

## In The News


### STAFF NOTE

It's a new name, but the same face. July 5, 2002 marked a big, but welcome, change in my life, when I married Jack Keating. I've been doing a gradual transition at the office, from *Kittelson* to *Keating* and my email address is now [keatingl@ada.org](mailto:keatingl@ada.org). In the meantime, I remain...Linda K.

### WB2003

 "SAVE THE DATE" for the 10<sup>th</sup> National Institute on Dentist Well-Being! The dates will be **September 4-6, 2003**, the Thursday-Friday-Saturday following Labor Day. The program title is "**Living, Loving, Working**," and sessions will be organized into three tracks: Families, clinical issues, and regulation and monitoring. There will be a special registration rate to encourage couples to attend together. Rooms are blocked at the Ritz-Carlton for conference attendees, and September is a GREAT time to visit Chicago! Attendees from the 2001 conference asked that we honor those who have attended all ten of the Well-Being Institutes. We will do this, and participants are invited to bring along old photos to share.



 **2003** will also mark the awarding of the first-ever Golden Apple Award for Excellence in Dentist Well-Being Activities! One award per year may be given to a constituent or component dental society whose well-being program demonstrates innovation, collaboration and efficacy. Information on this and the other Golden Apple Awards is on its way to the constituent societies. This first award will be presented at the Well-Being Institute.

**T**he Dental Section of the University of Utah School on Alcoholism and Other Drug Dependencies boasted its largest attendance in years, this past June in Salt Lake City. Drs. Pat Sammon of Kentucky and Mary Martin of Oklahoma served as section co-leaders. Participants gave the program's content and presenters high marks; students in attendance related how moving and informative the week had been for them.



**DISCLAIMER**  
This publication is informational only and does not constitute professional advice; readers must consult with their own advisors for such advice. The American Dental Association does not necessarily endorse any of the information, recommendations, products and/or services of non-ADA resources that may be identified herein.

**Dentist** involvement in IDAA (International Doctors in Alcoholics Anonymous) is noteworthy also. Last year's meeting was held in Palm Springs, CA, in August. Dentists were involved in key leadership positions, in continuing education, and as participants. More information about IDAA is available at [www.idaa.org](http://www.idaa.org) or by contacting Gordon L. Hyde MD, executive director, 3311 Brookhill Circle, Lexington, KY 40502, telephone: 859-277-9379. The 2003 meeting will be August 13-17 in Mobile, Alabama.



**A BIG THANKS** to Dr. Jamie Manders and all the Louisiana dentists who volunteered to help staff the well-being booth at annual session in New Orleans in October. We had a nice representation of dentists from other constituents as well, along with a great location and terrific materials. If you *and* your heart will be in San Francisco in October 2003, plan to spend a couple hours with us—or at least drop by and say hello!

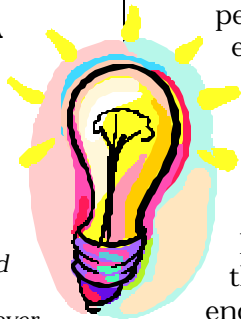
**F**OR THE DENTAL SCHOOLS:  
"Safeguarding Your Students Against Suicide" is a compilation of proceedings from an expert panel, co-sponsored by the National Mental Health Association and the Jed Foundation, to address the issue of suicide on college campuses. The document is specifically targeted to the 18-24-year old population, but those who are involved in student services in the dental schools may find many items of interest. The report contains statistics on incidence and prevalence of depression, suicidal ideation and suicide attempts among student subgroups (gender, age, ethnicity, etc.) and offers suggestions of prevention activities. More information can be found at [www.nmha.org/suicide/idex.cfm](http://www.nmha.org/suicide/idex.cfm).

**A** group called the National Partnership for Workplace Mental Health has prepared a free guide, "When Disaster Strikes: Managing Mental Health in the Workplace." Printed copies are available upon request from the American Psychiatric Association ([info@workplacementalhealth.org](mailto:info@workplacementalhealth.org)).

