

DO YOU KNOW?

Since 1999, the Department of Justice has released two reports dealing with the issue of mentally ill inmates. It found that fully 16 percent of the people in the nation's corrections systems were mentally ill, but that only 60 percent of those reported receiving any mental health treatment. Below are highlights of the reports . . .

- At mid-year 1998, there were over a quarter of a million mentally ill people incarcerated in prison or jail. An estimated 283,800 inmates -- or 16 percent of all incarcerated individuals -- reported either a mental condition or an overnight stay in a mental hospital, and were identified as mentally ill.
- Only 60 percent of the mentally ill in state and federal prisons reported receiving mental health treatment since being incarcerated.
- About two-thirds of the inmates in state facilities who receive counseling or psychotropic medications were in facilities that didn't specialize in providing mental health services in confinement.
- Half of the mentally ill inmates in state and federal facilities reported having three or more prior sentences.
- Mentally ill state prison inmates were more than twice as likely as other inmates to report living on the street or in a shelter within the last 12 months.
- Offenders between the ages of 45 and 54 were most likely to be identified as mentally ill.
- Mentally ill inmates were more likely than others to have been convicted of a violent offense (murder, sexual assault, robbery, or assault). Thirty-three percent of federal inmates identified as mentally ill had been convicted of a violent offense, compared to 13 percent of other inmates. In state facilities, 53 percent of mentally ill inmates had been convicted of a violent offense, compared to 46 percent of other inmates.

Sources: Bureau of Justice Statistics, "Mental Health and Treatment of Inmates and Probationers," July 1999; Bureau of Justice Statistics, "Mental Health Treatment in State Prisons, 2000," July 2001

"Mental Health and Treatment of Inmates and Probationers"

<http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtfp.pdf>

"Mental Health Treatment in State Prisons, 2000"

<http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtsp00.pdf>

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Appointments & Fees

In dealing with the various problems life presents such as divorce, problems with children, depression, symptoms of mental illness or substance abuse, sometimes information and the help of friends/family is simply not enough. In these instances, professional help may be needed. Professional help from Pathways is easily available by calling the office of your choice. Services are confidential and structured to meet the customers' unique needs. Pathways accepts most insurance or managed care coverage as well as Medicaid, MC+ and Medicare.

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RAISING KIDS WHO DON'T SMOKE

Parents are the single most important influence on children's decision to smoke, drink or use drugs, yet many parents do not fully understand the extent of their influence.

The National Center on Addiction and Substance Abuse at Columbia University. Malignant Neglect: Substance Abuse and America's Schools.

- ◆ The younger people are when they start smoking, the more likely they are to become strongly addicted to nicotine.
- ◆ More Americans die from cigarette-related illnesses than alcohol, car accidents, suicide, AIDS, homicide and illegal drugs combined.
- ◆ Almost 9 out of 10 lung cancer deaths are caused by smoking cigarettes.
- ◆ A person who smokes a pack or more of cigarettes each day lives, on average, seven years less than someone who has never smoked.
- ◆ Secondhand smoke contains 43 chemicals that are known to cause cancer.

YOU can significantly reduce the odds that your child will smoke, drink alcohol, use other drugs and engage in premature and unsafe sex. While smoking may not be your greatest concern, it's worth close attention because of its direct health dangers and also because it's associated with other risky behaviors.

from Philip Morris, Raising Kids Who Don't Smoke



The Unanswered Questions of Teen Suicide

By: Barbara Gray, EdD, Licensed Psychologist

“How do you
get that
lonely?”

Fans of 18 year old country singer/songwriter Blaine Larson will quickly recognize the title of this article, for his hit song by that name poses the question that friends and loved ones of teen suicide victims can never fully answer. “Completed” suicides and “attempted” suicides are studied by mental health researchers and statisticians as well as by clinicians in the field. These efforts can give us numbers and percentages, which are then disclaimed by the statement that this data is an underestimate of the true occurrence of this tragic act. In addition, these facts and figures still do not answer the question of “why?” to a sufficient degree to give the surviving mourners the closure they seek.

