

A Buddhist Approach to the Treatment of Drug Abuse Patients*

by Darryl Inaba

On June 7 of this year, the Haight-Ashbury Free Medical Clinic will celebrate its 20th anniversary. The clinic has now treated over 22,000 different substance users. It has been recognized as having an outstanding, innovative program and treatment. It has won a lot of awards; and people recognize our program for its effectiveness. I believe that to a great extent, the success of our program is due to our application of Buddhist teachings in our treatment process.

The clinic now treats 600 to 700 different addicts every month. Ninety percent of the people who come to the clinic, come on their own volition. They are not sent there by parents, probation officers, coaches, school counselors, or the justice system. They are people who look at their lives and recognize that a drug is causing a major problem leading to progressive impairment and dysfunction. They want to do something about their drug problem, but they cannot stop. They have developed what we call addiction; and that is what the clinic is involved with.

Many different types of addictions are being treated, from heroin to marijuana. Also, some of those who come to the clinic are addicted to drugs like caffeine or cigarettes. The new trend, especially among the youths we treat, is a drug called "dip", or "snuff", a chewing tobacco—like substance, which leads to another type of dependence. Other patients are addicted to coffee, or think they have a problem with sugar, chocolate, all kinds of different substances, even carbohydrates. But 99% of the clients we see are addicted to what society calls "hard drugs."

We have pretty much come to a conclusion in 1987 that it is hard to define a drug. People take in substances; and they cannot control those substances. Those substances cause a dysfunction or problem in their life. They develop a major addiction problem. Regardless of the substance causing addiction, we offer appropriate treatment. We are treating kids who were licking frogs and were getting psychoactive effects from licking frogs. A current abuse problem stems from young people sniffing glue. They are sniffing white-out, the typewriter correction fluid. Three weeks ago, a young adult male in San Francisco removed the paint brush from each of these little bottles, stuck a bottle in each nostril, and suffocated. All he breathed in was the white-out, the liquid substance, and he died of asphyxiation.

So we treat a great variety of drug addictions, but cannot define clearly what a drug is. I am a pharmacist, and I teach at the University of California Medical Center. My students often ask me to define what a drug is, saying "You're talking about sugar as a drug, chocolate as a drug, paint as a drug, and all these different things as a drug. How do you define a drug?" Nowadays, I just tell them that a drug is any substance that creates a scientific paper if you inject it into a rat. That is a funny definition, but we do see a wide variety of drug problems.

For a long time, since the beginning of our clinic 20 years ago, we have believed that drug addiction was an illness, a disease; an addict was not someone who was bad, stupid, weak-willed, or crazy, but someone who con-

tracted a physical illness we call the disease of drug addiction. The treatment at the clinic centers around understanding people and accepting them as people with an illness, just like heart disease, diabetes, or hypertension. Like others with illnesses, as soon as they enter treatment, they are starting to get into better health. They begin to recognize that they have an illness. They want to take care of themselves, and we treat addictions as a health problem.

However, it was only two years ago that the World Health Organization reclassified drug addiction as a disease. The American Medical Association last year in 1986 finally relented and evaluated the problem by looking at all the research, and finally accepted drug addiction as an illness, a disease. Like all diseases, drug addiction is a chronic process. You cannot expect somebody to go into a treatment program, and within one month, six months, or a year, become cured of this disease. It is a long-term process. It is an incurable condition, but it can be treated, arrested and minimized. We also know that it is progressive. To someone who comes in with all kinds of personal and family problems, and who thinks life is terrible, I quickly tell him that if he continues to use that drug—if he continues to use alcohol, or cocaine, or quaalude, or heroin—he will continue to progress, to get more and more impaired, more and more dysfunctional. He is going to progress toward deeper and deeper impairment.

