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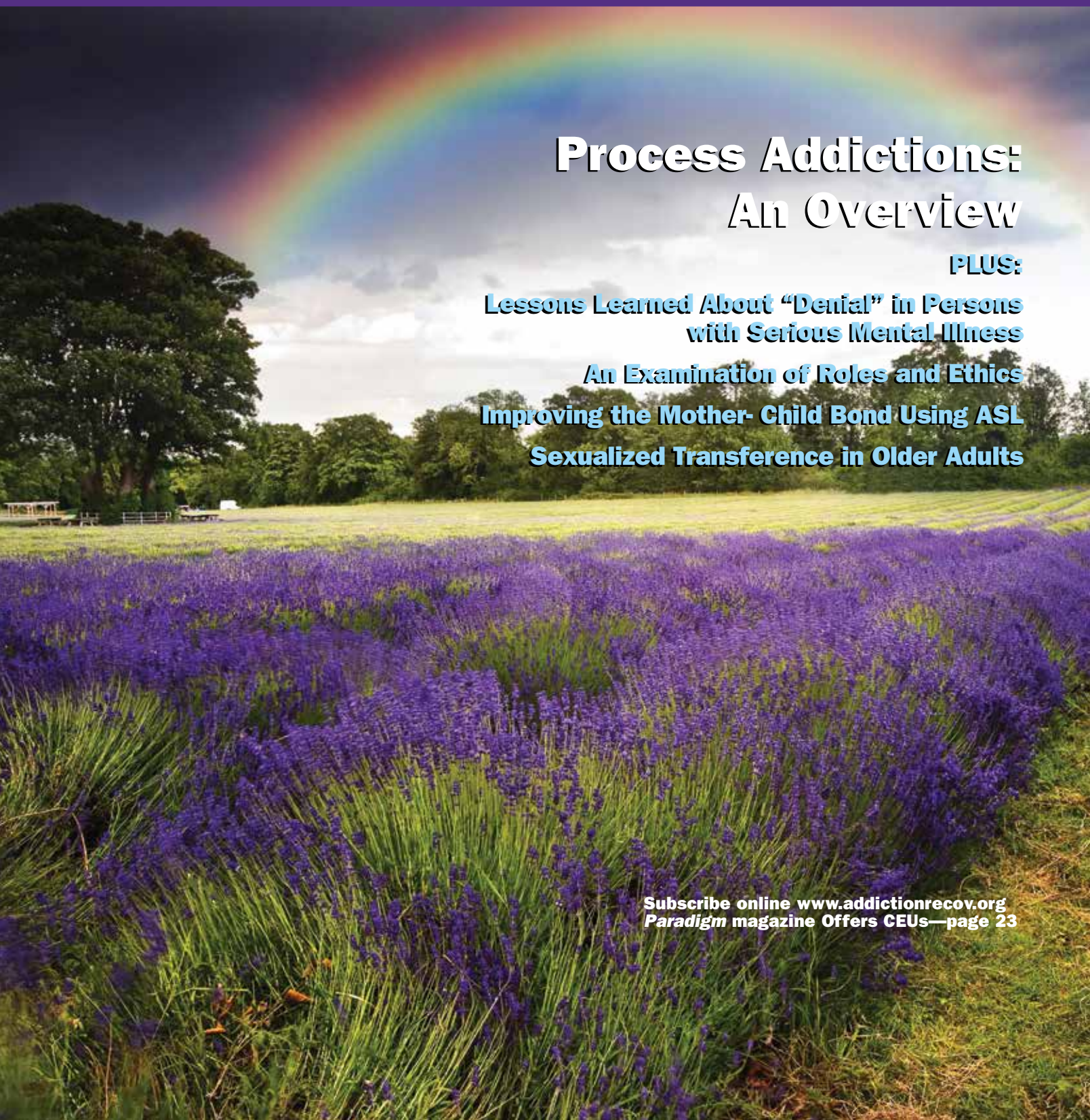

Process Addictions: An Overview

PLUS:

Lessons Learned About "Denial" in Persons with Serious Mental Illness

An Examination of Roles and Ethics

Improving the Mother- Child Bond Using ASL

Sexualized Transference in Older Adults

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HEATHER VAGLE MA, LPC, CADC

"I love to witness clients make progress, become motivated to tackle their challenges, and to simply have those 'ah-ha!' moments throughout the therapeutic relationship."

