Keeping Youth Drug-Free: Prevention, Intervention, and Redemption

THE SCHOOL'S ROLE

By Paul Cannon and Carol Cannon

Picture an institutional board room with its long walnut table, rows of chairs, and wooden gavel. The chairman of the board is a remarkable young genius—a corporate wizard. The most qualified individuals available are members of the board. The meeting is called to order.

Satan gathered the fallen angels together to devise some way of doing the most possible evil to the human family. One proposition after another was made, till finally Satan himself thought of a plan. He would take the fruit of the vine, also wheat, and other things given by God as food, and would convert them into poisons, which would ruin man's physical, mental, and moral powers, and so overcome the senses that Satan should have full control.[1]

A master plan was thus put into effect to ensure the corporate takeover of the kingdom of God on earth. The scheme included a highly sophisticated marketing plan and well-defined organizational structure. It was an ambitious, foolproof design.[2]

In spite of, or perhaps *because* of, our inside information about the enemy's plan, some Adventists have overlooked the obvious: Our youth are *targeted* by the plot, not exempted from it! Have we complacently trusted that drug and alcohol problems would not threaten Seventh-day Adventist children? Did we ever think that as many as 40 to 50 percent of our

Picture removed

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youth would be experimenting with or abusing chemicals by the time they reach their sophomore year in college?[3] Or did we assume that our children had a "natural immunity" from substance abuse, that their conservative Christian upbringing provided them with magical protection?

Avoiding the Problem—Minimizing and Denial

Many are inclined to minimize our drug problem, concluding that few young people are involved and anyone "dumb" enough to use drugs and alcohol is "undesirable" anyway! This "minimizing reflex" rapidly neutralizes one's natural urge to help troubled youth. Even if there were only two or three young people in each church who were drinking or taking drugs, imagine how many that would represent! And the percentage in many areas is much greater than that.

Another commonly held view in Adventist circles is the "impotence syndrome." We convince ourselves that drug abuse is an inevitable developmental stage—a hazard of adolescence that can't be avoided. This attitude also leads to life-threatening noninvolvement.

Finally and most deadly is our "institutional denial system." Denial is drug abuse's best ally. Both the young person and his or her family are blinded by denial. Anything or anyone encouraging this reaction actually exacerbates

Denial is drug abuse's best ally.

the problem. The church, which serves as the larger family or ultimate parent figure to the drug-taking person, uses denial to protect its pride and reputation. Members and leaders go to great lengths to avoid facing the pain of exposure or to defend the myth that "a family ought to be able to take care of its own."

We must rid ourselves of these misconceptions and stop hiding from the facts. The need to combat drug abuse does not necessarily imply a failure on the part of parents, teachers, or the church.

When we were asked to write this article, we were given the topic "techniques for getting young people off drugs and keeping them drug-free." Would that it were so simple—like describing the proper technique for changing the oil filter on your car! However, inculcating realistic attitudes and addressing the problem in an effective way will not be easy.

To identify chemical dependence as sin, stupidity, weakness, lack of love or commitment to family or God is a serious oversimplification.

Addiction as Disease—A Strategic Premise

Although many Christians do not like to define addiction as a disease (because they feel it negates the *sin* aspect), this concept is fundamental to any helping ministry. Drug involvement is not necessarily a manifestation of underlying psychiatric illness or social problems. In our opinion, addiction is in itself a disease entity—not the symptom of another condition.

A 20-year-old male with a long history of drug abuse was persuaded by his family to visit a counselor. After conducting preliminary sessions with the whole family, the counselor informed the young man that drugs were not his *real* problem. Unwittingly, this professional reinforced the young man's denial. While it may have been true that other problems existed, until the primary one—drug dependency—was removed, none

Addiction is a diseased state of mind and body that can cause unpredictable actions and emotions.

of the others would yield to counseling.

To identify chemical dependence as sin, stupidity, weakness, lack of love or commitment to family or God is a serious oversimplification. We have yet to meet an Adventist addict who uses the disease concept as an excuse to justify his or her excesses. Instead, the concept seems to give the young person a grip on the problem and an approach to developing a positive life-style that leads to recovery.