Like any disease, addiction is also a relapsing condition. It means that if you have a heart disease, and you are placed on some kind of treatment program, and you do not follow the program, what happens? Your disease gets worse, or it comes back to you even though it was controlled for awhile. Addiction is the same process. If you have an addiction, but you stop taking drugs, and you are doing well—let's say you are clean for five years—if you do not pay attention to your treatment, and you start using or playing

around with alcohol or drugs again, you go right back and become an addict again. It is very much a relapsing condition. That also qualifies it as a disease.

The most important point I would like to communicate is that a drug addiction problem is potentially fatal. That is a necessary condition for it to classify as a disease by the World Health Organization. That means that if you do not treat yourself for this disease and continue to take drugs, this disease will potentially kill you. We now know that is a definite fact, whether it is nicotine, alcohol, heroin, quaalude, cocaine, marijuana, all these different drugs. If you continue to use these drugs, the drugs will cause dysfunction, such as heart condition, blood pressure condition, lung condition, kidney condition, all kinds of complications and adverse effects that potentially can kill you.

From the standpoint of Buddhist philosophy, I think that rather than the physical death that occurs from the disease of addiction, it is more important to note the spiritual death we see in our patients. People who had been avoiding treatment but who finally come into our clinic are found to be suffering from a spiritual disease, a spiritual death. They do not have any belief in themselves, no self-esteem. They do not have any belief in life, any belief in any good in life, or living, any belief in anything whatsoever. What is important to them is the drug, and there is no purpose for existence other than that drug. As we learn from Buddhism and Jodo Shinshu, life is very much an illusion. Lot of illusion, lot of sorrow. People respond to this illusion and sorrow out of ignorance and perform acts that bring about their karma. Ignorant acts based upon this illusion bring about karma. The addict responds to the suffering, the sorrow, the illusion around him, develops a response by taking drugs and suffers spiritual death. His karma results in addiction. That is the way we see it, and that is the way we treat it. That is important to our

whole process of bringing people to understand how they can get better; how they can interrupt this process; and how they can stop this process. That is how they can enter the world of health and the world of recovery in terms of drug addiction.

It is especially important for the Asian-Americans and the Japanese American community that they recognize, without feeling guilty, that drug addiction now is a treatable family disease. By stating that it is a treatable family disease, we are not saying that the family is at fault. We are saying that the addict has an illness. The addict is not bad, dumb, stupid, crazy or weak-willed. The addict simply has an illness. In the same context, this is a family illness. Symptoms of the addict manifest in each and every member of the family. They slide over into the family. Families become very dysfunctional. They become very uptight. They enter into a deep sense of guilt, thinking about what is going on with this problem. The whole family system falls apart. In order for a person to get better, especially in the Japanese American community, we need participation, as much as possible, from the family members. They need to recognize that this is not something to feel guilty about but something we all need to address and work with and help the individual who is an addict, to confront him with the addiction problem, and to enter into the treatment process.

The treatment process we use in the basic parameters of the treatment is first to break denial. With every addict we treat, there is denial. Denial means a person is unwilling to look at the emotional systems in his life that are bringing about pain. He relies on ignorance and karma to get him through what continues as his addiction process. As the initial step in our work—our most important work—is to work on breaking through the denial. We need to have the addict understand that he has an illness, getting him to accept that he has an illness, and admit it to himself

and surrender to a real teaching process where they can enter into treatment.

In trying to break the denial, we have the person understand that the only way to break the cycle to get better and get healthier is to enter into abstinence. The only way to get rid of addiction is not to use that drug, understand that he cannot use that drug pretty much for the rest of his life. If you are an alcoholic, and you stop for awhile and then start drinking again, you would go right back into addiction. So, we have to get him to understand the need for him to remain a clean and sober person. We do this not by motivating him toward the negative of not taking drugs but by inspiring him toward the positive goals of a clean and sober, recovering life-style.

We also have to recognize that it is not just cocaine but all the drugs in his system that need to be treated. The patient may come to us and say, "Well, I'm coming here because my father thinks I'm spending too much money; my wife's mad at me, because we don't have enough money for rent and food in the house, and I have a cocaine problem, so please help me with my cocaine." We sit there and do an inventory. We ask him, "Do you ever use alcohol?" "I drink every night. I'm a social drinker; I never drink more than five drinks a day." "Do you ever smoke marijuana?" "I smoke marijuana, maybe two times a week." "Do you use valium?" "I need that to go to sleep, because cocaine makes me too jittery."