Heather is a counselor and clinical reviewer for Advocate BroMenn Medical Center in Normal, IL. She is from a small town in Minnesota about an hour north of Minneapolis. She earned her bachelor's degree at Dallas Christian College in Dallas, TX and then moved to Illinois where she completed her master's degree in Counseling at Lincoln Christian University. Heather began working in the substance abuse field in 2010 at Chestnut Health Systems, and in 2013 she started her career with the Illinois Institute for Addiction Recovery.

Heather is a Licensed Professional Counselor (LPC) and is a certified Drug and Alcohol Counselor (CADC). She conducts all of the insurance authorizations and reviews for both inpatient and outpatient services, and also provides clinical support for patients. Her favorite tasks are teaching psycho-educational groups, facilitating family programming, and counseling individuals and their families. It is her passion to serve others, and she says "I love to witness clients make progress, become motivated to tackle their challenges, and to simply have those 'ah-ha!' moments throughout the therapeutic relationship."

In her free time, Heather enjoys cooking, baking, DIY projects, and providing hospitality for others. She has been happily married to her high school sweetheart, Matt, for seven years. They have a 1 year old daughter, Avery, and recently adopted their newborn son, Beau.

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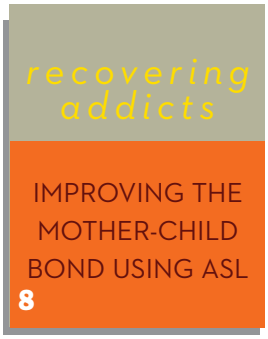

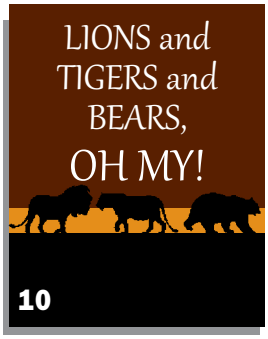

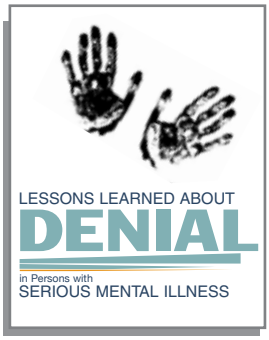

FEATURES

DEPARTMENTS

The Relationship Between Sexual Addiction and Sexual Fetishism

PLEASURE and PAIN

By Stephanie Billingsley, MS, PC, CDCA

Sexual behavior has played a role in human life since the dawn of time. At some point the first humans had to engage in copulation in order to produce offspring to continue to repopulate the earth. Historically speaking, non-reproductive sexual behavior has not been received with positive regard. Medieval theologians emphasized that sexual acts such as masturbation, sodomy and bestiality were among the worst of sins as they could not result in conception (Oosterhuis, 2000 as cited in De Block & Adriaens, 2013). It is possible that due to these historically punitive attitudes, unusual sexual behavior has largely been unacknowledged, misrepresented and misunderstood. Only recently has considerable empirical attention been directed toward atypical sexual behavior such as sexual addiction (SA) and sexual fetishism (SF).

"Hypersexual disorder is a persistent and pervasive pattern of behavior in which the individual loses control of their sexual fantasies, urges, or behaviors to a point that it causes that individual significant interpersonal distress and/or impairment." (Samenow, 2011, p. 108). While there is an operational, or working, definition of sexual addiction (SA), there is no formal diagnosis available for sexual addiction in the current *Diagnostic and Statistical Manual of Mental Disorders (5th ed)* (DSM-5). On the other hand, fetishistic disorder is a recognized disorder in the DSM-5. Criteria includes, "Over a period of at least 6 months, recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on non-genital body part(s), as manifested by fantasies, urges, or behaviors. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The fetish objects are not limited to articles of clothing used in cross-dressing (as in transvestic disorder) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator)" (APA, 2013, p.700). Hypersexuality is correlated with the experience of paraphilia. In a study cited by Garcia and Thibaut (2010, p. 258), "Paraphilia was associated with sexual hyperactivity in 72–80% of 120 evaluated men seeking treatment for paraphilias or paraphilia-related disorders." The DSM-5 (2013) also states that fetishistic disorder can co-occur with hypersexuality. In addition to co-morbidity, both sexual addiction and sexual fetishism share inter-related features that tie these constructs together.