Perhaps we should try to learn a few ways to intervene with young lives in trouble before they become a mortality statistic. In order to do this, we need to become aware of the warning signs of suicidal thoughts or plans. These can include:

1. Previous suicide attempts, even if the previous attempt was regarded as “attention seeking”
2. Giving away prized personal possessions
3. Collecting or discussing information on suicide methods
4. Statements that the person would not be missed if he or she were “gone”
5. Expressions of hopelessness, helplessness, and anger at oneself or the world around them
6. Themes of death or depression evident in conversation, writing, choice of reading materials, artwork, or music.
7. Scratching, cutting, marking on the body, or other self-destructive acts
8. Recent loss of a friend or a family member (or even a pet) through death or suicide.
9. Other significant losses and/or unwanted life changes such as divorce of parents, change of residence, loss of health, etc.
10. Unexplained changes in personality, usually involving withdrawal and isolation from others
11. Aggressiveness, moodiness, or new involvement in high-risk activities
12. Sudden change in academic performance (either decline or improvement), chronic truancy or tardiness, or running away
13. Physical symptoms such as eating disturbance, sleeplessness or excessive sleeping, chronic headaches or stomachaches, apathetic appearance, or a decline in hygiene and self-care
14. Use or increased use of mind altering substances

One of the greatest anxieties others may face when recognizing these “signs” is that they don't know what to do with this information. One may mistakenly fear that asking the teen about suicidal thoughts may “plant” the idea and “cause” them to act on these feelings. This is simply not true. Suicide is a desperate effort to be relieved of emotional pain. It is the result of too many stressors and too few ways to cope. Having another person to “anchor to” can be an emotional and literal lifesaver. Focus on LISTENING without judgement, criticism, punishment or forceful, unsolicited advice-giving. Concerned others do not have to be professional suicide counselors, they need to be attentive, patient, non-critical listeners. There is no “perfect” thing any one can say to turn the teen around. The teen wants to explore their own solutions, and they will do this when they feel safe and respected enough to undergo the same trial and error process we all used as we forged our way through adolescence.

Sometimes we may take the signs of suicide too lightly, dismissing the words and actions of the suicidal teen as “dramatic” or “attention-seeking.” While we try not to reward this type of suicidal behavior with lots of positive social reinforcement, we must take it seriously. After all, what if we were wrong in our assessment that the teen was “just being manipulative?” We should be grateful that their suicide attempt was not more serious or life-threatening. We should use this event as a starting point for improving communication, seeking professional help, looking at the social environment that the teen (as well as the other family members) are trying to cope with, supporting the teen in setting realistic goals for him/herself, etc.

So, is the question really “How do you get that lonely?” or should we look for ways to connect with our teens so that this degree of loneliness is never reached? While the option of professional help should certainly be considered, each of us needs to remember that we have something good to pass on to our teens, whether it be our own “survival” stories of adolescence, a willingness to listen and not judge their struggles, a desire to find interests or activities to give them a sense of connection with us, or perhaps a tolerance for their efforts to become unique, independent individuals.



Reflections . . .

By Dee Kempker, BA, CASAC

My boss asked me to write about "Doing the Right Thing" and I don't normally take requests for this column, but because I think it's an important issue, here are my reflections on this topic.

I will never forget my Aunt Teresa. She lived to be 90 years old and I believe that the only time I heard her say that she regretted something in her life, it was the fact that she never had any children. She married late in life and was only married for a few years before her husband died. Since she had no children of her own, she became a SUPER AUNT for all of her numerous nieces and nephews. She took us bowling, to the park, and to the country to visit even more aunts, uncles, and cousins. But I especially remember the Sunday afternoons when she would pile 10 or 12 of us kids into her old Ford and take us all to the movies. This would surely have gotten her arrested in this day and age, but back then, the streets seemed to be safer, with fewer cars, slower traffic, more courteous drivers and road rage was unheard of.

The reason I am reflecting on all of this is because Aunt Teresa became my measuring stick for doing the right thing. She was a very religious person and a very fair person. If something didn't seem fair, she would kindly let you know about it, and you never had to question her judgment because you knew that she was right. Even our Catholic priest remarked one time that if Teresa Shanks said that something wasn't right, then it wasn't right. So what gave her the ability to detect rightness from wrongness? I have pondered this subject for some time, and I have finally decided that it was because she was a totally unselfish person. She had no hidden agendas that colored the way that she saw things. She didn't look at something and say, "What is the benefit to me?" but she did ask "What is the RIGHT thing to do?" I think that all too often, we become so self-centered and self-righteous that our judgments reflect a one-sidedness, or unfairness to others. Perhaps it is because we feel threatened by society, and think that we have to look out for old number one. It comes from mistrust, greed, or a lack of knowledge of who we are. When you are sure of yourself, when you have looked inward and discovered your own personality, not just your faults but your strengths as well, then you can make solid decisions about your actions so that they do not use or abuse others.