Therefore, we consider the premise of addiction as a disease to be critical. Ellen White says that alcoholism is both a physical and moral disease.[4] Initially, a wrong moral choice is clearly implicated. However, once the chemical has saturated the system, *it* is in control; with repeated use, a disease of mind and body ensues. The physical organism has incorporated poison into its functioning and requires it as fuel. Now, more than choice is involved. The body has been damaged.[5] Teachers and parents need to realize the implications of this phenomenon.

Two inebriated college students came to our home one Friday night while we were teaching at an Adventist college. We talked with

them for hours, discussing religious matters and conversion. They were touched during the conversation and made a commitment to Christ. We were elated. However, the next morning they remembered nothing.

A Multifaceted Recovery Program

Early in our rehabilitative work for chemically dependent Adventist youth, when we treated addiction as a symptom of other problems, our efforts, though sincere, were only minimally successful. Once we began to appreciate the multifaceted nature of the drug problem, to understand that it is a disease and to provide a broad range of recovery skills, we saw significant results. The spiritual aspect always holds highest priority, but treatment must not exclude physiological, emotional, social, and moral aspects of the problem.

Jay was a sensitive boy—talented, musical, and creative. No one knows why or how he got involved with drugs but by the time he finished academy, he was in trouble. His family had no background of information about drugs and no idea where to turn for help. As is natural for Christian parents, they felt that all the strength necessary should be forthcoming from the Lord.

They tried an Adventist psychiatric unit and then a physical rehabilitation center. Neither of these programs was drug specific. No one thought to contact drug recovery professionals. Jay did not respond. His pastor did everything possible—prayed with him, read the Bible, encouraged him regularly in person and by telephone. The boy struggled valiantly to stay straight. However, one Sabbath he went to church, participated in communion, and returned home. That night, feeling utterly discouraged, he took his life.

Mike too was a gifted boy. He floundered in academy and got into drugs. After graduation he seemed to drift from failure to failure. Jobs, relationships—nothing worked out. He moved deeper and deeper into the world of chemicals, disappearing before his parents' eyes "into a darkness . . . , from which neither hugging nor hitting could bring him."[6] His parents discovered an inventory of marijuana in his room. By now desperate, Mike turned to God. He wanted to go to college and train for a meaningful career. He began to study the Bible and pray. He applied to an Adventist school and was accepted. Then he shot himself fatally.

To achieve successful intervention, every school must have a network of knowledgeable personnel, including the principal, who are qualified to address the growing problem of drug and alcohol abuse.

Long-term Support Needed

These dramatic stories underscore the fact that addiction is a diseased state of mind and body that can cause unpredictable actions and emotions. Prolonged polydrug abuse calls for both prayer *and* emergency treatment. Initial physical withdrawal can be easily managed with medical help. However, we dare not throw chemically dependent adolescents out into the world unprepared to cope drug-free. They need long-term support and an opportunity to develop the inward strengths necessary for survival. Otherwise they will relapse and/or die.

Depression is a common and normal byproduct of drug withdrawal. The chemical chaos in the brain sometimes creates psychotic symptoms for several months. These conditions may cause bizarre and undesirable side effects, even in those who are well informed about drug abuse. Consider the case of a young physician who thought he was well qualified to manage his own drug withdrawal because of his professional training. He also died by suicide.

Four Stages of Drug Use[7]

A description of the four-stage progression into chemical dependence follows. The choice of appropriate treatment must correlate with the person's location on the continuum. A specialized treatment program is mandatory in *every* case in which the drug problem has developed beyond Stage 2.

Stage 1. Learning the mood swing. The child's initial experiments with drugs is Stage 1. Lennie's first thought when he smoked pot was, "Wow, this is the feeling I've been waiting for all my life." This reaction pointed to the addiction to follow. A person inexperienced in the use of mind-altering drugs has no idea how it will feel, but he or she learns quickly that in *X* period of time, if he takes *Y* drug, he will have *Z* reaction. The user learns to identify the mood swing. If he or she happens to like it, Stage 2 may ensue.

Stage 2. Seeking the mood swing. The young person begins to actively seek the coveted feelings by planned use of drugs, graduating from weekend to weekday use. He or she experiences eu-

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secular courses. About 11,000 students are affected in one locale, more than 25,000 in the other. Also, the Reagan administration, which had been pushing for more public involvement in private schools, is nursing a wound.