Pleasure

A common purpose of engaging in sexual behavior is to experience pleasure that accompanies sexual arousal. Sexual arousal induces rewarding feelings that mitigate intolerable or distressing feelings such as boredom, loneliness, anger, frustration, guilt, shame, anxiety and interpersonal conflict or disconnectedness. Pleasure associated with sexual arousal is an amalgamated psychophysiological process wherein factors such as affect, motivation and learned experiences work together to define what stimuli an individual understands as rewarding. If one associates specific stimuli with the experience of sexual pleasure, this pairing may become salient within the brain and will be repeatedly sought-out in order to continue to generate pleasure (Berridge & Kringlebach, 2008).

Sexual addiction and sexual fetishism both allow for intolerable states to be converted into pleasurable states through the use of sexual behavior (Birchard, 2011). Opponent process theory states that painful or traumatic events are reversed and made pleasurable through eroticization. Kahr (2007, p.507) states, "trauma functions as a key ingredient in the genesis of adult sexual fantasies." Transforming an adverse or painful experience into a positive or pleasurable experience may be correlated with the development of some fetishistic behavior or sexually compulsive behavior. As stated by Birchard (2011, p.175), "Both paraphilia and sex addiction have the effect of reversal and conversion. They both turn helplessness into power and trauma into triumph."

Pain

Early literature casts a painful, stigmatizing light on sexual disorders, relating them to character defects, insanity and perversion. The message carried from centuries ago vilifies those who practice unorthodox sexual behavior as being inherently unscrupulous and morally corrupt (De Block & Adriaens, 2013). Furthermore, some sexual issues were so aberrant that it was unthinkable to even write or discuss such matters. Jefferis and Nicols (1930, p.271) remark, "And there are hundreds of other aliments so disgusting that they have no place in a work of this kind. In fact they need not be mentioned because bestiality and human depravity are not at all germane to the subject of sexual relations." While progress has been made, disorders pertaining to sex are still largely misunderstood and carry painful, stigmatizing undertones.

Newton and McCabe (2003) state that having a socially unacceptable sexual condition can cause issues within psychosocial development and interpersonal relationships. The experience of shame may contribute to a cyclical pattern of

sexually compulsive behavior for sex addicts. The need for control over negative affect states of life events may induce fantasy and sexual preoccupation. Sexual acting out occurs and after completion the individual may experience further shame regarding his/her sexually compulsive behavior. The experience of guilt, disgust, helplessness and desperation can occur. In order to escape these shameful feelings sexual fantasy is initiated again and the cycle may repeat (Carnes, 1991). Garcia and Thibaut (2010, p. 258) state, "Due to the embarrassment that sexual addiction patients may suffer, they rarely spontaneously seek medical advice. Usually the patient is referred to the psychiatrist for a suicide attempt or for depressive or anxiety symptoms."

In sex-positive societies such as the United States, which encourages sex for pleasure or recreation, fetishism is still regarded as culturally taboo. From a cultural standpoint people who experience fetishes are viewed as "sick, unusual, abnormal and deviant" (Bhugra, Popelyuk & McMullen, 2010, p. 242). Those who do not practice socially normative behavior are considered socially deviant as they not practice the in-group behavior (Bezreh, Weinberg & Edgar, 2012). Fetishism, even in legal and non-coercive forms, deviates from the cultural norm of sex as an expression between two consenting adults since SF tends to be a solitary activity involving the individual and the object of his/her fetish. The individual with the fetish may experience psychological harm if one feels s/he cannot disclose this information to others out of fear of social rejection.

The experience of being stigmatized has been linked to detrimental psychological consequences (Vogel, Bittman, Hammer & Wade, 2013). Stigma occurs because those who are marginalized are acutely aware of the lower value they hold in society due to possessing the stigmatized condition. Social shame may be stigmatizing as both SA and SF are seen as deviating from social norms. In order to reduce psychological stress created from public perception, many people attempt to conceal the stigmatizing conditions (Bos, Pryor, Reeder & Stutterheim, 2013). Fear of discovery can be extremely psychologically debilitating for those who attempt to conceal and lead to feelings of shame. In fact, the word "shame" itself stems from an Indo-European word meaning "to hide" (Birchard, 2011). The experience of adverse social or personal hardships as a result of sexual behavior may contribute to a reduced ability to experience a robust quality of life. This impairment is distressing and may lead to further seclusion and concealment of one's experiences and may prevent help seeking behaviors.

Call to Action

Individuals who experience stigma associated with SA and SF may employ a variety of methods to cope. Problem focused coping strategies include selective disclosure or compensating for stigma experienced in social situations by evading questions about one's personal life or avoiding social settings all together. Emotion focused coping strategies involve engaging in psychological defense mechanisms such as denial, minimization or attempting to view being stigmatized in a positive light (Bos et al., 2013). While some coping skills may offer some transient benefits, many of these coping strategies are maladaptive in nature as they involve things such as suppression, avoidance and minimization.