The brochure can be viewed and downloaded from [www.workplacementalhealth.org](http://www.workplacementalhealth.org). It contains information on disaster preparedness, normal reactions to natural or manmade disaster, mental "first aid" and the basics of self-care, how to determine if professional help is needed and a variety of other pertinent topics.

### HOW IT WORKS— IN NORTH CAROLINA

*Margie Graves, executive director of the North Carolina Caring Dental Professionals Program, wrote the following article. In it, she talks about a significant change in their mission, with the expansion of services to dental hygienists, and shares how she has tackled the problem of being one person to cover an entire state.*



Over a year ago, I took on the challenge of moving the North Carolina Dental Professionals to their next level of development as a fairly new Assistance and Advocacy Program for impaired dentists and dental hygienists in North Carolina. The Program had been developed in the mid 90's by a recovering dentist and a member of the Board of Dental Examiners who realized the need for an Assistance Program for Dentists in North Carolina. Recently, the State Legislature opened the Program to dental hygienists in NC. This year the Board of Directors also reviewed and updated our Bylaws and Guidelines to accommodate the addition of the hygienists. At this time, as the only paid full time employee, I realized that I needed to utilize all the volunteers we have who are on our committee as well as external consultants in order to move ahead. One of my plans this year has been to regionalize the State geographically, with a Volunteer Regional Liaison in each area. I used a model that I had seen

develop and flourish with our Charlotte group and realized that this group had great peer support and recovery was happening! We ask that the Liaison from each area meet at least two times monthly (some meet each week) for a meeting prior to attending a caduceus meeting with all the folks in his/her area. Sometimes these meetings are informal; however, quarterly I attend a meeting in each area to discuss pertinent issues, and to offer education and sharing. We are new in the endeavor, but reports have been favorable from the three areas "trying" to implement the plan. I have one area of the State that does not yet have enough participation to successfully implement the plan....but we are working on that.

One of the ways I've also found it helpful to manage the large geographical area of NC and our participants monitoring is to utilize a computerized monitoring company for urine drug screens. We also utilize our Volunteer Peer Assistants to help with interventions, education and speaking as well as one-to-one monthly personal contacts with our folks. I would not have been able to manage our cases and do the administrative work involved with the Program without their help.

The NC Caring Dental Professionals publishes a state-wide newsletter four times per year....that always generates calls and questions from interested parties. We currently mail to approximately 7,500 licensed dental hygienists and dentists who reside in North Carolina. I also have tried to utilize our dental society quarterly newsletter, our Board of Examiners newsletters, the

hygienist's newsletter as a forum to let folks know about the Program as well as mental health and substance abuse issues. Our fall conference this year was held together with the Physician's Health Program in North Carolina and was over a Friday, Saturday and Sunday. I did a "dental break out" session on Friday afternoon. However, we mixed and mingled with all the conference participants and volunteers from both Programs for the remainder of the weekend, enjoying great speakers and warm fellowship. Our dental folks have reported this was a favorable experience and we will hopefully try and do this again in a couple of years. We also are continuing to develop a support network of "recovering partners." This group began last year and we have found that we are able to support newly "recovering partners" through telephone networking. We have had a meeting of the "partners" at each of our events over the past year.

As 2003 begins, our next major goal will be to begin fund raising in order to provide loans and some educational scholarships to help with recovery needs. This is an exciting time for the NC Caring Dental Professionals and for myself as the Executive Director. Much of my prior experience has been in program development and my role

with this Program has allowed me to utilize my clinical and administrative background to enhance assistance and advocacy services to dental professionals in North

Carolina.

