treatment of individuals who suffer with chronic addiction or alcoholism would be a long, slow siege. Chronic means forever, with frequent recurrence. In 1955, the American Medical Association designated alcoholism as a form of physical and mental illness. An overwhelming majority of the literally hundreds of adult addicts and alcoholics whom I have spoken with over the past nine plus years began battling addictive usage of alcohol and drugs in their teenage years. People do not turn into alcoholics or addicts only because they get older; certain people are born predisposed to the disease.

Success, as it relates to an individual's recovery from drug addiction and alcoholism, can be defined many ways. I choose to believe that when an individual who once could not draw a sober breath and now has a desire for continuous sobriety and the willingness to go to any lengths to accomplish that end...they are a success.

My Daughter Mears

What Her Life was Like

Mears drank alcohol and used drugs to escape an inner emptiness. Her inner emptiness could only be temporarily filled. She lives like millions of other people addicted to alcohol and drugs, as victims to the deceptive, cunning process. She liked getting drunk with her cousin because they had fun and Mears looked up to her. "I felt closer to her when we would drink together. I felt, I felt cool." In the beginning, Mears drank and did drugs to fit in. She drank, not only to be closer to and accepted by her

cousin and other people; she drank to accept herself. You might ask, “How can an eleven-year old girl not accept herself?” And I answer, her lack of self-acceptance had nothing to do with what she had done or not done. I too lived a great majority of my life feeling as if I had an insatiable hole within me. Confusion and self-blame accompanied this emptiness. Drugs and alcohol temporarily deaden the pain of this emptiness. Her lack of self-acceptance, and inner emptiness were byproducts of both internal and external factors beyond her control. Like all individuals who suffer with chronic diseases, she had absolutely nothing to do with her plight.

Stage 0, identifies genetic susceptibility, family influence, and environmental conditions as contributing factors for increasing the potential for adolescent substance abuse (Muramoto et al., 144). Mears does not blame her Mom and me for her condition yet she realizes that alcoholic disposition can spring from heredity. “I think I got it from you guys, but I don’t blame you for it.” Nor does Mears support a hasty generalization that concludes that if the parents are alcoholic their kids are alcoholic. Mears recalls that her Mom and I “didn’t sit me down and tell me” how to drink but she believes that she “learned how to drink from my parents.” She thought that if her parents were getting drunk that drinking must be okay. However, Mears didn’t like her parents’ behavior when they drank nor did she “want to be around them when they were drunk.” I had my last drink during Mears’ ninth year and, at that time, had no clue that she learned how to drink from me.

Mears began drinking shortly after I started my first dating relationship during my sobriety. I say sobriety only because I no longer drank alcohol or used drugs. For some time, I remained unaware of Mears’ drinking simply because I lost myself in the

relationship. Within one year, I abandoned almost all of my fatherly responsibilities to Mears, practically moving in with my girlfriend and her children. One night Mears called me on the phone and I told her, “Don’t call me, I’ll call you.” Since her mother and I divorced five years earlier and up until then, Mears had been spending three to four nights a week with me; tragically, this pattern ended. During this debacle, Mears would only spend the occasional night with me. For all practical purposes over the next three plus years, Mears lived without a Dad.

Mears cannot remember the first time she drank alcohol or got high on drugs. Mears and her cousin would spend the night at their grandmother’s house and steal liquor from the bar. They would pour what they saw other people pour and “drink them as fast as we could and, uh, try to act like nothing was wrong.” Mears began to learn Stage One’s “drug induced mood swing” with her cousin as they drank and she “felt cool” (Muramoto et al., 144). Mears claims to have “never felt cool when I was growing up.” She discovered that the mood swing produced by alcohol would temporarily abate this discomfort. This alcohol-produced mood swing also tempered the loss of old school friends while quelling her uneasiness in a new school environment. In Mears’ early experimental stages she believes there were no problems, no throwing-up, no passing out, no loss of memory, only euphoria and companionship.

Mears began to rely on alcohol and its euphoria; alcohol worked its magic on her. Stage Two can be characterized by solitary drinking and marked by regular use that becomes increasingly situational (Muramoto et al., 144). She quickly passed into Stage Two, while seeking relief from everyday stress and depression. Although Mears cannot remember the first time she got drunk she clearly recalls the first time that she got drunk

by herself. One summer night, before her high school freshman year, Mears waited for her boyfriend to come over to her Mom's. She waited for many hours. Alone in the house, Mears began drinking the Maker's Mark that Cere had above the stove. At first she mixed it with Coke but

after a while I quit pouring coke into the glass. I was just drinking Maker's Mark by itself. I would stand in front of the mirror in my Mom's bathroom and look at myself and know that I was drunk. It got dark and I could not get a hold of him and I laid down on my Mom's bed and I passed out.

This went on all summer. Mears got drunk while she "waited for the phone to ring, or the doorbell, or whatever." Early that summer, she began displaying the subtle signs and symptoms of Stage Two. Late in the summer, Mears' pediatrician, through the proper channels, informed Cere and me that she believed Mears had participated in some unsafe behavior. I made my first trip to Kids Helping Kids.

When school began that Fall Mears once again felt "un-cool" because she hadn't gone to school with everybody like everybody else had. She met a new group of friends who introduced her to marijuana. She would lie to her Mom so that she could go to the Neighborhood Park and get messed-up with some kids. Mears continued to do this throughout the school year.

By the next summer she would be heavily engaged with a broader range of drugs. Mears had a new boyfriend who took pills. She wanted to please him so she started taking pills too. She began to throw-up and pass out on a regular basis "but I thought that that was what everybody did when they drank." Mears started having problems as a result of her drinking and drug use. She started doing whippets (nitrous oxide canisters) in early October. On Halloween she sped towards late Stage Two.

I took a bottle of wine out there and sat in somebody's car and did an entire box of whippets by myself because I did not want to share them with anybody. So, I had to go outside and hide them. I didn't want anybody to know what I was doing and, uh, I would pass out between every single one. I would wake up and just kind of sit there, like, 'What the hell just happened?' Then I would do it again, because I would realize that I was okay.

She truly believed that she was okay. Sadly, unbeknownst to Mears, the whippets were doing her. Alcohol and drugs were successfully deceiving her. They were lulling her into danger. Mears began slipping through the ice.

Almost four years before this point, when I quit doing the things Dads are supposed to do, Mears quit calling me Dad. As an absent parent, I occasionally intervened in her life attempting to unlovingly impart wisdom or control, two characteristics I did not possess. Sadly, we argued frequently. My first sober relationship just about killed me, and maybe the way I behaved while engaged in it just about killed Mears. When the relationship ended, earlier that summer, a dear friend of mine said, "Well, you abandoned Mears for that. Now what are you going to do?" I did not know what a father should do. So, I asked some men who I thought were good fathers what I should do. They told me to involve myself in Mears' life on a daily basis. I began daily prayer, pleading for God to

Help me be the father that You would have me be. Please stand in the gap that is between Mears and me. Your will, not mine, be done in our lives.

By grace, I ceased fighting with Mears. She still spent the night at my house sometimes when her Mom worked nightshifts. She hated this. I mailed her a greeting card with a handwritten note everyday for sixty days. She never mentioned them. I began calling her on the phone regularly. The conversations were short and one-sided. Occasionally, I

would give Mears a ride to school. She would not speak to me. Mears remained mostly unresponsive to me; however, when she responded she would be angry. I don't blame her one bit, never will. One November day in 1998 Mears' high school guidance counselor Signe Dunn called to inform me of and to discuss Mears' high absentee rate and failing grades. Cere and I began to put aside our personal grievances with each other so that we could focus on Mears' welfare, health and life.

Also, that November, Mears' boyfriend went to rehab and the loss of both his physical and emotional presence added to her devastation. Mears appeared depressed. Mears relied heavily on her boyfriend's presence. Possibly, she struggled to depend more on them because she learned not to depend on me. Mears' reliance on alcohol and drugs increased as her reliance on others failed.

I started feeling really bad. I started hanging out with people from school again and I was snorting pills, and taking Benadryl so that I could go to sleep and taking speed so that I could wake up. I was drinking all the time. I had liquor and vodka in my room. I was hanging with these kids on the weekends whose parents let them drink and get high. I was getting high with them after school and I was getting high with their parents.

This culture is not isolated to this instance, or to this neighborhood. This culture permeates a cross-section of our society. Mears and millions of other kids experience this process. She began doing cocaine on a daily basis. The other agents were not working their magic on her, of cocaine she recalls,

I really, really liked it. It made me feel...it made me feel different. Like when I was drunk, I was real...my speech was slurred. I didn't know what was going on, couldn't stand up straight. When I was stoned I would just get tired. When I would snort pills, you know, I would often times think that nothing would happen, so I would drink to kick up the effect of the pills. But with the cocaine I didn't need anything else. I didn't want to do anything else because I didn't want anything to

change what the cocaine was doing...and, uh, I was doing it every day while my boyfriend was gone to rehab.

Mears had reached Stage Three as defined by Muramoto and swiftly sank into the icy waters of Stage Four.

The differences between Stage Three and Stage Four are subtle. They both are marked by the daily usage of harder drugs, increase in behavioral problems, extreme family conflicts, failing in school, and angry outbursts are more common. In Stage Four, however, usage is nearly constant and family relations are severely disrupted. Mears also displayed physical symptoms common with Stage Four sufferers. She suffered with a constant cough, appeared fatigued most of the time, and possessed signs of malnutrition.