More advantageous forms of coping such as professional counseling services are underutilized by individuals who engage in SA and SF (Gordon, 2008). SA and SF are still largely poorly understood and treatment modalities for assisting those with SA and SF are under-developed (Guterman, Martin & Rudes, 2011). As with most emerging phenomena more questions continue to be raised than are answered (Reid, 2013) and research on these disorders is still largely underrepresented in scholarly literature. As researchers and clinicians we live in a stimulating and challenging era wherein we have the ethical obligation and privilege to provide improved empirical information regarding the examination and treatment of sexual disorders. A better understanding of the psychological, social and behavioral needs of those who practice SA and SF would assist individuals in this population who seek treatment, improve competency for practitioners who provide the treatment and may encourage the reduction of stereotypes and stigma of sexual disorders within our society.▼

Stephanie Billingsley *is a licensed professional counselor at Community Behavioral Health, located in Hamilton, OH. She specializes in forensic therapy and works extensively with forensic populations such as sex offenders, sexually oriented offenders, batterers and those who present with chemical dependency issues and process addictions including sexual addiction. Stephanie is an adjunct professor at Cincinnati State and teaches course on psychology and addiction studies. She may be reached at (513) 424-0921 ext 38 or at sbillingsley@community-first.org.*

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GOOD TIME

Maryland's Unique Jail-Based Career Center

...ex-offenders have needs very different than typical job seekers; ... they often have many more barriers to employment success.

By Coach Alisa Smedley

After a mock job interview exercise, I asked a 32-year-old male client to reflect on the experience. "I feel human again," he responded. He is a participant in a unique program located inside the Montgomery County Correctional Facility (MCCF) in Boyds, MD. The center, which was opened in 2006, is the result of a partnership between the Montgomery County Department of Economic Development, Montgomery County Department of Correction and Rehabilitation, and Workforce Solutions Group of Montgomery County, Inc. The partnership represents an innovative collaboration between public and private entities to create a program housed inside a maximum-security jail facility.

Participants in the MCCF program can spend as much as eight months before release working with the center staff. Inmates are referred to as "customers" in the program; this language signifies a shift in thought from traditional service delivery. Customers are considered equal partners in the process, not as recipients of services due to some personal deficits.

The curriculum is rigorous and demanding, while meeting each individual customer on his or her level. As the coordinator of the center I stress to our customers that the moment they leave the facility, life will speed up! Therefore it is wise for them to make the most of their hours while in here.

History

The MCCF center is a satellite One Stop Career Center, newly renamed American Job Centers (AJC). These centers are found throughout the United States and offer an array of services including job search assistance, training opportunities, and classes related to seeking employment. MCCF was one of the first centers in the country to operate within a maximum-security correctional facility.

A driving principle of the jail-based AJC center is the acknowledgement that ex-offenders have needs different than typical job seekers; they often have many more barriers to employment success. Specialized interventions are required for this population to compete on a level playing field with other job seekers. The program design, staff training, and physical layout of the center are all key factors that contribute to the effectiveness of the center.

Mission Statement

The re-entry department of the Montgomery Works ex-offender program developed a mission statement in 2012, directing the jail-based center "to provide a valuable Return on Investment for employers to meet their hiring needs and to support transformation in the lives of offenders one person at a time."

Return on Investment (ROI) and transformation are key themes. Participants are encouraged to commit to building themselves into strong candidates who will offer an employer a high ROI. This aspect of the training emphasizes the language and culture of business. Participants are persuaded that personal transformation is a core requirement for their future success.

Model and Approach

The center operates with two full-time employees and a part-time program assistant. Every aspect of scheduling, activities led by volunteers, and curriculum content is carefully planned and designed specifically for offenders. Full-time staff are certified Offender Workforce Development Specialists (OWDS), a credential sponsored by the National Institute of Corrections (NIC). Staff works three days inside the correctional facility and two days in the community at the local AJC. While staff is not considered correctional personnel, they are trained in jail protocols and included in inter-departmental meetings. One reason for the

success of the center is the relationship between the center and other jail-based programs. When customers are shared between multiple programs, integration and communication are vital. One program that works closely with the career center is the Jail Addiction Services (JAS) program.

Jail Addiction Services

Jail Addiction Services (JAS) is a comprehensive jail-based treatment program designed to provide intensive addictions treatment to eligible inmates of MCCF. This program is a collaborative effort between the Montgomery County Department of Correction and the Department of Health and Human Services.