As we look at these persons, they are taking a great variety of drugs. If they are going to get better, they have to understand that all of these drugs contribute and participate in their addiction, and they have to learn to give up all of them. We sit down and assess them. We try to break through that denial system. We enter into an understanding of abstinence. But also, especially with Japanese American youth, we have to break through an isolation

process. Many Japanese Americans become alienated, isolated. When they start using drugs, they become part of a special peer group of drug users. That's fun for awhile. There is a honeymoon phase. They can be part of this unique gang of people using drugs. They can be exotic, be mystical, have their own language, their own customs, and be secretive. But that does not last too long—at the most, about five years—and they continue to use the drug.

The drug changes your body chemistry; it changes your body cells, and changes your emotional state. Tolerance develops within you. Tolerance means it takes more and more of the drug to produce the same effect. What happens to an individual is that even though he had been hanging out with all the drug users, he becomes more and more isolated and alienated, increasingly retreating into himself. One of the quick things we have to do is to fracture that isolation. We have to get that person back into talking with people, back into communicating. This is hard for Japanese American youths. They are not used to it culturally. Even though they are sansei, yonsei, and even gosei youths now, they sit there and believe that they are not supposed to share their sufferings, their pain, their thinking, their insecurities with other people. They do not want to talk about it. If they do not talk about it, they will not get any better. Therefore, we have to break through that isolation and get them to participate, to start communicating more about what they are feeling and what their needs are.

Finally, if we are going to get somebody better, we have to bring a spiritual existence back into his life. We have to bring back something that they can put trust in, something that they can believe in, something to give them hope, something to work toward, some sort of knowledge, some sort of wisdom or higher truth that they do not have within themselves. And in this, the Buddhist Dharma can be that spiritual existence, that spiritual

meaning, that people can turn back into and find purpose in life again. That is further down the road.

Immediately for the first two or three years, we are just dealing with people to get them detoxified, getting them abstinent, getting them to understand that they have to stay clean. Ultimately, what we have to do is to make sure that they are going to have a good life, a fulfilled life, and in many ways, a better life than a straight person. I always believe that, for this reason, a recovering person is a better person than straight people. They have had to find some sort of spiritual existence again. So, that is an overview of our treatment process.

For our recovery process, our programs have been recognized, given a lot of boost and support from Buddhists all around the country. Last year, we were honored in receiving the Dana Award from the National Fujinkai (Buddhist Women's Association of the Buddhist Churches of America)—a very large award of over \$7500 to our program to help us reach more Asian-American and Japanese American youths. Through that gift of Dharma, the Japanese American staff and I had to review our program. We recognized that many of my staff, like myself, have grown up in the church, we were sent to church, we participated, but we could not be considered as being morally good. We did all kinds of crazy things, but somehow a lot of just being at church did rub off. We did gain something out of going to church. As a result, our clinic treats addiction as a disease according to the system I described above. Our clinic has always had a non-judgmental, non-punitive, sympathetic and supportive view of interaction with addicts in addition to providing health care. We always had the belief that health care is a right which should be provided to each and every individual in the country. It should not be doled out as a privilege. We rejected very strongly a Christian model; and I did not know why we were doing this at that

time, but now it became clear after we received the Dana Award. Many of us were Buddhists, so we were bringing our philosophy into our clinic, which was not Buddhist. We very quickly rejected the idea that we were charitable. We did not believe in charity. At that time, we thought we were being political—that this is a political cause, not a charitable cause. We rejected charity, because charity puts you at a different level than somebody else. It assumes that you are morally superior, more intellectual, that you are helping out the poor, unfortunate ones. That is not what we believe in; and that is not what we do. That is the reason that we have been so effective in our treatment process. It is because we have the Buddhist philosophy of compassion. We have compassion for the drug addict; we are not helping out the poor, unfortunate drug addict. It is compassion that drives us and brings us into our treatment modality and provides the main emphasis for what we do at our clinic. That is what we recognize; that is what we believe in. We have been doing that for a long time.