By implication the rulings indicate at least the following:

1. The high tribunal remains capable of emphatic reaffirmations of church-state separation despite the "conservative" or "accommodating" tendency of its 1983-1984 rulings.

2. In judging aid to parochial schools the three-part test adopted in the 1971 case of *Lemon v. Kurtzman* is alive and well. Under that test a law or program is permissible if its purpose is secular, if its primary effect is neither to advance nor inhibit religion, and if excessive entanglement of government and religion is not fostered.

3. The notion that some curricular aspects of parochial schools are "purely secular" is dubious, as are some of the child-benefit theories currently used to defend parochiaid.

The finding that on-site neutral services are not constitutional is reverberating nationwide. A chorus of sympathy for disadvantaged pupils, many of whose most urgent educational needs may now go unmet, is being heard. The morale of the participating high school teachers is down—they had vowed to function in a strictly separationist way, but now find their integrity being questioned.

There is also a search for alternative, more acceptable kinds of aid to parochial schools. Catholic leaders, for example, may put public school instructors in mobile classrooms parked adjacent to Catholic schools, or bus parochial students to nearby public schools during or after school hours (release-time in reverse). Third-party providers of remedial instruction (educational television) and neutral sites (such as storefronts) are also under consideration. Meanwhile, the White House is striking back with shopworn proposals to give parents of children in affected schools a tuition tax credit or an expendable voucher—proposals whose fate is uncertain.

Since 1971, the Court has reviewed more than a dozen varieties of aid to parochial schools. Only one or two have passed constitutional muster, most notably Minnesota's provision of a tax break for the payment of tuition. Right now Government's revenue preoccupations bode well for critics of parochiaid, as does the Supreme Court's careful scrutiny of practices that are litigated on church-state grounds. □

Sources of Materials

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riculum for elementary schools in New York state. For information, write to TEMPCO, Inc., P.O. Box 1982, Topeka, KS 66601.

8:30 Monday Morning is an alcohol prevention project for use with young people in grades 7 through 12. It is available from American Business Men's Research Foundation, Suite 1208, Michigan National Tower, Lansing, MI 48933.

The Peer Education Manual on Alcohol and Drugs for grades 7 through 12 costs $65 and is available from the County of Riverside Health Department, Attention: Monzoor Massey, 3575 11th St., Riverside, CA 92501. □

AU Educational Research Index

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Ladd, Karen. *A Comparative Study of the Psychological Profiles of a Selective Sample of Incarcerated Females Versus Non-Incarcerated Females,* August, 1984, 179 pages, Futcher.

Lukman, Roy L. *Androgynous Coping Behaviors: A Test of Bem's Sex-Role Theory,* July, 1983, 107 pages, Blitchington.

Melgosa, Julian. *Occupational Identity Assessment Among Middle and Late Adolescents,* March, 1985, 231 pages, Cruise.

Napper, Byron P. *A Comparative Study Between the Black and White Seventh-day Adventist Seminarians Concerning Their Attitudes and Perceptions of Their Ministry Relative to Selected Social and Theological Issues,* August, 1983, 257 pages, Harris.

Purcell, Stephen L. *An Empirical Study of Relationship Between Religious Orthodoxy Defined as Religious Rigidity and Religious Closed-Mindedness and Marital Sexual Functioning,* April, 1984, 183 pages, Thayer.

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Keeping Youth Drug-Free

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phoric highs with mild discomfort coming down. As a result, the user begins to develop a tolerance for the substance. Behavior changes occur; the user becomes moody, hostile; loses interest in hobbies and school; begins to have problems with the law. What started as *a* way to feel good (in Stage 1) becomes *the* way to feel good.

Stage 3. Preoccupation with drugs. Now the young person's whole life revolves around drugs. Being high is his or her sole interest. At this stage the drugs of choice are marijuana, alcohol, nicotine, pills, and sometimes cocaine. He steals and deals. Because body tolerance has increased greatly, the user feels physical and psychological distress when off drugs. After the euphoria, there is a backswing into pain. By this stage, the young person has severed relationships with straight friends and begins to experience school failure, police incidents, job

loss, and physical deterioration. Pathological lying becomes a way of life. Drugs are now *the only way* for the young person to feel good.