JAS offers addiction treatment and education. Participants reside in therapeutic housing units separate from the general population at MCCF. Treatment involves an eight week education phase and an ongoing aftercare phase for as long as they are incarcerated at MCCF. Therapeutic activities include community meetings, task, education and therapy groups, peer counseling, self-help meetings and cognitive behavior skill building. JAS participants, approaching their release to the community, are eligible for discharge planning and linkages to appropriate community based treatment services.

The program is designed to

- Encourage and increase the offender's willingness to participate in addictions treatment while incarcerated and the community;
- Provide assessment of drug/alcohol use and criminal thinking;
- Increase access to community based addiction treatment services to offenders released from MCCF;
- Reduce the recidivism rate of program participants; and
- Promote permanent abstinence from alcohol and other drugs.

Correctional officers working in the JAS program are trained to support the structure of a therapeutic community model of addictions treatment. Staff includes master-level therapists and support staff. The program is certified by the Maryland Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration.

One Stop Center Overview and Services

While still incarcerated customers may register for services if they 1) are within eight months of release, 2) have no detainers from another jurisdiction, and 3) are sentenced to MCCF. As the facility also houses individuals who are in a pre-trial status (with unknown lengths of stay), it is crucial to begin services with those who can be reasonably expected to complete the 20-week curriculum. For inmates who are ineligible to participate while incarcerated, the center has created a monthly "Welcome Home" session that explains available services and refers them to their local community-based AJC.

Staff members are referred to as "coaches." This sports jargon is very effective in the largely male environment of the jail. The coaches provide training, guidance, and drill exercises while the customer himself is responsible to put in the needed effort toward measurable success. This approach encourages independence and personal empowerment versus dependence on staff members.

After release, customers have the benefit of continuing the process by working with staff from the jail. This allows for seamless merging of ex-offenders into the pool of non-offender job seekers engaged at the community-based centers. In other words, they become "regular" customers of the career center, which is important, as many have expressed feeling disconnected when they have attempted to use the career centers in the past.

Leadership

Considered a national model jail, MCCF leadership includes Director Arthur Wallenstein and Warden Robert Green. In 2014 U.S. Attorney General Eric Holder, and U.S. Department of Labor Secretary Tom Perez toured the facility as they launched a funding initiative for jails.

Deputy Warden Gale Starkey is responsible for re-entry services including the career center. The center services approximately 250-300 inmate customers per year. As a national jail model, staff is often requested to share best practices at local and national conferences.

My role is to conduct daily operations, assisted by Workforce Development Trainer Coach Donna Rojas, and part-time staff member, Jacque Helms. We are committed to preparing customers to be both job ready and life ready upon release.

Results

On the eve of its 10th anniversary, the MCCF American Job Center boasts many success stories. The program maintains a high retention rate: 93%. While the majority of customers complete the program; reasons for not completing include being released earlier than expected, or opting to drop out. Many who drop out voluntarily often return to complete the program at a later time, or during a new period of incarceration.

Following customers' release, we often receive phone calls from parents, spouses and other family members who thank us for the changes they see in their loved ones. The components that contribute to the success of the program are simple: well trained staff, relevant and targeted curriculum, and customers who are ready to make the necessary changes. Like the customer who "felt human again," participants are exposed to an environment that treats them with respect, dignity, and caring.▼

Coach Alisa Smedley *is currently the re-entry employment coordinator of the full service American Job Center at Montgomery County Correctional Facility (MCCF) in Boyds, Maryland. Ms. Smedley is a native of Cleveland, Ohio. Her consulting firm worked previously with the Ohio's Access to Recovery program under a SAMHSA-funded grant. Smedley has worked at the MCCF American Job Center since 2011. She is currently in the Administration of Justice program at Howard University. Smedley is also a commissioner on the Montgomery County Commission on Children and Youth and serves as a board member of Montgomery Housing Partnership, an affordable housing organization.*

As the child of an incarcerated parent—her father spent 15 years in prison—she is passionate about re-entry. Her unique perspective and voice make her a popular speaker at re-entry and addiction conferences across the country. Alisa can be reached at coachsmedley@gmail.com.

For further information about the Montgomery County Correctional Facility's American Job Center, contact Deputy Warden Gale Starkey at (240) 773-9901 or via email at Gale.Starkey@montgomerycountymd.gov.