**(Note: The Bylaws of North Carolina Caring Dental Professionals, Inc., were revised as of May 2002. Contact Margie Graves for further information at 800-230-3934 or at [mgraves@nccaringdental.com](mailto:mgraves@nccaringdental.com).)**



Reuters Health (November 29, 2002) reported on a paper presented at the meeting of the American Gerontological Society, on the differences seen in men and women over-65 as they adjust to the loss of a spouse. The women in this study were more likely to feel stronger and more independent following a spouse's death, while the men found



themselves without a social support network and were more likely to be interested in dating and remarriage.

**Speaking** of grief, *The Wall Street Journal* (November 20, 2002) recently ran a column on the 'cost' of grief in the workplace. The death of a loved one is by far the most 'expensive' in terms of lost productivity, but even the loss of a pet can take a toll. Workers are best able to deal with their loss when they perceive the employer to be compassionate and when there is some flexibility for breaks. The Grief Recovery Institute has a wealth of information and resources that may be helpful to individuals or to organizations. Their website address is [www.grief-recovery.com](http://www.grief-recovery.com).

The American Psychological Association has published the Proceedings and Recommendations from the "Summit on Women and Depression," held in 2000. Women are twice as likely as men to experience a major depressive episode; papers presented at the summit explored possible explanations for this difference. Genetic risk may be different for men and women; hormonal differences may play a role as well as



differences between genders in socialization and societal norms. The proceedings indicate that women may be more likely than men to become depressed in response to a stressful event, and that major psychological differences in the importance of interpersonal relationships may also contribute to the illness. The document is available in full at <http://www.apa.org/pi/wpo/women&depression.pdf>.

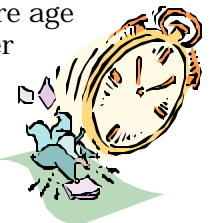


"Coaching" is a burgeoning movement with some possible application to well-being services. The *Psychotherapy Networker* published an article by senior editor Jim Naughton that looks at coaching from a variety of perspectives—what it is, who's doing it, who's hiring coaches, what it can and can't do. Various coaching models, Naughton says, have their roots in industrial and organizational psychology, psychotherapy, the human potential movement, or New Age metaphysics. In the simplest terms, coaches are hired to help individuals clarify needs and desires, set goals for change, and follow through on strategies to make the change. Coaching is an unregulated endeavor, though the International Coach Federation has training requirements for certification; several universities now offer coaching courses.

While many coaches are former therapists, many practitioners have little, if any, formal training in psychology. Naughton speculates that the public sees coaching as being free of the stigmatized

connotations of therapy. Men, in particular, he says, are attracted to the familiarity of an athletic model and the context of "the male-dominated world of the executive workplace." There is as yet little empirical data about coaching's effectiveness; its critics worry about poorly prepared practitioners exploiting vulnerable clients. (Naughton, J., *The Coaching Boom*. *Psychotherapy Networker*, July/August 2002, pp. 24-33).

Long-term consequences of early (i.e., before age 17) use of marijuana were studied in a group of 311 twin pairs in Australia. At the time of the study, median age of participants was 30. Each set of twins was discordant for early marijuana use—in other words, one member of the pair did initiate use before age 17, and the other did not. The early users were found to have a marked increase risk of other drug use as well as significantly increased odds of developing dependence on alcohol or other substances. This finding was not related to whether the twins were monozygotic. The authors did not speculate on why just one twin would be using cannabis, but did posit that early positive experiences with marijuana may encourage experimentation with other substances and bring young people into contact with dealers or peers with access to other drugs. (Lynskey, MT et al, *Escalation of Drug Use in Early-Onset Cannabis Users vs. Co-twin Controls*. *JAMA*: 289 (4), 427-433.)



Researchers at the University of Michigan in Ann Arbor have conducted an intensive study of postmortem brain samples of 35 known cocaine abusers and 35 non-drug users. Standard measures for the condition of dopamine brain cells were significantly lower in users than non-users. These changes offer a possible biochemical explanation for cocaine withdrawal symptoms and the depression often seen in chronic users. (Reuters Health, January 1, 2003.)



one estimate, people with psychiatric disorders smoke half of all cigarettes consumed in the United States, and depression is their most common problem.” Nicotine addiction is also associated with alcoholism and other substance use disorders, generalized anxiety disorder and panic disorder. Whether smoking is a cause or result of these disorders is not known. Approximately 90% of those with schizophrenia are addicted to nicotine, however, and this is thought to be an effort at self-medication.