Stage 4. Total obsession with drugs. At this advanced stage, the young person no longer feels pleasure from drinking or getting high. Drugs are used simply to keep from feeling bad. The user will take anything available. He or she gets careless in purchasing drugs and hiding the hardware. The confirmed user feels chronic anxiety and depression, even paranoia. He or she experiences extreme guilt, remorse, and ego erosion.

Tom, a young drug abuser, described it this way: "The devil offered me everything I ever wanted. But he came back to collect when I could least afford it. He took my wife, my business, my health, my money, my self-respect, everything." For the addict at this stage, drugs are the only way to avoid feeling awful. Life is no longer worth living.

How Long Does It Take?

Whereas an adult who abuses alcohol may require 7 to 12 years to become fully addicted, an adolescent abusing only alcohol may reach this stage in two years or less. The younger the child, the more quickly he or she will succumb. If the young person uses several drugs, full addiction may occur in just six months.

Certain other factors also influence the child's vulnerability to addiction, such as (1) parental addiction, which seems to create a physiological predisposition; and (2) extremely rigid, authoritarian parental attitudes, which may cause the young person to rebel and reject family values. Furthermore, teenagers from very conservative fundamentalist families are more likely than those from liberal backgrounds to engage in binge drinking, which is more predictive of alcoholism than drinking smaller amounts on a regular basis.

Those wishing to help drug-dependent youth must accommodate their response to the stage of the addict. A general rule of thumb is that spontaneous self-managed withdrawal is impossible beyond the middle of Stage 2. Promises notwithstanding, an addict cannot quit by himself. Moving the young person to a different school, going to a psychiatrist, offering bribes and ultimatums, suggesting rules and contracts—all are futile. Specialized treatment is the *only viable option.* In Stages 1 and 2, counseling, awareness classes, geographical changes, and family contracts *may* be effective.

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How do you get young people off drugs and keep them drug free? Teachers and administrators must recognize the problem and refer the student to someone who knows how to treat it.

Intervention

Effective intervention requires that the drug problem be recognized and that a caring adult intercede with both the young person and the family in order to intercept the user's downward spiral. This is the school's obligation. Treatment and drug abuse counseling are not the school's prerogative any more than performing surgery or prescribing contact lenses would be. However, detecting and diagnosing *anything* that interferes with the educational process is the school's responsibility. Teachers must recognize medical problems, mental handicaps, and drug involvement in order to make appropriate recommendations to parents.

Vernon Johnson, pioneer alcoholism treatment specialist, conducted a series of case studies among recovering addicts. He asked, "What event and which people caused you to realize and admit that you needed help? How did they do this? What events or persons, in your opinion, were not helpful but rather prolonged your inability to recognize your illness? Why?" The alcoholics' replies can be summarized in two general statements: (1) Those around the alcoholic need a greater knowledge of the nature of the illness; and (2) This knowledge must be applied by these meaningful persons to directly, consistently, objectively, and nonjudgmentally confront the alcoholic with the reality of his or her condition.[8]

Notice that this does not imply nagging, pleading, bribing, scolding, weeping, or threatening, but rather an *objective, nonthreatening* confrontation. Three specific components must be present to achieve an effective intervention: (1) a statement of objective fact, (2) an expression of the intervener's feelings, and (3) a message of positive care and concern.[9]

Mrs. Bixler, an academy typing teacher, observed a change in one of her pupils over summer vacation. Lori's performance in class was uncharacteristically low and her appearance and attitudes had deteriorated noticeably. Mrs. B gained the confidence of one of Lori's close friends and learned that Lori had been drinking and smoking marijuana during the summer. Because Mrs. B knew that Lori's family had a history of

alcoholism, she decided to step in immediately. Her approach was as follows:

(Statement of objective fact) "Lori, last year you were one of my star pupils; I was very proud of you. But this year things seem different. I believe that alcohol has become a problem in your life and has caused you to change in ways you can't see."

(Expression of speaker's feelings) "As your daily papers got worse and your errors multiplied, I felt more and more disappointed, because I had hoped to train you to work for me second semester. Now I'm just plain worried about you."

(Message of positive care and concern) "I have so much faith in you, Lori. I'd like to help you get back on your feet before things get more serious." This approach is followed by a recommendation for assessment and/or referral to a treatment program appropriate to the stage of addiction.