As a counselor, I have been trained to help others. This does not mean that I always accomplish that. At the end of the day, I have to ask myself, "Did I do the right thing for this client? Did I expect something more from them I would be able to accomplish myself? If I were in their shoes, how would I feel about our session today? What other tools can I give them that will help to build a sound structure for their future?" In fact, it's all about them and nothing to do with me. People who are responsible for making decisions for others, must use this yardstick: who is benefitting from this decision? Is this a fair decision? Is this the right thing to do? Hippocrates, the Father of Medicine, states in his Hippocratic Oath: "First, do no harm." This is a pretty lofty goal, but it is something to shoot for.

In everyone's daily life, sometimes the right thing to do means choosing between two difficult choices. Remember, there is a difference between doing the right thing for yourself and being selfish. Taking good, healthy care of yourself means that you will be a much healthier person, mentally and emotionally, so that doing the right thing for others just comes naturally.

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What To Expect When . . .

By Fred Overton RN, C

One of the most common resources for expectant mothers is; [What to Expect While You are Expecting](#) by Heidi Murkoff. The title gives the contents away, it is a guide of what to expect as parents enter an exciting yet stressful time, filled with change. Change occurs in all aspects of life including relational, physical, emotional, mental, spiritual and behavioral changes. As all parents know, life is a constant state of change that exists from conception on. Murkoff's book has grown into a series to help give comfort and guidance to parents of

shame, loss, anger, hopelessness, and regrets are common and normal. It is not easy, first of all, to admit that there is a problem but to have to admit that the problem cannot be dealt with within the family is very difficult. These feelings stem from two factors; our society's ongoing stigmatization of persons with mental illness and the belief that a parent must have done something wrong in order for the child to have difficulty coping or behaving appropriately. The majority of mental illnesses are caused from a number of coexisting factors; heredity, environment, temperament, physical injury or illness, history of trauma and history of loss. While parents have a direct impact on some of these factors, many are beyond their control. There is no shame involved in seeking care for a child with asthma or chicken pox and, there is no need for shame related to the treatment of a mental illness.

It is important to remember that change is a slow process, and the speed at which we change varies from person to person. If treatment is initiated at age 12, it is necessary to change behaviors and coping mechanisms which have been practiced for twelve years! Looking at our own lives, how easy is it to just one day decide to stop smoking, cracking our knuckles, popping our gum or eating sweets? Change takes time, patience, practice and perseverance! For those who have broken what we consider our bad habits, have you ever experienced a back slide or a relapse? At times of conflict or great stress it is easy to fall back on ingrained patterns of behavior. Management of mental illness and substance abuse is often more about decreasing symptoms and their severity, not completely eradicating them. If our

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children who are ever changing, growing and evolving. One change event, which is often unanticipated, is the initiation of professional help for behavioral, mental or emotional problems. This help may include support groups conducted by professionals, individual counseling, group therapy, substance abuse treatment and residential or even inpatient care. For many parents this is their first exposure to mental health care, and they have no idea what to expect.

At the time of initiation of treatment, parents experience a wide range of emotions which are often conflicting. Guilt, helplessness,

expectation is that the people in our lives will act or perform perfectly then we will often be disappointed.

Children live as part of a family system. The best chance a child has at long-term recovery from mental illness or substance abuse is if the entire family is involved in treatment. It is intimidating or even frightening to think about a mental health professional poking about in family business. The best of these professionals are not interested in blame, they are committed to helping their clients become part of a healthy, happy family. Often participation in family therapy facilitates additional support or outlets for family members. Many managed care companies are now requiring family therapy to be a component of the treatment process of a child regardless of what problem is being treated. This can easily be seen as an intrusion, but in reality it is an opportunity; an opportunity for the family to grow in hope and love as opposed to hopelessness and despair.

If you are considering or have sought professional help for your child, get involved! Be patient but at the same time ask questions. Find out what to expect and what you and your family can do to assist in the recovery or return to health of your loved one.

Conduct Disorder and Behavior Problems in Children: bad kids or kids that act bad?

By: C.J. Davis, PsyD

Approximately 10 percent of school-aged children demonstrate or display behavioral problems that require either academic or professional intervention. These behavioral problems may range anywhere from fire setting or cruelty to animals to defiance or noncompliance. No matter what professionals call the behavior it is frustrating to most parents leading many to question the effectiveness of their parenting. It is also normative for parents to begin asking themselves questions such as "So what does it mean when my child has a behavior problem?", "Is he or she going to be like this forever?" or "Will they inevitably break the law in the future?"