Mears slowly became aware of her world crumbling around her. Her boyfriend came back from rehab and did not want to spend time with her. She and her cousin were wasted on Christmas at their grandmother's house and the day ended in lies and fights. She acknowledges that "it all went downhill from there." She constantly got wasted by herself and cried. The day after her sixteenth birthday [January 25, 1999] her best friend came over to her house to tell her that

he never wanted to see me again because he didn't know me any more. And when he left I just, I wanted to die. Like I never thought about committing suicide, I just thought, "I want to die. I don't have anything anymore, I don't have anyone to talk to, I don't have any friends, you know, alcohol doesn't do anything for me anymore, all I do is throw up. I don't want to start doing cocaine again because everyone will know. I didn't want anyone to know. I don't like smoking pot. These pills aren't helping. What am I supposed to do now? I didn't know what I was suppose to do. And that lasted for a couple of days, me being all mopey. I didn't drink, I didn't do any drugs, I didn't, I didn't do anything, I just kind of sat in my bed.

Mears experienced broken relations even with her drug using friends. Loneliness and an imminent fear of abandonment haunted her. Mears needed drugs and alcohol to feel normal and “to avoid the profound and nearly constant dysphoria” (Muramoto, 144-146). This statement indicates only the forming of a suicidal idea, a Stage Four characteristic.

What Happened? A Turning Point Of Time

Mears’ first epiphany, as it relates to alcohol and drugs in her life, occurred when she instinctually realized that alcohol could temporarily fill her inner emptiness, the hole inside of her. Mears’ second epiphany may well have been her acute awareness of what cocaine did to her. If not then, Mears definitely experienced another epiphany in February 1999. Until this moment, Mears did not know that she did not know that drugs and alcohol were slowly and surely taking her life from her.

Mears had a party at her Mom’s house for Valentine’s Day and drank so much that she passed out in the bathtub. When Cere came back to a wrecked home she went to bed, woke up the next morning, and waited for Mears to wake up. When approached by her Mom, Mears denied everything—even undeniable evidence. Her Mom told her that she "couldn't stand to look” at her anymore and left the house. People had been leaving throughout Mears’ life. To begin with, during her fifth year, Mears’ nuclear family life ended in divorce, then I left, then her boyfriends left, then her best friend left, and now her Mom left. The combination of the loneliness, fear of abandonment, need for drugs to feel normal and to avoid dysphoria, and the severity of problems continuing to increase culminated to push Mears to the jumping off place. She remembers

sitting in the living room trying to clean the carpet and I just started crying. And I, I threw my arms out in the air and said, ‘I can’t do this anymore. I don’t want to do this anymore.’

This cry for help proved an epiphany that turned Mears life around in the opposite direction. Mears reached out through her painful dread and asked for help.

Mears wrote her Mom a letter, telling her everything.

I hate the person that I am. I can't stand to look at myself in the mirror anymore because I've become the person that I hate. I've become...I am a monster. I've become something that I never, ever wanted to be.

Mears might have seen what she had become or may well have seen her parents in the mirror. Thankfully, she avoided physical death, although, a self-destructive part of Mears died that day. Her pain carried her to a new life.

Ten days later we admitted Mears into Kids Helping Kids. Initially, Mears mainly felt fear and anger while being without alcohol, without drugs, without boyfriends, without friends, and without home. Mears' fear motivated her, she recalls,

I was scared. I was scared that if I didn't, if I didn't get better, that my parents wouldn't want me anymore. I was mad at my parents because they put me in here. I felt that this place was too much. I was scared what would happen if I didn't follow the rules here. So, I did everything that they told me to do.

It breaks my heart to think that Mears felt and or believed that we wouldn't want her anymore. The thought crushes me and reminds me of how I felt during parts of my life, particularly—how I felt unwanted by my Dad. Drugs and alcohol helped me to suppress those feelings and thoughts. I learned how not to feel. After I started getting sober I told a friend of mine that “I couldn't get in touch with my feelings.” He replied, “You keep not drinking and your feelings will get in touch with you.” He could not have been more correct. Mears' feelings wasted no time in getting in touch with her, either. She had

been without drugs and alcohol for ten days when she arrived at KHK. For the first three days in treatment, she cried constantly.

It is natural for children to love their parents. It is also natural for children to be deeply hurt by either one of their parent's behaviors, especially if the parent continually fails to properly love their child. As stated, during a vital time of Mears' life I failed to provide her with the assuredness that can only come from a loving, responsible parent. Mears remembers that she "hadn't wanted to see or talk to my Dad in like five years and, uh, he was the only person that I wanted to see or talk to for the first night" at KHK. The absence of alcohol and drugs allowed Mears to feel the pain and anger that she did not want to experience. Children do not want to feel the pain that springs from the absence of a parent. Some people live their entire lives trying to avoid this pain.

Although Mears hated me she had realized, only during the year before KHK, that she could rely on me. KHK requires that Second Phase Kids write letters to their parents. In her letter to me dated May 1st 1999, Mears wrote that she didn't

understand how or why you continued to show me the care and support you did despite the way I was treating you and everyone else. Oftentimes I feel undeserving of that love. Its hard for me to believe that I acted the way I did and you were still there for me, though I obviously did not want you there.

It is now clear to me that you saved my life by putting me in here, and I am forever grateful for that. I know that I would have never been able to say these things to you had you not cared enough to get me help.

Let me make it clear, I did nothing more than a loving parent should do. At the time, my actions only appeared to mean so much to Mears because she knew me as an unreliable person. Her feeling "undeserving" of love stemmed from my inability to provide love and security. I needed help in becoming the father that Mears deserves.

Mears knows that she needed help too. She needed help sorting out her life. She needed help from someone who really understood. She needed help from someone who had been where she recently came from. She needed help from someone who had escaped the hell that she had been living in. She needed help from someone in rehab. According to Mears, without a doubt, the most beneficial help for her came from other kids. The other kids encouraged and helped her to live in reality.

On March 12th 1999, after being at KHK for eighteen days, Mears earned talk-time with Cere and me after Open Meeting. Mears and her peer counselor, or old-comer, Bethany peeked around the corner at Cere and me. Mears looked like the child that I remember from years past—excited, bright-eyed, and with a huge smile. Mears and Cere hugged. Then Mears and I hugged each other for the first time in five years. Bethany kept a loving hand on Mears while we hugged. We all cried. We sat in a tight circle and Mears made amends to Cere and me for the wrongs that she committed before treatment. She cried “those big hiccup cries when you can’t really breathe.” Bethany kept notes as Mears poured herself out. Mears told me that her pride had blocked her love for me and that she made a decision to hate me four years ago. The fifteen minutes passed like a second. We hugged and cried more. Bethany held Mears’ belt-loop as they left the room. Mears completed her amends to Cere and me the next Friday night. Bethany never left Mears’ side.

On March 26th when the four of us sat down Mears explained that for the last two weeks she had been doing amends and now she would tell us what her resentments towards us are, beginning with, “I’m mad and really hurt.” She looked directly into my eyes, never missing a beat, and described my previous behavior and actions. With tears

moving down her cheeks, she explained that I had left her, and she did not know what to do. I agreed with every word she spoke. I told Mears that I made a choice in early sobriety, a terrible mistake, and that I had wronged her. We held each other and cried. Bethany lovingly kept her hand on Mears. Mears continued this healing process with Cere. Although, these visits were only fifteen minutes in length, Mears' desire and ability to honestly express her thoughts and feelings began to heal her past, changing her life and ours.

Mears worked extremely hard to prepare for these visits. She wrote moral inventories (MIs) every day during treatment¹. While a first phase newcomer Mears shared her daily MIs every night with an old-comer. This process effected at least two general benefits. First, Mears and the old-comer related to each other establishing a bond of trust, and second, Mears began to look directly at some realities in her life. Mears recalls that

there were some Moral Inventories where I did really get a lot out of what I wrote about because I had to look at what I did. You have to put 'em through the steps. Like you look at your defects and you look at who you hurt and you look at how you felt when all this happened. It puts you back in time.

Mears learned one skill of introspection by continually working KHK's adaptation for kids of the 12 steps. Mears realizes that her sober perspective of past events provides a different view.

On her 52nd day of treatment Mears went home.

I was allowed to go home on the weekends. I was supposed to build a relationship with my parents. At this point the people, the counselors and the staff at KHK thought that I was ready to go

¹ The scope of my thesis does not allow for an in-depth examination of "Moral Inventories," on which entire volumes could be written. Nor does the thesis scope provide for in-depth examinations of the other KHK modalities.

home. They thought that I had worked on my drug problems enough at that point and they were ready to send me home so I could start working on other things. Looking back I don't know if I was ready.

At the time, to me, she seemed ready. Mears makes this statement in hindsight. She continues to evaluate her past. Her introspection continues to bear fruit. Mears explains that at the time she did not feel afraid of anything, "I was just happy to be home." She now realizes that as she progressed through the phases the greater she feared that she would be setback on first phase. She never got setback because she did everything, for the most part, required of her. Mears reflects that,

A lot of the things I did were out of fear. I was afraid that I was going to get in trouble and not be able to talk to my parents. So, I was afraid that I was going to get into trouble and my parents were going to be disappointed in me.... I thought that I was getting sober and working the program because I wanted to. Part of that was true, but part of it, I was working it for my parents because I didn't want to disappoint them because I had been disappointing them, I thought, I'd been disappointing them my whole life.

Some of Mears' anxieties are byproducts of a need to please Cere and me. These anxieties did not begin after Mears started KHK. These anxieties had burdened Mears for some time. Our individual' expectations, or our combined expectations of Mears added unnecessary stresses to Mears which, in turn, manifested themselves in Mears as anxieties. Mears may well have used alcohol and drugs in an effort to tune out these persistent menaces.

Miraculously, during treatment, Mears realized that her part of these anxieties belongs to her, and that Cere's part belongs to Cere, and that my part belongs to me. I say miraculously, however, these changes occur frequently when, for whatever reasons, individuals give themselves to the KHK program model like Mears did. Ideally,

individuals realize, as Mears did, that in order for treatment to really work that they must want to recover for themselves, not for their boyfriend or girlfriend, not for their parents.