In 1974, Dr. William Pone, a Ph.D. entomologist, came to our clinic. Dr. Pone was once a professor at the University of California, Davis. He was a fifth-generation, traditional acupuncturist, a Malaysian-American. He was also an alcoholic and a drug addict. He came to us out of alienation, out of frustration, and out of despair. He could not find treatment service in San Francisco, a city with 22-25% Asian-American population. He could not find treatment services that were sensitive to his cultural needs, to his language needs, or even to understand what Dr. William Pone was all about. He came to the Haight only because we had Asians with a high profile on our staff. He saw us on TV and recognized that at least there were Asians there and that maybe he could get help there. He asked us for treatment; we helped him to get into a continual recovery effort. He provided to us an acupuncture approach. We provided free acupuncture for many years to help

drug addicts stay clean and sober.

What is most important, in 1974, William Pone challenged me and my clinic on Asian-American substance abuse issues. He said that we were not paying attention to Asian-American drug issues, that we did not even know that there were any drug issues, and that we were not doing enough for Asian-Americans. He wanted us to investigate what was going on among Asian-Americans. As a first step, we at the clinic had to deal with our own denial and our own misconceptions about Asian-Americans and drug abuse problems. One of the biggest misconceptions and problems that we had to face very early was that many Asian-American people, even the sansei and yonsei (third- and fourth-generation Japanese-Americans), had accepted the imposed values of other societies upon our culture. We accepted what other people were saying about us as being a model minority. We were proud of that. We thought it was a good thing. We thought the Asian minority were the good kids. We do not abuse drugs; we do not do things like that. We had to recognize very quickly that that was the major problem, both in terms of preventing us from looking at problems but also preventing us from getting help from these other communities to deal with our problems. So, we had to address that issue. More importantly, we had to recognize that we, too, had a total misconception about drug abuse and drug addiction.

We also had a misconception that Japanese-American youth, the Chinese youth, all Asian-Americans were probably immune to substance abuse. We used to think that they were a population that could play with drugs, smoke marijuana, snort cocaine, and take a little bit of heroin, or drugs like Quaalude, and control our use without developing problems like other people. We believed that we had more ability and more strength of will. It was only the other population—only the blacks, the Hispanics, and the Cauca-

sians—that could not handle it. Asian-Americans were strong. We can take the drug. We will not have drug problems. That was a serious and eventually very dangerous misconception.

Recently I have come to believe that the only completely non-prejudiced, non-biased, non-stigmatized, the only objective system in the whole world is that of drug abuse and addiction. It is the only thing that does not care who you are. It does not care how rich or poor you are, what kind of family you come from, what ethnicity you have, what kind of education you have. If you use drugs and continue to use drugs with increasing progression in impairment and dysfunction, you will become an addict. There is no doubt of that in my mind. So we had to again apply that in ourselves and recognize that maybe we may not have been looking at Asian-American drug abuse issues. Maybe we were comfortable. Maybe we were saying we were special. So what we did originally was to form an Asian-American substance abuse task force in San Francisco. There were thirty-four meaningful groups that identified themselves as Asian-Americans in the City and County of San Francisco. The task force included ministers from many different churches, and people from the congregations of different religions. We got the criminal justice system involved. We managed to get together many Asians to work together. We soon discovered that there were really significant Asian-American drug problems that had not been addressed in San Francisco. All the churches, all the ministers, everybody involved in the task force said that there was a growing problem in the Asian community, but abusers were not getting help; they were not going for treatment. There was nothing being done.