The National Institute on Drug Abuse (NIDA) has a new publication, *Science and Practice Perspectives* that aims to improve the dialogue between researchers and clinicians working in the area of drug abuse. For its inaugural issue, Drs. Thomas R. Kosten and Tony P. George wrote an article, “The Neurobiology of Opioid Dependence: Implications for Treatment,” that is a review of new research in the areas of brain structure, function, and action of neurotransmitters. Opioids have effects on multiple brain processes to produce liking for the drug, tolerance, dependence, and addiction (meaning intense cravings and compulsive drug use). Findings from recent scientific research seem to support the “changed set point” theoretical model of addiction; opioids act upon the nucleus



A comparison study of young (average age 22), heavy marijuana users (average 91 joints/week) and peers who smoked less (average 11 joints/week) revealed a severe impact on memory, intellectual reasoning functioning, and manual dexterity. Researchers noted that those particular mental functions are controlled by the hippocampus, prefrontal cortex and cerebellum, areas that have rich concentrations of cannabinoid receptors. One of the things that was particularly significant about this study is that all participants had documented abstinence from marijuana for thirty days prior to testing. (Reuters Health, November 29, 2002.)

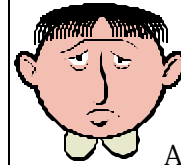
**The Harvard Mental Health Letter** (August 2002, pp. 6-7) carried a story on smoking and depression. The article notes that the proportion of smokers within the American population has decreased from 40% to 25% in the last 40 years. There is a strong correlation between smoking and psychiatric disorders—the article states that, “according to



accumbens to raise the level at which dopamine is released, so that those activities (eating, sex, exercise, etc.) that would normally stimulate the release of dopamine are no longer able to do so in the brain of chronic users. Treatment implications of neurobiological findings include patient education, behavioral interventions (avoiding trigger-

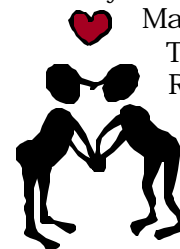
filled situations, for example) and pharmacological agents (such as naltrexone). Subscriptions to this journal are available by faxing a request to: 240-632-0519 or emailing

[nidaperspectives@masimax.com](mailto:nidaperspectives@masimax.com). The publication may also be viewed on NIDA’s website, [www.drugabuse.gov](http://www.drugabuse.gov).



Another study has come out of the National Longitudinal Alcohol Epidemiological Survey, about the association of major depression with a history of alcohol dependence. Rates of recent or current depression (using *DSM IV* diagnostic criteria for major depression) assessed among persons diagnosed with alcohol dependence but who had not drunk for at least one year. The risk of depression among this group was approximately four times that experienced by people without a history of alcohol dependence. Of note was the finding that “the majority of subjects with major depression used substances two or more years prior to the interview, which eliminates acute intoxication or withdrawal effects as an explanation of their depressions.” (Hasin, DS and Grant, BF, Major Depression in 6050 Former Drinkers: Association with Past Alcohol Dependence. *Archives of General Psychiatry*: 59 (9), online at <http://archpsyc.ama-assn.org>.)

**The Wall Street Journal** (8/6/02) ran an article called “How Eye-Rolling Destroys a Marriage; Researchers Try to Predict Divorce Risk,” on new research into marital dynamics. The strongest marriages are those where



positive interactions outweigh negative ones by at least five-to-one, where the couple has high expectations for marriage, and where the couple have traditional views of gender roles. Marriages at greatest risk are those where interactions are characterized by contempt, criticism, defensiveness and stonewalling.