Mears states that,

It didn't start to be about me until I was almost graduated. I remember a couple of times talking in group when I realized that I just can't go back to the way I use to be. I remember one time, just as I was getting ready to graduate, it might be the week that I graduated, and I was up in group and I started crying about how I didn't want to go back to the way that I was. And I couldn't go back to the way that I was. I was afraid that I was going to die. I'll never forget that.

Mears' painful past fortunately helped to produce the willingness to work the KHK program model. Mears looked at her part desiring to live a new sober life for herself.

I wanted to be something different. I wanted to be something better. I wanted to be proud of myself. I wanted my parents to be proud of me. I wanted to have friends. I didn't want to feel miserable all the time. I wanted for the first time, you know, since I was like five to be happy. And I thought that the only way I could do that was if I did this program. And so, I did it as best as I could.

That's a blessing of tremendous proportion. Until Mears worked the Kids Helping Kids program model, she had been without the desire for happiness since she was five years old. Kids Helping Kids proved itself as an effective benefit in Mears' life when she applied its methods to her life—it works if you work it.

What Her Life is Like Now

Mears recognizes the completion of her six-month aftercare program as a tremendous accomplishment. During her follow-up, she told me that “This is the most important part of my rehab.” She realized that while she participated in the KHK model as an in-treatment client that her choices were limited. To propose a strong and possibly

false dichotomy—you either do the program, or—you don't get out. Mears discerned that the aftercare program allowed for more freedom with her personal choices. There were still requirements during follow-up and Mears could choose not to abide by them and consequently be penalized, but the impetus became what she wanted to do—not what she needed to do. That is not to say that Mears wanted to meet all of the aftercare requirements, however, it is to say that Mears wanted to stay sober and chose to meet the aftercare requirements.

Mears' inspirational aftercare performance found its beginnings in her desire to abide by the conditions of the detailed contract that she, her Mom and I drafted during Mears' Fifth Phase. If Mears violated any contract conditions during her aftercare, the violations were benign. Mears' inspiration derived more from pursuing the contract's positive aspects, not from avoiding the contract's negative consequences. For example, back then, if given the chance, Mears could sleep quite late in the mornings, but she sacrificed that option so that she could be at KHK aftercare on time every Saturday. She went to a Twelve Step meeting everyday for six months and she worked closely with a sponsor. A sponsor is an individual who, like an old-comer or peer counselor at KHK, helps other people with working the steps of recovery. Mears remembers that during her follow-up she realized that she “wanted to work at KHK, to be a counselor at KHK.”

Mears lived with KHK graduates and their families, in Ohio and Northern Kentucky, the summer of 2000, before her senior year in high school, so that she could work at KHK as a junior staff counselor. KHK graduates may continue escalating through certain conditions and become junior or senior paraprofessionals, or accredited employees. Mears completed the conditions as a KHK junior staff counselor that

summer. Her rewards were great. She became cognizant of her love to help other kids. That fall she moved back home to Lexington to begin her senior year at the same high school she attended before going to KHK.

Mears cannot remember, but she thinks that about at the start of that school year that

things started to get a little shaky. My boyfriend and I were having problems. Dad and I started having problems. We couldn't, we weren't talking to each other, or I wasn't talking to him. My Mom was having some problems. She wasn't talking to me. I was starting not to go to school.

Understandably, not unlike many people, including myself, the condition of the relationships with significant others is of vital importance to Mears. However, in recovery, Mears' tendency has changed.

I'm not in bad relationships anymore. I don't wait around for some guy. Um, I don't.... I get lonely, but it's not the same kind of lonely. It's not the do all end all, I'm going to die, kind of lonely.

Problems in relationships are unavoidable, but she no longer allows problems in relationships the power to dictate her entire life.

During this same period, Mears began having doubts on whether or not she has alcoholism. She recalls that she would go to meetings and say

I don't know if I'm an alcoholic. I don't know if what I was doing was just normal. And people told me that I needed to go out and try some controlled drinking and that really pissed me off.... So I quit going to meetings. I quit listening to them.

It is common for people in recovery to question their condition. Some people may opt for drinking or using drugs in an effort to answer their question. Mears came frightfully close to drinking; but through an effort to help another fellow sufferer she realized that

she did not need to drink or want to drink. She realized that many consequences would accompany the drink and one of them would be “not being able to come up and work at KHK, and that’s what I really wanted to do.” And that’s what Mears did.

Two days after graduating from high school (no small feat by the way), Mears and her excitable puppy moved into an apartment, by themselves, in Cincinnati, Ohio.

The following Tuesday, she started working at KHK.

It was good to be working with people and helping people and doing what I loved to do and doing it for the place that saved my life. ‘Cause Kids Helping Kids saved my life. If I hadn’t gone through that program, I don’t know where I would be right now. I don’t know if I’d be dead yet. But, uh, at the rate I was going, it wasn’t far off.

Mears became a senior paraprofessional at KHK in the summer of 2001. As a peer counselor to kids whose lives have been devastated by alcohol and drugs, Mears reaped a bitter yet abundantly sweet harvest. Mears gave her heart back to the process that both saved and changed her life.

That summer, Mears faced difficult challenges and remained sober and clean. She realized that working full-time at KHK did not allow her sufficient time to care for her puppy. Sadly, she made the tough decision to give her puppy to someone else who had sufficient time to care for the puppy. Several times before, she had experienced the loss of pets and puppies, but never as a result of her choosing. In addition, Mears noticed that she began losing, what eventually equated to, almost twenty percent of her body weight. Fear accompanied Mears during the diagnostic period but it did not cripple her. After extensive tests, over a six-week period, doctors diagnosed Mears with Graves Disease, her second rare, chronic and treatable disease. She struggled to understand, “Why Me?” In the meantime, she continued to perform her work responsibilities and to

properly take care of herself. Eventually, Mears realized that, in all likelihood, had she not been sober she may have learned about Graves Disease only after the disease caused irreparable damage. She matched calamity by soberly struggling with reality and she now accepts the hand dealt to her.

In December 2001, I approached Mears with a request that she consider telling the story of what her life was like, what happened, and what her life is like now. After deliberating for several weeks, she agreed. On February 12th 2002 Mears celebrated her third year of sobriety. On March 27th, after the final interview for this effort, as I left her apartment, she asked,

“Daddy, how high did you use to push me in the swing?”

I remembered the last time I pushed Mears in the swing. That happened in the fall of 1988, during her fifth year, right before her Mom and I separated. After reflecting, I said, “Probably ten maybe twelve feet, Honey.”

With a wonderfully bright countenance, she dreamed, “I thought I could touch the sky.”

Then we hugged and kissed each other, both saying, “I love you.”

Mears has taken full advantage of her opportunity, her chance for a new life. On March 29th 2002, Mears worked her last day as a senior paraprofessional peer counselor at Kids Helping Kids. Within weeks, Mears independently secured a job as a bank teller. Mears soberly walks through her life, once again reaching for the sky.

This current phase of Mears’ life and recovery is somewhat similar to her KHK aftercare program. What will she choose to do? How will she stay sober? The answers to these questions are for Mears to decide—and no one else. I respect Mears in a manner

that I cannot describe in mere words. I hope only to continue to become the father that she deserves. On the one hand, paradoxically speaking, Mears Green has survived and flourished through a lifetime's worth of experiences and may well have been robbed of her childhood. On the other hand, consequently, Mears now possesses the tools that will help her to live a full life.

CONCLUSION

Age does not preclude individuals from drinking alcohol or using drugs. Today, some people may be shocked to hear that a six-year-old drinks alcohol and smokes marijuana on a regular basis. However, our society is no longer unfamiliar with children, in early adolescence, who engage in the use of alcohol and drugs. Millions and millions of adolescents drink alcohol and use drugs. Approximately ten percent of these kids become addicted to alcohol and or drugs—this is reality. In all practicality, this reality will not be reversed. Today’s adolescents are exposed to readily available chemicals or drugs that I label as accelerators that propel many of these kids towards alcoholism, addiction, and perhaps even death.

As a general rule, the majority of people misunderstand the addicted individual. Typically, the alcoholic or addict has been contrasted with the drinker or drug user that society accepts as normal. The normal drinker or substance user can consume and then behave within a range of conduct that our society prescribes as normal. These individuals possess immunities that the addicted individual lacks. The normal drinker and substance user does not have socially defined problems with their consumption practices. Nor do they have the chronic, deadly disease. Norman Denzin deduces that “the mythical social drinker who drinks normally epitomizes America’s relationship with alcohol, alcoholism, and the alcoholic” (Denzin II, 3). Society struggles to accept individuals who do not drink or use drugs within the normal range of conduct. As a general rule, abnormal drinkers are considered enigmas. This group of individuals exists in perpetuity whether or not they are understood by society. These individuals need help. Many of them have a disease.

I have the disease of alcoholism. Based on factual evidence, I am convinced, in both my mind and heart, that if I were to take one drink of alcohol that there is no absolute certainty as to when, or if, I would be able to not drink again. If I were to drink, I believe that I would quickly return to where my drinking career ended, at death's door. No longer am I ashamed of myself, nor am I ashamed of the disease that I have. I am both thankful and blessed to be alive. Like Mears, many friends of mine have died as a consequence of their drinking alcohol and or drug use.

I heard, and continue to hear, the comment about some kids, "Oh, they're just going through a phase. They'll grow out of it." This is true for many and untrue for others. Some kids don't live to grow out of it. Some kids live in this phase for the rest of their shortened lives. Not all of the kids who join the group become addicted to alcohol and drugs but many use alcohol and drugs as if they are addicted. Hundreds of thousands of kids join this culture annually.