In 1978, there was a study done of California correctional institution inmates. What we discovered was startling to us. Out of close to 1000 self-identified Asian-American prisoners, over 90% felt that the

main problem they were in jail was not because they liked robbing people, liked stealing and committing all these anti-social crimes, but because they were addicts. They were addicted to drugs and did these other activities to support their drug addiction. The next startling statistic was that of these addicts, only 5% had ever thought of getting treatment. The rest of these Asian-Americans did not think of drug addiction as a disease, so they did not get treatment. Further, there were no programs for Asian-American substance abusers, thus alienating this population from tax-subsidized service. Not surprising to us in the treatment field, when we sat down and looked at this population again with another questionnaire, we found only 1.7% of this population had ever received any kind of drug education, or treatment, for their drug problem. Immediately, we felt confident that there were significant problems, and somehow Asians were falling through the cracks. They were being missed. We need our community to become more aware that Asian-Americans are not immune to drug abuse, and we have to face these problems as well.

The next step in our process as a committee was even more difficult. We then had to deal with a society that had a bias and had originally identified Asian-Americans as a model minority and had imposed that value upon our community and was not willing to look at drug problems within the Asian-American community. We went before the City and County of San Francisco to inform them that we had identified significant problems among Asian-Americans, and that we needed to provide for some sort of targeted, focused intervention. We needed to have a high profile Asian-American treatment service and delivery system for drug abuse in order to start addressing these problems. But the City and County of San Francisco insisted that we did not have problems with drugs. They said that only 1% of all the patients in San Francisco treated for drug problems were Asian-Americans, so they wanted to know why we

needed money for Asian-American substance user problems. They refused to recognize that the reason the Asians were not coming in, even though they had drug problems, was that the problem needed to be addressed.

As the next step, an ethnographic effort was begun. We wanted to show the authorities that there is a multiculturalism that occurs with drug abuse. Every group of people has its own customs, its own language, its own slangs, its own way of doing things, and even its own separate cycles of drug abuse that occur within the larger spectrum of drug abuse in the United States. Ethnographers were hired to look at different youth populations, 13 to 16 and 16 to 19. We wanted to get a handle on four youth populations in San Francisco: the black population, the Hispanic population, the Asian-American population, and the white middle-class population. We finally found four locations that would give us that, but the Asian-Americans were too diverse for an Asian-American study, so we narrowed our focus to a Chinatown study with the understanding that there are some similarities of drug use among the Chinese, The Japanese, the Korean, and the Filipino youths.

We found that the black youths, 13 to 16 and 16 to 19, in 1983 to 1985, liked drugs like cocaine, rock cocaine, the crack cocaine, or smokable cocaine, mixed with marijuana which they called champagne and caviar. At that time, these drugs were specific to that culture, to their self-esteem, and to their values. They felt proud that they used those drugs. They thought that if you use alcohol, you are sloppy; if you use PCP, you are crazy. Their drug esteem was related to crack cocaine and marijuana.

The Hispanic youth population we looked at in San Francisco during those years liked the drug called PCP. Among them, there was an epidemic of PCP, an animal tranquilizer that makes you psychotic and causes

psychedelic reactions. Also, there was a very alarming 20% use of heroin among the very young youths in the Hispanic population.

For the white middle class population in San Francisco (since we could not find an area in the city that was predominantly white, we had to go to Pacifica), we found that these youths liked alcohol. In addition to beer and wine, they liked "booze," all kinds of hard liquor, including tequila and scotch. They did not like to drink just any scotch. They were partial to particular brands and drank in all kinds of patterns. They were also taking a drug called "crank" which is a methamphetamine—a stimulatory drug, a diet pill. They would take it and drink more alcohol. The two drugs went together.