Dr. George E. Vaillant, the Harvard psychiatrist who is perhaps best known for his longitudinal research of physician health, is a Class A (nonalcoholic) trustee for the Alcoholics Anonymous (A.A.) General Service Board. Writing in the Fall/Winter 2002 edition of *About AA: A Newsletter for Professionals*, he has this to say:

“Singleness of purpose is essential to the effective treatment of alcoholism. The reason for such exaggerated focus is to overcome denial. The denial associated with alcoholism is cunning, baffling, and powerful and affects the patient, helper, and the community. Unless alcoholism is kept relentlessly in the fore-ground, other issues will usurp everybody’s attention.”

SAMHSA (HHS’ Substance Abuse and Mental Health Services Administration) released findings from the 2001 National Household Survey on Drug Abuse as it kicked off observance of National Drug and Alcohol Recovery Month (September). The press release is packed with data, including the following:

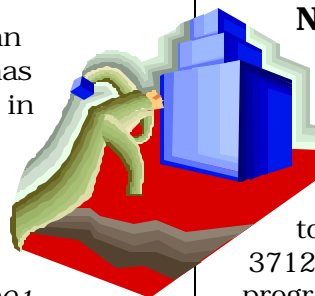
- Current illicit drug use increased in persons age 12 to 25, from its prevalence in 2000; rates of use among adults 26 and over remained stable.
- The number of persons who had ever tried Ecstasy (MDMA) was 8.1 million in



2001, compared with 0.7 million in 1998.

- 957,000 persons reported use of Oxycontin for non-medical purposes at least once in their lifetime in 2001; 221,000 reported having done so in 1999.
- The number of persons with substance dependence or abuse in 2001 is estimated to be 16.6 million, or 7.3% of the population. In announcing the study, Dr. John Walters, director of the Office of National Drug Control Policy, noted, “We have a large and growing denial gap when it comes to drug abuse and dependency in this country.” A full report is available at [www.DrugAbuseStatistics.sahsa.gov](http://www.DrugAbuseStatistics.sahsa.gov).

A study on physician career satisfaction has just been published in *JAMA* (Landon, BE et al., “Changes in Career Satisfaction Among Primary Care and Specialist Physicians, 1997-2001. *JAMA* 289:4, 442-449). When findings from across the country were analyzed in the aggregate, 80.1% of primary care physicians (family practice, internal medicine, pediatrics and ob/gyn) indicated they are either very satisfied or somewhat satisfied with their careers; 17.9% are either very dissatisfied or somewhat dissatisfied. Of twelve locations singled out for more intense study, dissatisfaction levels ranged from a low of 8.8% in Lansing, MI, to a high of 34.2% in Syracuse, NY. Several possible variables were examined for their impact on career satisfaction measures—clinical autonomy (including a



## NEWS FROM THE TREATMENT CENTERS

**Hazelden-Springbrook** (Newberg, OR) has two new toll-free numbers: 800-333-3712 is for admissions and program information; 866-866-4662 is to reach staff members and for other inquiries.

**Pine Grove Next Step** (Hattiesburg, MS) has recently opened *Living Sober*, an extended residential treatment program for those who need a structured, therapeutic environment for the first six to twelve months following treatment.

**Little Hill-Alina Lodge** (Blairstown, NJ) is in the planning stages for construction of a Women’s Center, to better meet the needs of the increasing numbers of women coming to them for treatment.

**Father Martin’s Ashley** (Havre de Grace, MD) has appointed a

physician’s ability to get additional services for patients) was “the most consistent and powerful predictor” of changes in satisfaction over time. (Staff note: In the 1999 *Survey of Career Patterns*, conducted by the Survey Center of the ADA, only 6.3% of dentist respondents reported any dissatisfaction with their choice of profession. Dentists typically practice with a great deal of clinical autonomy. The authors of this physician study noted that “whereas physicians once practiced primarily alone or in small autonomous groups, they now are more likely to practice in large groups and are increasingly subjected to profiling, administrative requirements, and preapproval for procedures and treatments. Evidence suggests that some physicians are becoming unhappy in this environment.”)

new CEO to succeed Father Martin, who has retired.