Joseph Califano, once a presidential adviser and now the executive director for Columbia University's Center for Alcohol and Substance Abuse (CASA) estimates that America suffers an annual 400 billion dollar negative economic impact from drug and alcohol addiction. CNN Primetime's "Wasted" reported that an estimated 20 million adult Americans suffer from alcoholism and that an annual negative economic impact exceeds 100 billion dollars (excludes drug related data). CASA statistics indicate that 75% of the individuals who inhabit America's penal system facilities committed their crimes while under the influence of drugs and or alcohol. When did these people begin using alcohol and drugs?

Again, please do not misinterpret me; I do not believe, as a general rule, that alcohol or legal prescription drugs are harmful to society as a whole. I believe that there exists a certain group of individuals who not only harm themselves but also harm others when they use alcohol or drugs. It is this group of individuals who I wish to help. I hope to help this group of individuals, so that they may help themselves. When Mears asked for help I told her that I could find help for her. Kids Helping Kids provided that help. Kids Helping Kids both changed and saved Mears' life. Mears now understands her plight. Fortunately, Mears knows freedom from the bondage of drugs and alcohol.

Millions of kids are only beginning to experience the bondage from which Mears, for now, has escaped. Many of them will survive the life threatening realities of their experiences, many will not. Some of the survivors will need help; still fewer of them will want help.

The problem of adolescent substance use and abuse exists. We have a humane responsibility to provide these kids and their families with some solutions.

APPENDIX

TRANSCRIPTS: MEARS GREEN, FEBRUARY 15TH,
FEBRUARY 25TH, and MARCH 27TH, 2002

February 15th, 2002

(Brief background conversation)

I hear a lot of people talk about the first time they drank or the first time they got high and I don't remember the first time I drank or the first time I got high. I've tried to remember for the past seven or eight years and I can't think of where I was or what it was or who I was with and I...sometimes, I wish I knew when it all started. Maybe I would feel a little bit more comfortable if I knew where it all started or I knew why. I feel like I've been cheated because I don't know. I don't know why I am the way that I am and I feel deprived because I think other people know why they are the way that they are because they remember when it all started.

(A knock on the door and brief background conversation)

Anyway, um, I think I started drinking when I was eleven. I used to steal alcohol. My grandmother had a liquor cabinet in her house and my cousin and I would go over there and would sneak into the living room where the liquor cabinet was. And we would pour, you know, bourbon and coke and what we saw the other people pouring and we would drink them as fast as we could and, uh, try and act like nothing was wrong. We would get real loud and we would spend the night with my Grandmother, just so we could do that. Just so we could drink.

I liked getting drunk with my cousin because I would have fun with her. I looked up to her a lot. And uh, I wanted her to think that I was cool. I wanted her to think that I was fun to be around. I wanted her to want to be around me. I felt closer to her when we would drink together. I felt, I felt cool.

And I never felt cool when I was growing up. I went to a private school and I grew up with a small group of people that I called my friends and we all went to a different middle school, and when I went to the middle school I wasn't cool anymore, and this helped a lot.

My cousin used to pick on me when we were younger and I thought that since I drank with her, it was kind of insurance, that she wouldn't pick on me anymore. It didn't get really bad for probably a couple of years. Like I would, my friends and I would sneak beers from our parents or I would drink at my Grandmother's house and I didn't really think there was a problem with it. Like I wouldn't throw-up or pass out or do anything...like I could usually remember what happened.

And, uh, I remember the first time that I got drunk by myself. It was the summer before the freshman year in high school. I was waiting for my boyfriend at the time to come over. And he, he was older. This was _____ by the way and he was supposed to come over. My Mom had gone to work for the night. He was going to come over and we were going to hang out and I started drinking. My Mom had Maker's Mark above the stove, and I started pouring the whiskey into a glass and I would pour coke into it and I had a couple of drinks and I started, you know, started to get drunk and I waited for him. I sat in the chair in my living room and I waited for him for a couple of hours. Every couple of minutes I would go to the front door and wait to see if he was there. I would look for him.

After a while I quit pouring coke into the glass. I was just drinking Maker's Mark by itself. I would stand in front of the mirror in my Mom's bathroom and look at myself and know that I was drunk. It got dark and I could not get a hold of him and I laid down on my Mom's bed and I passed out.

I woke up about five hours later, and I ran into the bathroom and I threw-up. I checked the machine and he had called. I called him back and he came over and when he came over I was running into the wall. I couldn't stand up straight. I didn't know, I didn't know what had happened to me, I didn't know that I had passed out. I knew that I had fallen asleep, but I thought that I was just really tired, I didn't know that I passed out because I was drunk. And that went on that summer, like that. Whenever he would tell me he was coming over or tell me that he was going to do something and he didn't, I would drink while I waited for the phone to ring, or the doorbell, or whatever.

And I started high school that summer in August, I was, I really knew a couple of people that I went to middle school with, but pretty much, again, I was un-cool because I hadn't gone to school with everybody like everybody else had. I think I met a group of friends, and they drank on the weekends and we would go to the park in the middle of the night. I would lie to my Mom and say, "Oh, were going to the park to play basketball, or, somebody's parents will be there."

I hadn't started smoking pot yet I don't think, but that came soon enough. I was drinking with them and I would always get drunk and end up puking. Then we started doing drugs together and I don't really remember my freshman year after that. My sophomore year is when it got really bad. The summer between my freshman and sophomore year I met another guy and he did a lot of drugs. He smoked a lot of pot and he did a lot of, uh, he took a lot of pills and I did it with him because I liked him. I liked hanging out with his older friends and I liked getting high. We'd pass the bong around and I thought it was fun to get drunk, like I was cool again. Not a lot of bad stuff had happened at that point. I mean yeah, I would pass out and throw up, but I thought that that was what everybody did when they drank.

And, uh, probably in October I started doing a lot of inhalants. I started doing whippets and I would buy boxes of them and do one after the other. I remember on Halloween I sat in somebody's car and did them all by myself. I took a bottle of wine out there and sat in somebody's car and did an entire box of whippets by myself because I did not want to share them with anybody. So, I had to go outside and hide them. I didn't want anybody to know what I was doing and, uh, I would pass out between every single one. I would wake up and just kind of sit there, like, "What the hell just happened?" Then I would do it again, because I would realize that I was okay.

He went away to rehab in November. Like five days after this happened and while he was gone, I started feeling real bad. I started hanging out with people from school again and I was snorting pills, and taking Benadryl so that I could go to sleep and taking speed so that I could wake up. I was drinking all the time. I had liquor in my room and vodka in my room. I was hanging with these kids on the weekend whose parents let them drink and get high. I was getting high with them after school and I was getting high with their parents.

One night before a dance, they introduced me to cocaine. I thought that was great. I really, really liked it. It made me feel...it made me feel different. Like when I was drunk...I was real...my speech was slurred, I didn't know what was going on, couldn't stand up straight. When I was stoned I would just get tired. When I would snort pills, you know, I would often times think that nothing would happen, so I would drink to kick up the effect of the pills. But with the cocaine I didn't need anything else. I didn't want to do anything else. Because I didn't want anything to change what the cocaine was doing.

I never had to pay for coke. They would just give it to me and I would take it from them and I would take it home with me and I would snort it and I would stay up all night long and I would watch a movie at my Mom's house. And, uh, I was doing it every day while my boyfriend was gone to rehab.

When he came back he told me that I looked like shit and wanted to know what I had been doing while he'd been gone. And I thought it was funny and so I told him that I'd gotten into coke and he was real disappointed. He took me to my Grandmother's house on Christmas day and I was high and he left after about an hour and a half because he couldn't stand to be around me anymore. And that night my cousin and I, of course, got drunk at my Grandmother's house and we snuck out and made up this big, ridiculous lie that I can't believe now that I thought somebody would believe it. We got caught, came back to the house, my Grandmother's house, at about four in the morning the day after Christmas, and my Grandmother called me a tramp. And _____, that was when _____ yelled at _____ and _____ and I sat up until

six o'clock in the morning and we took our presents and drove to my Mom's house.

And it all went downhill from there. I started having parties at my Mom's house when she wasn't home. I never did a really good job of cleaning up. I, uh, was drinking by myself, pretty much every night. I would sit in the garage and listen to sad music and mope about how miserable I was, about how I didn't have any friends, about how I didn't feel close to anybody.

I would just sit there and cry and I would drink because my Mom had a bunch of leftover liquor and beer from the holidays. She'd bought it for friends of hers and she bought entirely too much because it had been so long since she bought alcohol that she did not know how much to buy. It worked out well for me. Then I remember one time, it was the day after my birthday, the day after my sixteenth birthday [January 25, 1999], my best friend told me, came over to my house and told me that he never wanted to see me again because he didn't know me anymore.

And when he left I just, I wanted to die. Like I never thought about committing suicide, I just thought, "I want to die. I don't have anything anymore, I don't have anyone to talk to, I don't have any friends, you know, alcohol doesn't do anything for me anymore, all I do is throw up, I don't want to start doing cocaine again because everyone will know." I didn't want anyone to know. "I don't like smoking pot, these pills aren't helping. What am I supposed to do now?" I didn't know what I was supposed to do. And that lasted for a couple days, me being all mopey. I didn't drink, I didn't do any drugs, I didn't, I didn't do anything, I just kind of sat in my bed. I went to school, but...I always went to school.

Then I had a party at my house for Valentine's Day, and I drank so much that I passed out in the bathtub. I thought that I had done a good job of cleaning my house, but Mom came home, she saw that the house was a wreck and just went to bed. And when I woke up in the morning she started yelling at me. And she walked me through the house and showed me all these things that were evidence of the people I had over and I was lying to her. There were beer cans all over the place, the house smelled like smoke, I was sleeping in the damn bathtub, and I sat there and I lied to her for about five minutes. "No Mom, I didn't have anybody over. No, I don't know where that pound of bacon went. I didn't eat it, it must have disappeared."