When we did the Chinese-American study, it validated everything we believed in terms of drug abuse in the Asian community. The Chinese youths were involved with Quaalude abuse. Quaalude is a sleeping pill. It used to be sold in the pharmacies, but no longer. It is a tablet that helps people get to sleep. It makes you very drowsy, very sleepy. We found 43% of all the youths we surveyed in Chinatown in our Chinese study (120, in ages 13 to 16; and, in ages 16 to 19) were using Quaalude. That is a high proportion abuse of the drug. We had a Quaalude epidemic. It became clear to us why they use Quaalude. They have a real difficult time talking to members of the opposite sex, or expressing themselves at meetings, or anywhere else. Asian youths are very shy, very inward people, so when they take Quaalude, it is like drinking alcohol. It lowers their inhibitions, puts their inhibitions to sleep. It makes them feel more awake, more alert, more "with it," more open, and more willing to talk. Usually the person slumps over and goes to sleep, but in his mind, the alert feeling is an illusion—just as Buddhism teaches that all life is an illusion. This drug gives them the illusion that they are more talkative and friendly, and that everybody likes them more. Actually, they are

sitting in a chair, slobbering all the time, so that is why some of them said they like it; but there were a few in the Chinese youth study who said that the drug gave them all the same benefits and feelings that alcohol provides. However, when they take Quaalude, they do not get red in the face, feel nauseated, have a hangover, or vomit. They do not have any of the side effects one gets from drinking alcohol.

Quaalude is a very addictive substance. It is a drug that changes your brain chemistry, changes your body and causes addiction. It causes you to need that drug over and over. When the youths come into our program, they have been taking at least five Quaaludes per dosage, about ten Quaaludes a day. They take five tablets at a time to get sleepy and drowsy. Since tolerance rises, they may start taking more at a time. If you take up to eight to ten Quaaludes every day for about thirty to sixty days, your body changes. It changes to the point that if you try to stop, you would go into convulsions, get headaches, and vomit. You might go into all kinds of reactions. So in order to prevent yourself from getting sick, you would have to keep taking it. That is part of the addiction process. This drug, then, was specific to the Chinese population.

At that time, we were also seeing Japanese, Filipino, and Korean youths. Quaalude was the drug that was endemic, or popular, within the Asian-American population. Because it totally supported and validated what we were trying to tell the City of San Francisco, we took the information to the city authorities. They were saying no Asians had problems with drugs, because no Asians came in for treatment. But we sat there, and we looked at the Asian-American population statistics and said, "They do have a drug problem, but where in San Francisco do you have a Quaalude treatment program? You have a heroin treatment program, alcohol treatment program, other kinds of

sedative treatment programs, the cocaine treatment programs. How come you don't have a Quaalude treatment program? Maybe if you had a Quaalude treatment program, and you identified the other drugs that are popular and predominant within the Asian community, maybe there would be a reason for the Asian kids to try to get help. There's no reason for it now. There's no one treating the drugs they're abusing."

The outcome of all this was that we went political, trying to get as much political support as possible. We accused everybody, and we got everybody mad at us. But due to this effort, we got two programs funded. One of these is the Bill Pone Unit. Unfortunately, Dr. Pone contracted cancer and died in 1980. We named our program after him, the William Pone Memorial Unit, an outpatient program established to treat specifically Asian-American drug problems. We have an inpatient unit called Asian-American recovery service program. The Asian-American outpatient program, treats now 70 to 80 different Asian-Americans every month. We were funded for forty treatment slots, but we treat 80 by using volunteers and doing benefits. In the Asian-American residential program, we are funded for 15 beds, but we overstack our program and have 20 beds full, around the clock. So, 20 addicts are treated as inpatients.

The Dana Award was extremely beneficial. In the process, we learned about Buddhist Dana, which is giving without any expectations. As taught in Buddhism, it is the pure act of giving. With the Dana Award, we started an Asian-American recovery group among Asian-Americans, an AA-type of group, a self-support group of Asians helping Asians staying clean. The Asians need a place where they can feel comfortable in discussing their drug problems and talking over things. That out-group is now very strong. A lot of people are helping themselves, helping to stay clean, and continuing to stay clean from drugs. We are appreciative of the help we

received from the Buddhist Women's Association.