Rarely is an intervention as simple as the one described above. Parents, as partners in denial, often require an intervention themselves, which must be done very tactfully and skillfully by school administrators. Obviously, to achieve successful intervention, every school must have a network of knowledgeable personnel, including the principal, who are qualified to address the growing problem of drug and alcohol abuse.

Recommendations[10]

1. Administrators and school personnel must be provided with accurate and up-to-date information about drugs and drug abuse. Where there is a credibility gap, there will be a gullibility fill. Educators must know more about drugs and alcohol than their students if they hope to help their pupils choose a drug-free life.

2. Conference educational departments should develop in-service training programs for supervisors, administrators, and teachers.

3. Local school administrators should arrange for drug and alcohol awareness presentations to the school board and parents. Many communities have excellent drug education programs that can be of assistance in this area. A cooperative community involvement plan could be of inestimable value.

4. Join the Association of Adventist Parents for Drug-Free Youth and develop a parenting organization or local parent support group for families of drug- and alcohol-involved Adventist youth. For information, contact *Listen* magazine, 6830 Laurel St. NW, Washington, D.C. 20012.

[In drug information,] where there is a credibility gap, there will be a gullibility fill.

5. Institute an early intervention curriculum in academies for students caught using drugs or alcohol. Such a program gives these students the option of joining a drug awareness class as a disciplinary alternative. During ten one-hour sessions, they assess their level of addiction and develop their own treatment plan. This is done in cooperation with the parents. For information on the DARE (Drug Awareness and Responsibility Education) program, contact The Bridge, 1650 Pleasant Grove Rd., Bowling Green, KY 42101.

6. Design consistent, uniform working policies for your school. This will require an educated school board.*

7. Set up an intervention team drawn from school faculty and administration to whom other teachers and work supervisors can report behaviors of concern for follow-up and assessment.*

8. On the college level, provide support groups for young recovering Adventist alcoholics and addicts. The 12-step program of Alcoholics Anonymous is very useful, but it is difficult for a recovering Adventist addict to find an A.A. group that is smoke-free; thus a "clean-air" support group on campus would be beneficial.

9. Manifest greater compassion for the weak. Good children from wonderful homes get into drugs. We need to cut through traditional stereotypes and stigmas to offer our fellow strugglers the understanding we would want if we were in their place.

10. Take special note of this inspired mandate:

> In the midst of churches, religious institutions, and professedly Christian homes, many of the youth are choosing the path to destruction. Through intemperate habits they bring upon themselves disease, and through greed to obtain money for sinful indulgence they fall into dishonest practices. Health and character are ruined. Aliens from God, outcasts from society, these poor souls feel that they are without hope either for this life or for the life to come. The hearts of the parents are broken. Men speak of these erring ones as hopeless; but not so does God regard them. He understands all the circumstances that have made them what they are, and He looks upon them with pity. This is a class that demand help. Never give them occasion to say, "No man cares for my soul."[11] □

*Sample drug policies for schools and a list of behaviors of concern are available from the Bridge Fellowship, Inc., 1640 Pleasant Grove Rd., Bowling Green, KY 42101.

FOOTNOTES

[1] Ellen G. White, *Temperance* (Mountain View, Calif.: Pacific Press Publishing Assn., 1949), p. 12.

[2] *Ibid*, pp. 13, 14.

[3] This figure is not based upon documented evidence, which is not yet available, but rather upon subjective data and limited surveys of juniors and seniors at a variety of boarding and day academies located in rural and urban areas of the South and Midwest United States. Additional

input was obtained from academy principals and college dormitory deans. The surveys inquired about respondents' involvement with tobacco, alcohol, marijuana, "uppers" and "downers," cocaine, and heroin.

[4] _____, *The Ministry of Healing* (Mountain View, Calif.: Pacific Press Publishing Assn., 1969), p. 172.

[5] *Temperance*, p. 36.

[6] Grace Paley, *Later the Same Day*, quoted in *Time* 125:15 (April 15, 1985), p. 98.

[7] Adapted from Miller Newton, *Gone Way Down* (Tampa, Florida: American Studies Press, 1981), and Vernon Johnson, *I'll Quit Tomorrow* (New York: Harper and Row, 1973).

[8] Vernon Johnson, "Why Do They Have to Suffer So Long," pamphlet (Center City, Minn.: Hazelden Educational Materials, n.d.).