And she left. She told me that she couldn't stand to look at me anymore. She left. And I didn't know when she was coming back. I started to clean the house and, uh, I remember sitting in the living room trying to clean the carpet and I just started crying. And I...I threw my arms out in the air and said, "I can't do this anymore. I don't want to do this anymore."

And I wrote my Mom a letter. I told her everything. I told her that I needed help. I told her that I wanted something different, that I hated the person that I was. I told her that I couldn't stand to look at myself in the mirror anymore because I'd become the person that I hated. I'd become...I was a monster. I'd become something that I never, ever wanted to be.

And ten days later, they put me in Kids Helping Kids. I was scared. I was scared that if I didn't, if I didn't get better, that my parents wouldn't want me anymore. I was mad at my parents because they put me in here. I felt that this place was too much. I was scared of what would happen if I didn't follow the rules here. So, I did everything that they told me to do.

You know...I went through the phases and it wasn't till I was about to graduate that I realized that this was what I really wanted. This was what I wanted to be. I didn't want to be the person that I was anymore. I wanted to be something different. I wanted to be something better. I wanted to be proud of myself. I wanted my parents to be proud of me. I wanted to have friends. I didn't want to feel miserable all the time. I wanted for the first time, you know, since I was like five, to be happy. And I thought that the only way I could do that was if I did this program. And so, I did this program and I did it as best as I could.

And since I've graduated from Kids Helping Kids, I've graduated from high school, I've moved up to Cincinnati, I've started college, and I work at KHK now, I'm a senior staff member. I have my own apartment. I pay my own bills. I'm responsible. I'm respectable. I feel good about most of the things that I do and most parts of the way that I am. I'm not in bad relationships anymore. I don't wait around for some guy, um, I don't....

I get lonely, but it's not the same kind of lonely. It's not the, "Do all end all, I'm going to die, kind of lonely." It's the "I want some company right now," kind of lonely. I feel really good most of the time, about the work that I do here. I like helping people. I like telling these kids that they don't have to be the way that they were. I like letting them know and showing them that there is another way...that they don't have to die like that.

I've lost a lot of friends to drugs and alcohol. Two friends of mine shot themselves. One friend of mine died in a drunk driving accident and the driver was his best friend, and he's sitting in jail right now for manslaughter. And I don't, I don't want to be in the newspaper for something like that. I don't want to be remembered for that. Even if I'm not remembered for anything spectacular, I definitely don't want it to be because of that.

I'm kind of running out of things to say. There's a lot of people outside getting pretty loud. If I think of anything else pertinent to my

story, then I will let you know, Dad, and I'll give you a call, maybe fax you something.

(End of tape)

February 25, 2002

I was at my Dad's house the morning of February 23rd, 1999. I was getting ready for school and I didn't know why she was there. I had just gotten in a lot of trouble and she had bought McDonald's for breakfast for me that morning and told me that we were going to go to family counseling. I didn't really know what was going on or what kind of counseling we were going to go to. They just me told me that I needed to hurry up and finish getting ready because we had to be there at a certain time and they didn't want to be late.

Well, we got into the car and I'm eating my McDonald's and my Mom had worked the night before and, uh, I didn't know why you know, she, they had scheduled an appointment to go to family counseling so early, but I didn't really think to ask. I think I did ask my parents why I got Mac Donald's, and I look back now I look at that my last meal as a free person, 'cause we weren't going to family counseling, I was going to rehab. And I did not know it.

We were in the car for a really long time. I didn't know where we were going and I thought it was kind of weird that my Mom was letting my Dad drive. And I was sitting in the back seat and I was allowed to smoke in my Mom's car and I was smoking in front of my Dad and nobody really said anything about it, but I was just kind of going along with what was going on. But I didn't know what questions to ask. I didn't think to ask anything.

Well, when we crossed the Ohio River and got into Cincinnati I started to get a little curious. I was asking where we were going, you know what kind of counseling was going on and my parents were starting, you know, were getting kind of nervous. They told me, "You'll find out when you get there." I was asking them if I was going to come home that night and, uh, they didn't say anything. They said that, "You'll find out when you get there." And when I got there I, uh, got out of the car, slammed the door and walked inside. And, uh, I didn't say goodbye to my parents. And I saw a tall, skinny guy, who looked about my age and a woman with blonde hair, who told me to follow the skinny guy, so I did. And I heard the door lock behind me.

They showed me into a room, sat me down and told me that I was in long term drug rehab and that I wasn't going to be going home tonight and I probably wasn't going to be going home for a couple of months. At that point, uh, I started crying and I didn't stop crying for three days. They told me about the program. I wasn't really paying

attention. They told me a lot of rules and stuff and I didn't hear, I didn't really hear any of it. They had to search me. They had a girl who was on a phase, you know there's five phases of the program and they had a girl that was on second phase and she had to search me. I had to take all my clothes off. She had to make sure that I wasn't carrying anything that I wasn't supposed to have. I felt like I was in jail. I'd never been in jail before, I'd never been in trouble with the law before, well I had a curfew violation but I didn't really count that. And, uh, I had an opportunity to say goodbye to my parents and I didn't want to say goodbye to my Dad. I just wanted to see my Mom. I thought if I could just talk to my Mom for one minute that I would be able to go home, she'd change her mind and want to take me home and that didn't happen. They came in and they hugged me and they were both crying, and I was crying and that was the last time I saw them for five days.

You know, like I said, I cried for the first three days I was in treatment and the first night in treatment I had this, I don't know what happened, but I wanted my Dad. I hadn't wanted to see or talk to my Dad in like five years and, uh, he was the only person that I wanted to talk to for the first night. I was far away from home. I was in a city called Milford, I'd never even heard of Milford before. I wanted to go home. I didn't want to be there. And, uh, during the day I had to like get up at 5:30 in the morning and had to be in treatment at 7:30 in the morning. I was going to be there for the next thirteen hours and I hated every minute of it. People kept asking me if I thought I needed to be there, and, uh, I said, "Yeah, I need to be here. I need help, but I don't need this kind of help."

You know, counselors were coming up and trying to talk to me. I met my clinician, Michele Walton. You know, I tried to convince her that I didn't need to be there. I had tried to lie at first about the drugs that I have used and how much I have used because I thought if I wasn't too bad, then they'd let me go. And they didn't. And, uh, the first time I saw my parents was on a Friday, and I didn't get to talk to them, I really didn't get to look at them unless they were talking to me, and I cried the entire time that they were in the same room as me. I hated them for doing this to me. I hated them for dropping me off somewhere and leaving me. I felt that way for a while.

And after week two, over two weeks of being in there I was allowed to talk to my parents. And, uh, I was supposed to make amends with my parents for the things that I had done before I came into treatment and I cried the entire time like, I was crying those big hiccup cries when you can't really breathe. Nothing is coming out. And, uh, that's how it was for the next fifty-two days.

On my 52nd day of treatment I went home. I was allowed to go home on the weekends. I was supposed to build a relationship with my parents. At this point the people, the counselors and the staff at KHK

thought that I was ready to go home. They thought that I had worked on my drug problem enough at that point and they were ready to send me home so I could start working on other things. Looking back, I don't know if I was ready. I got off the first phase of the program relatively quickly, more quickly than most, you know, 90% of the people that go through treatment. And uh, I was afraid. You know, at the time I wasn't afraid of anything, I was just happy to be home, but the higher I got up on all my phases the more afraid I was that I would miss something and get set back and have to be on first phase again.

That didn't happen. I never did get set back while I was in treatment. That's also something that doesn't happen too often. Most people have at least one or two setbacks. I didn't have any and a lot of the staff didn't trust me because I never got set back. I did everything that I was supposed to, for the most part when I was in treatment.

A lot of the things that I did were out of fear. I was afraid that I was going to get in trouble and not be able to talk to my parents. So, I was afraid that I was going to get in trouble and my parents were going to be disappointed in me. I was afraid that people were going to not trust me and that they would look down on me, and think that I was a bad person so I did everything that I was supposed to do.

I never did anything dishonest while I was in Kids Helping Kids. And, uh, when I was in treatment I thought that I was doing all that stuff for myself. I thought that I was getting sober and working the program because I wanted to. Part of that was true, but part of it, I was working it for my parents because I didn't want to disappoint them because I had been disappointing them, I thought, I'd been disappointing them my whole life.

And it didn't start to be about me until I was almost graduated. I remember a couple of times talking in group when I realized that I just can't go back to the way that I used to be. I remember one time, just as I was getting ready to graduate, it might be the week that I graduated, and I was up in group and I started crying about how I didn't want to go back to the way that I was. And I couldn't go back to the way I was. I was afraid that I was going to die. I'll never forget that.

There have been times, since I have gotten out of treatment that I've thought maybe, you know, I'm not an alcoholic really. I mean KHK helped me, it saved my life, but maybe I didn't need to be there, but I've never forgotten that time, I've never forgotten that fear of going back to the lonely, miserable person that I was. I graduated treatment after nine months. And I was really happy to be out, I was really happy to be, you know, to have a normal life again.

And I hadn't had a normal life in so long. I thought that I had learned everything that I needed to learn when I was in treatment. I didn't think that I had missed anything along the way. I thought that I was a good example. I did a good job and I deserved to get out, which I did.

And, uh, I've developed relationships with people. I've made friends with people. I've changed. I was a different person. After KHK, after I graduated KHK, I had six months aftercare and I went to meetings everyday on the six months aftercare. I got a sponsor and I started working with my sponsor. I was meeting with her once a week. I was going up to KHK on the weekends and hanging out with my friends that were, you know, in the graduate group. I was going through the steps with my sponsor. I went back to my old high school. I realized where I wanted to work, at KHK, to be a counselor at KHK. I was getting along with my parents. Everything was going really well. I had started dating somebody and I didn't think that life could get any better. I can't remember, I think about the start of my senior year things started to get a little shaky. My boyfriend and I were having problems. Dad and I started having problems. We couldn't, we weren't talking to each other, or I wasn't talking to him. My Mom was having some problems. She wasn't talking to me. I was starting to really not like school. I'd moved back to Lexington. I'd lived in Cincinnati for the summer, and I moved back to Lexington to finish high school.