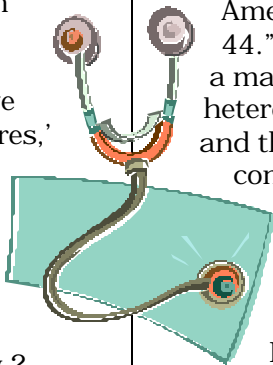
**Sierra Tucson** (Tucson, AZ) has posted the 2003 schedule for their enrichment workshops. Each of these is four days in length, and they are held at the Miraval Resort. Details are available at [www.sierratucson.com](http://www.sierratucson.com).

### FOR THE PEERS NETWORK

Hopefully, many dentists read the cover story of the December 2002 *JADA* (Vol. 133, pp. 1619-1630), "Use of HIV postexposure prophylaxis by dental health care personnel: An overview and updated recommendations." Written by Dr. Jennifer Cleveland and colleagues from the Centers for Disease Control and Prevention (CDC), the data should offer reassurance to clinicians worried about exposure since none of the 208 dental exposures reported to the national surveillance system (from June 1995 through August 2001) resulted in HIV infection. The article includes updated CDC recommendations for managing occupational exposures as well as some suggestions for individual practices.



New health workers in the National Health Service of Britain, whose work would involve 'exposure-prone procedures,' will reportedly be required to test negative for HIV, HBV and HCV before they can begin work if draft guidelines are adopted (Reuters Health, January 2, 2003). These guidelines are open to comment until April 30.



Dentistry is identified as one of the groups to whom the guidelines would apply. The article notes there have been only two cases, worldwide, where HIV has been transmitted from an infected health care worker to a patient. Neither of these cases has been in Britain.

Writing in *The Hopkins HIV Report* (January 2003, vol. 15, no. 1, pp. 12-14), Dr. Thomas Quinn provided a summary of UNAIDS' annual report on the global epidemic. Major trends include the shift to HIV infection occurring in increasing numbers of women and documented effectiveness of prevention efforts in some areas. Resources for prevention and treatment in many of the worst affected countries have become even more desperately insufficient; some countries of sub-Saharan Africa—Botswana, for example—have HIV prevalence rates well over 30%. High prevalence rates in turn have devastating economic consequences that threaten political stability. Reflecting on U.S. trends, Dr. Quinn noted the continued shift of the epidemic into marginalized populations with fewer resources; "AIDS-related illnesses remain the leading cause of death for African American men aged 25 to 44." Here, as elsewhere, is a marked increase in heterosexual transmission, and the threat of complacency in resource-rich countries.

The AIDS Institute of the New York State Department of Health has published a set of clinical guidelines for primary care

practitioners, *Oral Health Care for People with HIV Infection*. Publication date is December 2001. Some copies are available through the Well-Being Programs office; additional information is available at [www.hivguidelines.org](http://www.hivguidelines.org).

In a paper presented at the 49th annual meeting of the Infectious Disease Society of America, psychiatrist Ewald Horwath, M.D., reported on a survey of 130 physicians who treat patients with HIV and 235 of those patients. The physicians reported that more than 80% of their patients suffer from the symptoms of depression or anxiety. While some of these symptoms may be due to the disease process and/or the continued use of street drugs, physicians report concern that some antiretroviral therapies are precipitating depression or anxiety. The story was published on [PsychPORT.com](http://PsychPORT.com) (a news service of the American Psychological Association) on October 25, 2002.



Reuters Health (August 8, 2002) reported on a study comparing a group of HIV-infected people who are members of an AIDS activist group with a group of HIV-infected people who are not members such a group. While there was no difference in the health status between the two groups, those who were organization members were more aware of—and more apt to utilize—HIV/AIDS information resources. They were more likely to use problem-solving strategies rather than 'wishing their problems would go away,' to have stronger social support networks, and to be more compliant with treatment schedules.