[9] Sharon Wegscheider, "Inside Structured Intervention," *Alcoholism Magazine* (July-August, 1982), p. 35.

[10] Recommendations and other information in this article drawn from the "Capable of Caring" program—a drug-awareness workshop for concerned Seventh-day Adventist educators, parents, and leaders, by Paul and Carol Cannon, The Bridge Fellowship, Inc., Bowling Green, Kentucky.

[11] *The Ministry of Healing*, pp. 171, 172.

Influencing Legislation

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citizen involvement in temperance laws.

There can never be a right state of society while these evils exist. And no real reform will be effected until *the law* shall close up liquor saloons, not only on Sunday, but on all days of the week. The closing of these saloons would promote public order and domestic happiness.—*Temperance*, p. 208.*

The honor of God, the stability of the nation, the well-being of the community, of the home, and of the individual, demand that every possible effort be made in arousing the people to the evil of intemperance. Soon we shall see the result of this terrible evil as we do not see it now. Who will put forth a determined effort to stay the work of destruction? . . .

Let the voice of the nation demand of *its lawmakers* that a stop be put to this infamous traffic.—*The Ministry of Healing*, p. 346.*

*Italics supplied.

We should not work solely for our own people, but should bestow labor also upon noble minds outside of our ranks. We should be at the head in the temperance reform.—*Temperance*, p. 220.

In other churches there are Christians who are standing in defense of the principles of temperance. We should seek to come near to those workers and make a way for them to stand shoulder to shoulder with us. We should call upon great and good men to second our efforts to save that which is lost.—*Testimonies for the Church*, vol. 6, p. 110.

Reaching Legislators With Your Concerns

Letters to legislators and concerned groups are read with great interest. Such correspondence greatly influences the votes of congressmen and state representatives. Letters from children and young people are very effective in shaping the opinions of lawmakers regarding healthful living. Here are a few principles to keep in mind when you and your students write to such people:

1. Write in your own words.
2. Be brief.
3. Give your reasons for taking a stand on the topic you are writing about.
4. Ask for a response.
5. Be kind and courteous.
6. Use the facts and be accurate.
7. Write a letter of thanks if you get a response.
8. Don't write on every issue.
9. Keep copies of your letters.
10. Keep informed on legislative issues. Be extremely vigilant.

Remember, your efforts to obtain good laws and ban commercial advertisements for health-destroying substances demonstrate love in action. □

Caffeine—A Drug of Educational Concern

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creation of a false energy, and its anxiety-producing properties are significant hazards. Its practical effects on test performance should particularly be noted. Students should realize that using caffeine may prevent them from achieving the academic success that they seek.

Students who are high on caffeine are . . . likely to be disruptive, belligerent, and less receptive to instruction.

In closing, Ellen White's counsel is inspired wisdom for us today: "Tea is poisonous to the system. Christians should let it alone."[13]

"Coffee is a hurtful indulgence. It temporarily excites the mind, . . . but the aftereffect is exhaustion, prostration, paralysis of the mental, moral, and physical powers."[14] □

FOOTNOTES

[1] Ellen G. White, *The Ministry of Healing* (Mountain View, Calif.: Pacific Press Publishing Assn., 1909), pp. 326, 327; _____, *Testimonies for the Church* (Mountain View, Calif.: Pacific Press Publishing Assn., 1948), vol. 2, pp. 64, 65.

[2] Institute of Alcoholism and Drug Dependency, "Influences Promoting Abstinence From Alcohol and Drugs Among North American Youth Delegates," Technical Report 85-1. Berrien Springs, Michigan, Andrews University, 1985.

[3] B. A. Mosher, "Caffeine," Report by American Council on Science and Health, 1984. For information write to 1995 Broadway, New York, NY 10023.

[4] P. Mutch, "What's All the Fuss About Caffeine?" *Listen*, vol. 37, No. 1 (January, 1984), pp. 10-13; J. Scharffenberg and F. Soper, "What's in That Coffee Cup?" *Listen*, vol. 38, No. 8 (August, 1985), pp. 10-14; Richard H. Zander,

NOTE

Because of space limitations, this article has dealt primarily with alcohol and tobacco. However, many opportunities can be found to influence legislation dealing with the manufacture and distribution of both legal and illicit drugs, such as tranquilizers, amphetamines, marijuana, hallucinogens, cocaine, and heroin.