Probably about the very beginning of the second semester of my senior year I quit going to school pretty much. My boyfriend and I broke up. I'd started seeing somebody else. I quit going to meetings. In February of 2001, I think, I got my two-year token and that was the last meeting that I went to on a regular basis. And I didn't tell anybody this. I was having doubts on whether or not I was an alcoholic. I would go into meetings and I would talk, and I would say, "I don't know if I'm an alcoholic, I don't know if what I was doing was just normal." And people would tell me that I needed to out and just try some controlled drinking and that really pissed me off. And I'd be sitting there saying, "I'm not sure if I'm an alcoholic, I'm not sure if I need to do this," and people would tell me to go out and drink.

So I quit going to meetings, I quit listening to them. I wasn't going to school hardly at all and my counselor called my Dad. My guidance counselor called my Dad and said, "She hasn't been to school in a while, she's going to fail, she may not be able to graduate". And my Dad tracked me down at my boyfriend's house and asked me how long I'd been drinking and I got really, really upset and offended. I'd thought about drinking but I hadn't really thought about it. I thought about it but I knew it was not an option and it offended me that he would say that, that he would think that. I quit wanting to see my Dad. I don't even know why it started. I didn't want to spend the night at his house. Things were pretty much going back to the way they'd been, and I still to this day don't know why. I've got to stop for a second.

(tape off- then restarted)

I can't remember where I left off, but I remember that it was getting bad. I quit going to meetings, my Dad and I weren't getting along, not going to school. I was freaking out about not being able to graduate. I was getting real stressed out and I was thinking that I wasn't an alcoholic.

And I remember it was one night after work, Ryan and I went out to a friend of ours' house, he was having a party from work and everybody was drinking there. And, um, I'd been talking to a guy that I worked with who'd been in AA, knew he was an alcoholic, but was drinking. And we talked about the program and talked about being sober and, um, he'd sat there with me at the bar at work, drinking a beer, telling me that I needed not to start drinking again, because it was awful. He would be like, "Mears, look at me, I can't do this, do not start drinking again. Do not start drinking again." And I'd look at him and would be like, "How the hell can you tell me that?"

And we were at this party at my friend's house, and, uh, I was really thinking about drinking. I was talking to people about it; I was trying to rationalize it in my head. I was asking myself questions like, "What would be the big deal, nobody's telling me not to except for this guy and what the hell does he know." Then, in the same breath, I'd be like, "Well, he knows a lot because he's an alcoholic too." And I ended up not drinking, because I knew if I ended up drinking, I wouldn't be able to come up and work at KHK, and that's what I really wanted to do.

So, this guy, the guy from AA and I made plans for me to meet him at a meeting, on a Saturday morning, and he never showed up. And I saw him the next day at work and he told me that he'd gotten drunk the night before and ended up passing out and not waking up. He told me, he's like, "That last night I told myself that I wasn't going to drink and I wasn't going to do anything and the next thing I know, you know, I'm drunk off my ass at a bar." I told him that it was okay, that we would meet again and so we made plans to do it again. And the same thing happened. He didn't show up.

So, at that point I'd realized that I didn't want to drink anymore. I don't know what happened. I don't if, you know, I thought maybe it was just a phase, maybe it's just one of those things where its like, you know, well I haven't had a drink in so long, I don't know what would happen, you know, nobody can guarantee me what would happen. I may be able, you know, to get drunk that night and not ever get drunk again. Whatever it was, I didn't do.

And I moved up to Cincinnati the day after I graduated high school, and I did graduate high school, just barely. Got an apartment, started my job the next day, or no, I moved in on a Saturday and I started KHK on a Tuesday, and it was good to be back. It was good to be working with people and helping people and doing what I loved to

do and doing it for the place that saved my life. 'Cause Kids Helping Kids did save my life. If I hadn't gone through that program, I don't know where I would be right now. I don't know if I'd be dead yet. But uh, at the rate I was going, it wasn't far off.

And, uh, since I've gotten sober, I've been to one funeral for a very good friend of mine who got killed in a drunk driving accident and two funerals for friends of mine that shot themselves because their lives were so messed up. And, they were messed up because of drugs and alcohol. I don't want that to be me. I don't want to be remembered that way. Like I said before, I don't know how I want to be remembered, but I don't want to be the girl that died when she was nineteen, or eighteen or sixteen, twenty four, whatever, or even fifty five, because of drugs and alcohol. I'm not going to go out like that. And, uh, on February 12th of this year, I was three years sober.

(End tape)

March 27th, 2002

Finn:

It is March 27th. Mears and I are in her apartment. We are going to record the last interview with her, which consists of ten questions. Okay. The first question Mears, is what part, if any, do you think that your family played in your drinking and drug use?

Mears:

Uh, I think I learned how to drink from my parents. They didn't sit me down and tell me, like, what to do. I know a lot of people have gotten drunk with their parents, and, you know, they would tell them what to drink and what to order so you wouldn't get sick. My parents didn't do that. You guys were both sober by the time I started drinking. But I, you know, remember what drinks you guys used to think were good and I remember what my Mom would order when we'd go somewhere and I remember what kind of beer you would drink. I don't know now, but I used to. And, uh, I remember seeing, like, and saying that my parents did this and it seemed to be okay.

But when I got older and I'd been drinking more. I knew that they didn't seem, like you guys didn't seem to be okay. I knew that there was something wrong. But by then I didn't really, not that I didn't care, I just didn't, uh, I didn't do anything about it.

I knew my Mom still smoked weed when I was getting high. I was like; she's supposedly sober, so it must be okay. She gets up and goes to work every day, and she doesn't yell at me and she doesn't beat me, so she must not be crazy. There would be times when I would get upset and pissed off because of something my parents said to me and I

would go out and get drunk. Sometimes I would drink because I knew my parents did not want me to.

I didn't know why my parents drank when I was a little kid. I knew that it made them do things that I didn't like. It made them act ways, you know that I did not want to be around them when they were drunk. I didn't want to be around them when they were acting that way or anything. But when I got older I didn't really think about all that stuff. I didn't think about it anymore.

I don't blame you guys for what happened, or how I turned out. I think a lot, I think alcoholism is hereditary. I think I got it from you guys, but I don't blame you for it. I mean I know people, like _____, her Dad is an alcoholic and she doesn't drink. I know people that, uh, their parents aren't alcoholics and they are. So, I don't know what else to say.

Finn:

Do you think that our divorce had any part to do with it?

Mears:

No, I never, not really. I think it had a lot, I mean, it was upsetting for me, like it wasn't something that I was okay with. I never blamed myself, though. I never would go out and feel like my parents split up because of me or I wouldn't think about you guys being divorced when I was drinking. Cause by then I realized that you guys were closer then you had ever been when you were married. I mean I didn't know you all very well when you married. I was so young. I didn't really, I mean, you don't get to know your parents until you get older, and by then you guys were divorced and it was completely different, so...

Finn:

What do you believe to be the most beneficial part of Kids Helping Kids?

Mears:

The positive peer pressure and peer influence. Um, I have counselors, you know, that were forty years older than I am and my parents tell me many, many times that "alcohol is not my friend." My Mom said that one night after I threw up in her car. And I didn't care. I didn't listen to her at all. When you came over on New Year's Eve you were telling me that you were afraid that you were going to lose me to the streets, it was so.... I laugh about it now cause it just seems so funny, but you know I wasn't paying attention to you. I wasn't listening.

And even now, like when adults tell me stuff now, like when Michelle Dool was telling me that I needed to quit smoking and when

she was talking to me I looked really dizzy and I was like, “I am not listening to you right now.” You know, “I don’t want to quit, your wasting your breath.”

And when you go into KHK there’s people that are your age. People that, you know, you would not necessarily have hung out with, but the age group that you would have hung out with talking to you about the dangers of what happens, you know, when you drink and do drugs, if you have a problem. That’s what it was. Kids my own age and that’s why it is so important to have the peer staff, you know, that are, you know I’m older probably on average by about three or four years than the kids that are in there, but when I was in there I was sixteen. I was their age. And that’s what it is. To have somebody your own age to tell you your screwing up and there’s another way to do things. That’s what works the best for me.

I mean, that’s what, that’s how they get people. Like their motto, like you know, “if your kid is lost then one of our kids will find them.” That’s what they say and that’s what happens. That’s Kids Helping Kids. Its not like diplomas helping kids, or some clinical woman, I mean they play a big part, like Michelle played a big part in my program and in my treatment but if she would have been the only person I would have dealt with I wouldn’t have been sober still. I wouldn’t have made it. She’s older; she doesn’t have what I have.

Finn:

What do you believe to be the least beneficial part of Kids Helping Kids?

Mears:

Um, as best as we try, I don’t think we prepare them for.... I don’t think we are as honest with them as we can be.

Finn:

With who?

Mears:

With the kids. Cause we tell the kids, like you can never hang out with certain people, you can never, um, listen to this music. If you wear those clothes you will relapse, if you go to this place you will relapse, if you go to this concert or, you know, date this type of person, or whatever, you will relapse. That’s not necessarily true.

Um, I think on the one hand, like, when you go into KHK you swing like completely to one side of the spectrum, because in your past you were completely on the other side. When you get out you’re supposed to go back to the middle, the pendulum-effect. But I think we tell the kids a lot of things that, not that they’re not true, but in

hopes to scare them. Like...I know we have like good intentions of doing it but there's things that we say to them that I don't agree with.