Findings from a large epidemiologic survey about suicide attempts among gay and bisexual men were published in the August 2002 edition of the *American Journal of Public Health*. This is one of the first studies to use a population-based sample of men who have sex with men (MSM) rather than a convenience sample. Twenty-one percent of the survey population had made a suicide plan, with higher risk among younger age groups (i.e., under age 25). Of that 21%, 12% had actually attempted suicide—and almost half of those, multiple times. Harassment and lack of support from families, peers and the immediate community emerged as contributing to the risk. The article is rich in detail, both in terms of data from this study and a review of prior investigative efforts in this area. (Paul, JP et al, Suicide Attempts Among Gay and Bisexual Men: Lifetime Prevalence and Antecedents. *American Journal of Public Health*: 91 (8); pp. 1338-1345.)

## REFLECTI ONS

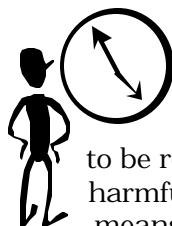
Granted, the holidays are over, but this essay is used by permission of the Betty Ford Center, and its wisdom may be welcome any time of year:

“Give Yourself a Holiday Gift”—  
by John T. O’Neill, LCDC  
(From the Fall 2002 edition of “Findings,” the newsletter of the Betty Ford Center)

Oscar Wilde said, “No man is rich enough to buy back his own past.” The typical alcoholic or addict owns a past that evokes shame, guilt, fear, remorse and self-directed anger. If we could only buy back our



painful past and undo the hurt. If only there were some magic way to repair the damage, correct the mistakes, heal the pain. Actually there is such a miracle available if we can find the courage to make it happen. It’s called forgiveness, and the most difficult form of forgiveness is being willing to forgive ourselves.



To forgive ourselves it helps to make a distinction between culpability and guilt. To be culpable means to be responsible for a harmful act. To be guilty means to have committed the act with intent and malice. Legally the degree of guilt (intent and malice) is taken into account when a crime is committed. I may be fully responsible for an act but the degree of premeditation and intent come into play. So it is with the bad, stupid, crazy behavior of the alcoholic or addict. To be sure, we are fully culpable and totally responsible for our past drinking and drugging behavior and the pain that it caused. But because of the pathological craving and the blinding delusion that are the essence of addictive disease, we are not guilty of deliberate intent and premeditated malice.

For those who have been at the receiving end of hurtful, costly, frightful intoxicated behavior, this may be a difficult concept to accept. But the fact is we didn’t do those things on purpose. For the alcoholic or addict this distinction between culpability and guilt is crucial in learning to forgive ourselves. As long as we cling to the notion that we had the power to control our addiction and didn’t apply it, we have not really taken the first step toward recovery; admitting we were powerless. Under the influence we did much we really

didn’t want to do and failed to do much we should have done. It is one thing to deeply regret those occurrences and accept responsibility to make amends wherever possible. But to take on inordinate levels of guilt is as though we did all those things with willful intent and deliberate premeditated malice is self-defeating.

The problem with shame and guilt is that it paralyzes us. Instead of getting about clearing the wreckage of the past, we’re stuck feeling guilty about it. All that does is encourage inaction and block forgiveness. Before we can forgive the boss that fired us, or perhaps an ex-spouse who divorced us, or the judge who chastised us, or the brother-in-law who ruined our reputation—or any of the many imagined or real hurts of the past—we have to forgive ourselves. As long as we cling to the notion that we had the power to not act as we did, we are prevented from the admission of powerlessness that will keep us from repeating those acts.

So, if you have been wasting your spiritual energy feeling guilty, give yourself a holiday gift. Write that letter, make that phone call, pay that overdue visit, forgive others and then forgive yourself. Focus your holiday energy on making amends and one day at a time rebuilding the life God meant for you and those you love.