First and foremost, it is important to understand that children who display these types of behaviors are not necessarily bad children. They are certainly acting in ways that we consider bad,

but referring to them as "sociopaths" or "psychopaths" can be very damaging to the child and not accurately depict the problems they are experiencing. Essentially, there are two types of behavioral or disruptive disorders that are observed in children that often require professional intervention. The first condition is Oppositional Defiant Disorder, which is often referred to as ODD. These children experience a longstanding pattern of negative, defiant, or hostile behaviors. They will often lose their temper easily, argue with authority figures, and frequently blame others for their mistakes. These behaviors are often in response to some type of parental demand or interpersonal expectation. The second disruptive disorder, and much more serious, is called Conduct Disorder. Children with this condition may display aggression toward people or animals,

destroy property, steal, and in many cases, violate societal rule. It is important to note that not all children with Oppositional Defiant Disorder also have Conduct Disorder.

These behaviors should also be distinguished from typical or normative adolescent behavior. For example, many professionals and lay people suggest that defiance in adolescence is an expected behavior, and in many cases it is! Adolescence is a time of exploration and searching for identity and autonomy. Unfortunately, a pathway to finding this identity and separateness from parents comes in the form of acting-out or defiant behaviors. Not until a chronic pat-

tern emerges should parents become concerned and seek professional assistance. Children with Conduct Disorder and ODD should not be viewed as "budding psychopaths" or destined to future involvement with the legal system. In fact, only 50 percent of children with Conduct Disorder continue to experience like difficulties as adults. Rather, these are children who are simply acting bad, and in some cases, attempting to communicate

their psychological pain to others through their behaviors. A child with a behavior problem is simply a child with a behavior problem! Perhaps our society can look beyond the label of their behaviors and more into why the behaviors may be occurring. Our job as professionals, parents, and family members is to refrain from giving up, be mindful of the impact of labels, and provide unconditional support.



Being a Positive Sporting Parent

By: Jon Bair, MS



The rush I feel watching my son run up and down the field at his 4th grade soccer game is amazing. Who knew I would be privileged to such emotions from watching an athletic event? The downside of these situations are the negative emotions and behaviors that some parents exhibit at sporting events.

How exactly does being a parent, the number one fan of a son or daughter at an athletic event turn into an out-of-control and sometimes even dangerous situations like the shooting of a football coach this spring in Texas or the stabbing of a referee in Florida? Is that the kind of drama that happens only in other places, but not in our league or neighborhood? Or does it happen every day, maybe not as physically damaging as an assault, but in the form of rude statements towards the coach, referee and players. It is amazing to hear comments that flow out of the mouths of otherwise kindly folks, almost like a second language.

One need not look far to find the foundation for this behavior because it exists in all of us. The difference is some of us have much better coping mechanisms to keep emotional issues under control than others. If you look at three levels of human relations; rational, emotional and survival, you will find that rational reaction to events is the most difficult reaction to sustain because humans are chemically driven to be emotional. Additionally, our existence over thousands of years have required our survival reaction to many emotional events. Now add to that the fact that most sporting events for

both fans and players require emotions and instinct, which further drives away rational reactions. Therefore, sporting events are fertile grounds for negative, irrational behavior from normally nice, law-abiding parents.

Now that we have ascertained that sports whip us into an emotional frenzy; add into that the fact that we have a child who drives our protective (a type of survival) instinct. We do not want to see him or her hurt, embarrassed or humiliated. We are flooded with emotions when our child succeeds and overcomes the hurdles and milestones of sports, but we are crushed when he or she fails. Dealing with that flood of emotions is a difficult event with the best coping skills. Many parents add to the emotion by putting too much emphasis on the meaning of sporting success. They see their child's failure as a direct reflection on themselves. Their child then is inappropriately put in the position of satisfying the parents' ego needs. There is the old story of the father who wants to relive his youth through his child; he wants his child to succeed where he failed. This behavior puts tremendous pressure on a child and un-needed emphasis on the importance of performance at a sporting event.

So how do we battle this beast within? There is no easy answer, but it starts with knowledge. It's important to know that you will become emotional during sporting events. You can assume if you have had some difficulty during the day it's easy to lose emotional control during sporting events. Take a realistic, self-inventory about what you (the parent) want out of the activity for your child. Your rational thoughts might be for your son or daughter to learn a skill, learn to work with a team, develop socially, develop physically, or even learn how to handle emotional ups and downs. When the urge hits to yell at a coach or referee, fight with an opposing team parent, or even put down a child, remember the rational reasons you chose to have your child in sports. Does any of the negative behavior mentioned above correlate with the reason your child is playing sports? Calm or positive enthusiasm is just as contagious as bitterness and fighting. Have a fun and safe summer at the ball fields.