Finn:

Like behavioral stuff like what you're just saying.

Mears:

And even though we say that stuff, like we still, like, I've had that stuff said to me and I had to make up my own mind and make my own decisions to talk to who I wanted to talk to. And I was able to recognize like, "I'm not going to be able to talk to this person." But when I was in there, like you can't even give yourself the option. It's one way. It's black or white, and it's not.

Finn:

Do you think that while you were in there, though, that that helped you or it didn't help you?

Mears:

I think that it did. It helped me then, because if they'd have told me when I was in there that you could hang out with your druggie friends when you get out then I probably wouldn't have listened to a lot of the things that they said. Not necessarily that I wouldn't have listened, but like, I would have been hanging on to that and looking forward to that.

Like when I was in treatment I completely cut off any ties. Completely cut off any contact with anybody that I knew before. And I think that was important.

But it just seemed like they were telling me, like, this, you know, you have to change everything. And I haven't changed everything. I still listen to Led Zeppelin. I still listen to Bob Marley. I have friends that drink. I dated somebody that drinks. And I haven't, you know, it hasn't made me want to. And there are some people that can't, that can't hang out with their friends that can't listen to certain music or wear certain clothes or go to certain places, or whatever. It just seems, you know, that it is this way. Like absolute.

Finn:

But it being absolute for a period of time helped you?

Mears:

Yeah. That's why I guess I really didn't answer the question.

Finn:

No, you did great. What do you believe to be the most beneficial part of Kids Helping Kids for the family members?

Mears:

Um, You take Kids Helping Kids home with you. Like, even though you guys didn't take household, and weren't around the kids on a daily basis. Like you were around the kids once a week and you did see the kids and you did know what we did in group and you had to go through education and you had to go through groups. There were rules that you all had to follow.

I mean there is no way that anyone could know what going through KHK is like unless they go through KHK but its not, like the parents go through too.

And the brothers and sisters, like I can't imagine being a sibling of somebody in KHK, cause you give up your life, pretty much, you know for a year. You can't have your friends over. You can't listen to music if there's clients in the house. So I think involving them that much is the most beneficial part.

But, is the next question what is the least beneficial part? Okay. There is not enough involvement. They try, like they do well with involving them, but I don't think there is enough.

You know, going to one parent education group a week is not enough, cause there's some, I've dealt with some pretty sick people. Pretty sick families that are, you know, are required to spend two hours every Friday in a group lead by somebody that's not sometimes competent to lead the group. You know, we have people that, we have peer staff that don't know what their talking about in certain, about certain issues that they are trying to educate these parents whose kids are in treatment.

And we have parents that don't want to, you know, they just think "my kids in here, I'm not in here." And that's not true, at all. "I don't have to go through KHK, I'm not the one that is drinking and doing drugs." No, you're not, but your kid was. There was something wrong, cause they did not want to be around you either. You know. You don't get a kid coming into KHK that had a great family relationship and was out smoking crack everyday. That's never happened, never going to happen.

Finn:

You said some of the families that you know that a couple of hours a week isn't enough help because they're very sick. Without naming any of the families, just describe some of the things that you think were problems with those families.

Mears:

Um, them thinking that, you know, we weren't competent to deal with their children, though they place their children in our care, we did not know what we were doing. They never took the time to like, listen

to what we had to say. They just wanted to hear, you know, “Is my kid coming home tomorrow?”

People that are in relationships that aren't healthy, you know, mothers that are in relationships with men that, you know, beat them or treat them poorly or beat their other kids. Like there was a girl, both of her parents were, you know, active alcoholics and they used to get in verbal disagreements and used to beat her when she was in the program. And they never came to parent groups. How can you expect your kid to change if you're doing the same thing? I mean, I think its possible for kids to change if their parents stay the same, but its really not possible to have a relationship with, I mean, she doesn't have a family relationship. She can't, cause her parents are so screwed up, so...

Finn:

But did she change?

Mears:

She changed, yeah, but that part of her life didn't, her family didn't.

Finn:

So the Kids Helping Kids part worked, but the part about helping the family didn't work?

Mears:

And, you know there's people that have. Okay, then there's a family in there, okay there's a family that is not real committed to the program like they do not agree with a lot of the things that goes on and they threaten to pull her out of treatment whenever something goes wrong. That's not okay. And she's got two older sisters that, one of them drinks a lot and gets kicked out of the house and is really negative about the program. Her and her Dad don't get along. Her Mom is real codependent. Every time something goes wrong, they threaten to pull her out of treatment. That's not any level of commitment. I mean its really difficult for her, because day to day she doesn't know if she's going to come back.

Finn:

So, those are some of the least beneficial things with family members, but do you see, ah, which way do you see it? It helps families more often or less often?

Mears:

I don't know. I...I mean I can think of just as many families that it hasn't helped as it has. And whether or not the kid changes, I don't

think it has a whole lot to do with that. Like my best friend, her family, her Dad and her step Mom were just as bad if not worse, I mean her and her step Mom don't talk anymore,

Finn:

Do you think that if the family gets better and participates that the kid has a better chance of getting better?

Mears:

Oh yeah. Yeah.

Finn:

So it's important that the family changes?

Mears:

It's important that the family changes, but it's not, uh, I don't think it makes or breaks what the kid does. It could, but it doesn't.

Finn:

What do you think about how your family did during the program?

Mears:

Um, I think, I know that I was really lucky to have two parents that were in sobriety that understood the disease while I was going through treatment. Um, I don't know a lot of people like that, that are able to have two parents, or even one parent be in, like, in sobriety while they are in treatment.

I did have a hard time for awhile. Mom had a pretty bad attitude towards a lot of the things about the program and she would tell me. She would voice her opinions to me and that was really difficult for me. Because a lot of it, in the beginning, I was doing it for my parents, and, but she would complain about the program, like, what am I doing this for?

My mom was also getting high while I was in treatment up until the point that I made Second Phase. It got to the point where I wasn't going to be allowed to go home with her. I mean, you know, she stopped. I don't know if she stopped so I, I think she stopped at first so I could come home with her. I don't think she stopped because she wanted to.

But, uh, I think I was lucky, because you guys understood what was going on, but at the same time, like, you did, you understood what was going on. I couldn't avoid stuff; I couldn't not talk about things. Which is not a bad thing, it's just at times it was, like, "Just shut up- I want to talk, you know, talk about this without you guys analyzing everything I say." So...

Finn:

That's five questions. Do you want to take a dinner break?

Mears:

Yeah.

Finn:

Well, dinner break.

(Break in tape)

Finn:

Okay. Obviously we are back from dinner. Let's see Mears. briefly, tell me about the phases, what the goals are and the lengths of them.

Mears:

Um, well the First Phase minimum is fourteen days, but it can be anywhere from two months, to, you know, a year and a half. It's the, I think it's the one, it's the hardest one. It wasn't the longest one for me. I completed First Phase in like fifty something days, fifty-two days. Its like when you come in and, uh, you're called a newcomer and you can't do anything by yourself, you can't go to the bathroom by yourself. You're not allowed to have knives. It's pretty bad. There's nothing about First Phase that was appealing. I never wanted to go back to first phase.

You're supposed to focus on your drug problem, and you can't really, your not suppose to, well, you can talk about other things. But most of the time your up in group you're supposed to talk about your drug problem, how you feel about being at Kids Helping Kids. Its just, it's rough. It's miserable. It's long. That's why I didn't want to be on it very long.

Most kids have a hard time, like, if, especially if they don't want to be sober, it takes them awhile to get off first phase. You have to, to get off of First Phase; you have to demonstrate your knowledge of your problem. You have to recognize that you have a problem and show a little bit of willingness to want to change and to want to have something different.

I don't really remember a whole lot in particular about my first phase, I just remember that I did not like being on it. You talk to your parents for like fifteen minutes every week with somebody else there. And all you can do is apologize. You can't talk about anything else. You can't, you know, ask how your friends are doing or yell at your parents or anything. It sucks. It's no fun.

Second Phase, like you have no privileges at all. You can't go outside. You can't be alone. You're in group all day, every single day. That's it.

On the Second Phase, you start to go home again if you're an in-town person, you live within fifty miles of the program you go home to your parent's house and you take household. You take newcomers, other first phasers home with you and you have to help them out, talk to them and teach them what you have learned and make sure you're responsible for them, make sure that they follow the rules. You, you know, you are around your family again and you start to have family counseling with your clinician.

The minimum for that is seven days. Most people are on it for about a month or so. You don't have a whole lot, like, your allowed to be alone but you don't have a whole lot of privileges.

And then Third Phase, you go back to school. Or work.

Finn:

Or both?

Mears:

Or both. I went to, I made Third Phase during the summer, so I worked during the summer and when school started, I went back to school. Um...

Finn:

Do you have to work?

Mears:

No. They like, if you make Third Phase around summer time, they like for you to go to work. What it's supposed to do, like, the reason that you go back to school or work is to integrate you back into society, like where your around normal people again, and you're out in public. You get to spend time away from the program. You're not in the program all day long every day. Uh, I mean you obviously have to come back after school and work sober. And, uh, I don't really...

Finn:

Fourth phase.

Mears:

Fourth Phase, uh, is ninety-one days long, or ninety-three, its three months long. Thirteen weeks, I think. Its technically the longest phase, but, I mean, I, some kids make First Phase the longest phase.

Fourth phase is where you get all your privileges back. Up until this point you've not been allowed to listen to music, or talk on the phone, or watch TV. You start to get days off from the program. You

have to come back at night and go to household but you don't have to be there all day.

You start working on morals. Um, talking about, you know, how you want to be. Start making, like, at school you can start making friends again, but on Fourth Phase you go days off with other clients in the program. Or you can talk with productive people that you knew before or you can hang out with people you knew before you start going to AA meetings. You're supposed to go to one every week.