In San Francisco, we treated last year 600 to 800 different Asian-Americans for substance abuse problems. No place in the world, no place in the United States is there such a high utilization of Asian-Americans participating in the treatment of drug abuse problems. It is so remarkable that a lady came from Japan to study our work with Asian stimulant abuses. That is the second big drug abuse we are seeing now. Japanese-American youth are into the use of cocaine. She came because she has seen much Japanese-American abuse of cocaine and wanted to learn from us what our treatment processes were. Four people came from the People's Republic of China. They have never been outside of Peking. They spoke perfect English and were very intelligent. They sat down with me, and the first thing they said to me was that they have no drug problems in the People's Republic of China. So I asked why they were here, because I did not understand this. They said, they were interested in what our program was seeing in terms of Chinese youths. We began by saying that we have this problem with Quaalude. They asked what Quaalude was. We said that it is a sleeping pill. All their eyes went wide open. They remarked that they had the same problem. The youths in China were taking sedative medication as well. So we were able to share that.

Our programs have expanded to treat many Asian-Americans with specific drug abuse problems. Quaalude still being the number one drug, followed very quickly by cocaine. We also treat alcoholism. Alcoholism is something that has not been looked at enough in Asian-American cultures. Marijuana is a very popular drug among Asian-American youths. We even have a significant number of Asian-Americans who are heroin addicts. There are more Japanese-American than Chinese heroin addicts. There are also a

few PCP users among Asian-Americans.

We have to wake up in our community and recognize that all the problems that exist outside our community are also within our community. A real startling thing for me to find out was that forty Asian-Americans in San Francisco were diagnosed as having an AIDS condition. About 14 Japanese Americans died of AIDS over the last three years, so it is also a problem within our culture, and we should pay attention to that as well.

A great variety of drugs are being abused by the Asian-American community. Drug abuse is within our community. But drug abuse is a very treatable condition. We need in our community to dedicate ourselves to two things. Recognize that we have it and help our children and people who have contracted this disease to get into treatment and get better. The other thing is that we have to start paying attention to the need for better education and prevention, and not feel that it is for people outside our community. We must address these problems so we can prevent them before they happen.

One thing that I think is important in our treatment process, very early on, with any addict we see is that we have to try to make them understand three basic things that are very spiritual. These three things are needed for an addict to really progress in life. They have to somehow obtain serenity to deal with those things in life they cannot change. When I was growing up, I always had problems about karma. I used to think karma is something that you had done wrong, or something bad that pops up in your life. Recently someone clarified for me that karma is your ignorant acts based upon your illusions, based upon untruths. Things happen to you in your life, and how you respond—your ignorant acts based upon things that happen—creates the karma. You can control these things in your life. To obtain a sense of serenity, addicts

have to learn that they have to deal with those things they cannot change in life. There are many things in life you cannot change. I cannot change the fact that I was born short. I cannot change the fact that I was born Japanese. These are the things I cannot change. You have to accept things in life that you cannot change and learn the serenity that comes in accepting that there are things that you were born with that you cannot change in life. Also, things happen in life: you have accidents; you have tragedies, death in the family; you have grief, your dog dies or something. Those things happen, and you cannot change that. You have to learn the serenity to accept those things in life you cannot change. Then, somewhere along the line, the next thing you have to do is to find the courage and strength and understanding to face up to the fact that you can change. You can change the way you respond. You can change the way you approach life, or set your priorities. Perhaps the church is a higher priority. These are things you can change. You have to gain the courage and strength to address these things that you can change. But the most important thing in this process is that out of the Dharma, the teaching, the truth or

something, you have to obtain the wisdom to know the difference between these two things. If you do not know the difference between what you can change and what you cannot change, you are going to be in trouble. When an addict begins to understand this process and accept those three things in the recovery process, that is when we have people entering into a happy, contented, fulfilled life—a life that is full of health, happiness and wisdom. That is what kept us working in the clinic for 20 years. That is what keeps the Japanese-American youths who are working with me actively involved. They, too, are Buddhists. I believe that some of our dedication, understanding, and compassion came to us through the Buddhist teaching and ideas we might have resisted and did not pay attention to in our youth, yet somehow contacted to our great benefit.

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