Since Fourth Phase is, you know three months long a lot of people have a hard time. They just get into this slump, like they get into the routine of everything. A lot of kids get set back on Fourth Phase, because sometimes, like having all the privileges and having all the responsibility gets to be too much and, so some, a lot of kids get sent back when they're on forth phase.

Fifth Phase, you are preparing to graduate. It's the phase of giving back to other people your, that's a, sixty something, its like nine weeks long, starting to give back to the other kids more than you have been. You're allowed to be, you don't have to sit in the group. You're allowed to walk around. Uh, you're allowed to work with clients more than you have been because you're allowed to talk to them more. Um, you have to, every week, like you have to pick somebody that you want to focus on. It's, I mean, that's really what it is its giving back to other people and preparing to graduate.

You work on a contract for your follow-up with your family and your clinician. Um, and you get a vacation. You get a week off from the program; you don't have to be there at all. Which was really nice. A lot of people, like, go on an actual vacation. I went back to Lexington and took my driver's test, registered for school and went and visited my old high school.

Uh, you get, like you have your privileges back on forth phase, but, like, on Fifth Phase you get more freedom. You don't have to write permission, like on forth phase, when you go on a day off, you have to write a permission. You have to tell staff, you know, everywhere your going, exactly what you are going to be doing. You don't have to that when you are on Fifth Phase. What else? You can go outside, like you can be further away from your parents. You have to be within yelling distance, I think, of you're parents. And then you graduate.

Finn:

What about the Seventh Step?

Mears:

My follow-up was six months long. Uh, I moved back to Lexington, I went back to high school. When you're, I think the follow-up now is four months long. For the first two months you're not

allowed to date. For the first three months of my follow-up I wasn't allowed to date or be on a one-on-one situation with a guy. You're not allowed to smoke, I mean you weren't allowed to smoke the entire time you are in the program or follow-up.

You have to put in a certain numbers of hours in group with the program every week. Every Saturday morning you have a Seven-Step rap. It's just a group of the graduates that are on their follow-up meet Saturday morning from ten to twelve. You have to put in ten hours in group and that counts for two of your hours. Another two of your hours you can do AA meetings, but the rest, the other six hours you have to be in group. It's kind of like you are a Fifth Phaser.

The contract that you wrote with your parents on Fifth Phase is for the follow-up. I had a pretty, I mean, we didn't have a whole lot of problems making my contract. A whole lot of kids have a hard time coming up with a contract. Like, they're out, and they want to do what they want to do. But you still, you still have to have rules. Honestly, I don't think we every looked at my contract after I graduated. It wasn't like we threw it out the window, it was just, like, I wasn't breaking any major rules or having any problems. I wasn't coming home late or not coming home at all. I was getting good grades at school until my senior year, and I didn't really go to school. And life kind of goes back, well, it doesn't go back to normal because there was never a normal, but, you're out.

Finn:

What about the moral inventories—the MIs? And are they anything at all like the 12 steps of AA?

Mears:

The MI's are based on the Twelve Steps. What you do every night the entire time you are in the program, First through Fifth Phase, you have to write an MI. It's a, you call them challenges. Each challenge, while you are on the First Phase, you have to take two times from your past, like drug using times, and run 'em through the Twelve Steps. Like you write down the time and then you say how it was powerless and unmanageable and then you write, you know, like what the Second Step, "I take faith that this will change." and you go through all the steps and apply it to that time or that problem. You have to do two of those.

When you are on Second Phase, you can write one time and one problem, like a current struggle that you're having. And, uh, after you've finished the challenges you write three good characteristics about yourself, one good thing about that particular day and three goals you can accomplish within the next twenty-four hours. Like I'm going to read a certain chapter out of the AA book or I'm going to write about my day, or whatever.

When you're on the First Phase you go over your Moral Inventory with your old-comer every night. They have to relate with you and give you feedback. When you get on the Second Phase you go over them with you're parents. And you go over them with you're parents as long as you're an old-comer.

When you first come in the program, MI's take about, you know an hour and a half to write. When I graduated I was able to do them in, like, twenty minutes.

I didn't like writing MI's for a while and then I started to realize that the more I put into them the more I would get out of them. If I was just doing them just to get them done, I wasn't going to like them. Sometimes, like, I remember, I don't remember any specific ones, but I remember there were some Moral Inventories where I really did get a lot out of what I wrote about because I had to look at what I did. You have to put 'em through the steps like you look at your defects and you look at who you hurt and you look at how you felt when all this happened. It puts you back in the time.

Like I didn't think I was going to be able to remember, you know, how I felt when I got high when my, you know, when Whitney came over. I was high once when Whitney came to give me a Christmas present. Like, I think about it now, I really feel guilty about it. I knew that she was coming over, I knew that it would make her uncomfortable, if I was high, but I didn't really care. So it forces you to look at stuff like that.

And then, like even sometimes toward the end when I was on Fourth and Fifth Phase, it just seemed like it was a hassle, and a lot of people get that mind set like, "this is a hassle, this is a nuisance and I don't get anything out of them." And I think its because they're doing them just to get them done. I mean, some days, that's like what it was. "I'm just going to do this because I have to."

I don't write, people ask me, "do you still write MI's?" and I don't. I remember how to do them, it's something you never are going to forget how to them, you do them everyday for nine months or however long, I mean you don't forget the format. You don't forget what you do, but I do write everyday about my day or, you know, if something important happened. I'm glad I don't have to write them anymore. But I'm glad I did have to.

Finn:

What do you think about the open meetings? Friday night Open Meetings?

Mears:

They're long. They're real long. Sometimes, my first couple of Open Meetings, I don't, I remember them, but I only remember, you know, being in there and knowing that I couldn't talk to my parents or

that my parents were probably going to get up and say something I didn't want to hear. I cried a lot.

They signified the end of the week. I know that once I got on Second Phase I was able to go home after Open Meeting. A lot, you know a lot of the open meetings I just wanted to be over.

And there are some, like when somebody gets to run home, I mean, that's, I still cry every time somebody runs home. Cause I remember, like, how excited I was to be able to go home. And before I was able to go home, I remember like seeing other people run home, like, "God, I really want to do that." So I mean I still, you know, three years later, I still get emotional when I see kids run home. Cause its just that's its so, they've worked so hard and they've do so much and they're so excited to see these people that they've hated. I mean a lot of kids just hate their parents when they come in, but when they run home, their just like, "I'm coming home!" It's great.

Finn:

Tell me about your experiences with staying at in-home, in-town family.

Mears:

My first night I stayed with a girl whose Mother was just...she had a lot of problems. I didn't want to be there, I wanted to go home. I felt uncomfortable for a long time being in other people's homes. I didn't do that. Like I wasn't one of those people that like, spent the night out a whole lot. I mean I was good, like parents liked me, but I didn't, you know.... It's just weird, like you're not in your own home, and you have to follow somebody else's rules like.... It's just uncomfortable, at first.

Some of the homes, like one of the houses I used to go to was not very sanitary at all. It was disgusting. I hated being there.

And then, you know, another one of the homes, like, this girl had a huge family. Her parents were great, like you felt you were a part of that family. And I think that's the best part. They never, you know, they were, they were always talking to me and asking me how I was doing, like, they were so helpful and so thoughtful and there's really, you could tell how much it meant to them. And how much they wanted to do that. And you can also tell when parents don't want to do it. You can tell when parents don't want to have kids in their house.

I mean once I moved on to where I was an old-comer, and I wasn't a new-comer anymore I would go home to people's houses and help them out. I was a foster sister and so it got a little bit better, but I mean you could still tell when parents didn't want to take household. In the homes, like, the home where you know that that means a lot to them to be able to do that, that's what makes it enjoyable to be out.

Finn:

What do you like about letting other kids know about, showing them that there's another way...that they don't have to die doing drugs and alcohol?

Mears:

I know that I, that I am not responsible for anybody's success. But, I also know that, like, I've helped people realize that they don't have to do that. And it's just, when you can look at a kid and look at how they were when they came into the program, and look at them, you know, five or six months later or a year later and they are so completely different. Knowing that, like, you had a part. Not necessarily that you had a part in that, but you were there to see it happen.

I remember people, when I was in the program, and people still now, that have me helped out. Like you remember what they, exact things that they've said to you. You remember where you were, you know. It's kind of like people remembering where they were when Kennedy was shot. Like I remember where I was when so-and-so said this to me. I remember, you know, exactly what he said and not necessarily what day it was, but I remember what group it was.

And sometimes they didn't even have to say anything. Like when I was on Second Phase I was in a group talking about this time when I was in my garage. It was like the day after my birthday, and I was in my garage and my best friend came over and told me he never wanted to see me again. And, um, I was talking about it, it was a smaller group, and my counselor was the one that was leading it. He just listened. Like every time, like, I was bawling about how miserable I was, and how lonely I felt and just, I just didn't know what else to do and, sitting in my garage drinking by myself and I was just talking about it and I just would look up and he would be paying attention. Like, and he knew what I was talking about cause he had done that before. You know he'd felt that before.

And so being able to just look at people change and know that, you know, they know they don't have to do that any more. Seeing it happen is the best thing.

Finn:

Last question. What, if anything, would you change about the program at Kids Helping Kids?

Mears:

I wouldn't change anything at all. I mean, a lot, during a lot of these questions I've been speaking as a staff member. But speaking as a client, there is nothing that I would have changed about being in there.

KHK works. It's the kid that doesn't work. You know. Whether they graduate or not and complete their follow up or not, if they decide to relapse, it's not because of anything that was wrong with the program. It's because, you know, they didn't do the work. KHK works. It's worked for God knows how many people and it worked for me. I wouldn't change anything.

(End of tape)

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