IMPROVING THE MOTHER-CHILD BOND USING ASL

By Bonnie J. Kissel, EdD, ARNP, MSN, Tonette S. Rocco, PhD, Thomas G. Reio, Jr., PhD, and Vivian Bango-Sanchez, EdD, ARNP, MSN

Over five percent of pregnant women age 15 to 44 are illicit drug and substance abusers (ID/SA; SAMHSA/OAS, 2008). Illicit drug and alcohol abuse during pregnancy are leading preventable causes of mental, physical, and psychological problems in infants and children (March of Dimes, 2006). Risks include mental retardation, heart defects and an inability to respond to another human face or voice. Severe speech and language disorders have been reported in infants exposed in utero to the use of polydrugs (Budden, 1996). Compared to men, ID/SA women have lower self-efficacy and higher levels of anxiety (Porter & Porter, 2004). Women who abuse drugs and illicit substances during their pregnancy are at risk of not achieving their goal of becoming successful parents (Coyer, 2001). Infants exposed to drugs before birth may or may not suffer withdrawal symptoms at the time of birth or may become distressed and constantly tense after going home (Bauer, 2003), creating parenting difficulties which may overwhelm a new mother and thereby increase her struggle to end her own drug dependency (March of Dimes, 2006).

Stressful parenting experiences can arouse anxiety, undermine parental self-efficacy, and create overall discomfort in the parenting role, particularly among those who are drug or substance impaired (Porter & Porter, 2004). Parents and children can create feelings of inadequacy in each other when a child has difficulty making needs known and a parent has difficulty interpreting and responding to a child's cues. This parenting-related stress can produce maladaptive coping strategies, such as a relapse into drug use (Velez et al., 2004).

Residential treatment programs that include participants' children have been shown to be effective in helping ID/SA mothers significantly reduce their drug and or alcohol use following treatment (Social Care Institute for Excellence, 2005). Many treatment programs facilitate mother-infant interaction and foster harmonious mother-child relationships through activities that facilitate the improvement of communication skills (Porter & Porter, 2004). Residential programs also address issues of shame and guilt and contribute to the mother's sense of empowerment by providing services that meet the often vexing needs of the mother and family (Kissel, Rocco, Reio, Bango-Sanchez, 2014).

Early effectual communication between a mother and infant establishes a lasting foundation for the infant's physical, intellectual, emotional and spiritual development and health (Garcia, 2006). A promising parental tool for improving parent-child communication and ID/SA mother's self-efficacy and decreasing mother's anxiety is the use of American Sign Language (ASL). Through learning ASL, ID/SA mothers have another means to communicate with their infants in a stress-free and motivational way. ASL is the fourth most commonly used language in the United States (National Institute on Deaf and Other Communication Disorders [NIDCD], 2000). ASL is a language with its own rules of grammar, punctuation, and sentence structure. ASL uses hand shapes with position and movement, body movements, gestures, facial expressions and other visual cues (NIDCD, 2000) to form its words. Hearing parents who communicate with their hearing infant using ASL find by the age of 8 or 9 months these infants can effectively communicate through signing, often knowing as many or more words than a hearing child at a similar stage of development without ASL exposure (Garcia, 2006).

We facilitated an ASL program to residents of a rehabilitation center where mothers and infant/children resided together, either voluntarily or by court order due to a drug felony. The mothers who were caring for a medically stable child less than two years old were invited to participate. The treatment program followed Porter and Porter's (2004) intervention protocol, which included: 1) *four weekly classes lasting roughly one hour;* 2) *a protected meeting place within the facility;* 3) *specific instructional strategies (e.g., demonstration and practice, group discussion, and question and answer periods);* 4) *simple songs to promote maternal infant communication (e.g. "Row, Row, Row Your Boat");* and 5) *evaluation data using self-administered questionnaires*. The sessions were interactive with demonstration first by the instructor, followed by the mothers applying what they learned with their child. A selected group of words (e.g., people and food; actions and feelings; body and clothing; colors and animals) was taught each week using Garcia's (2006) ASL guidelines. Garcia's guidelines included: 1) understanding infant communication; 2) recognizing sign language (e.g., benefits, hand shapes, vocabulary, movement, facial expressions); 3) knowing when a child was ready to start; 4) appreciating the best time to introduce sign (e.g., being opportunistic and consistent); 5) understanding how to begin a signing sequence (e.g., use of the appropriate initiating sign); 6) valuing the utility of games for promoting learning; 7) recognizing and greeting infant sign gestures with the appropriate response and encouragement; and 8) repeating and reinforcing sign gestures patiently.

Signs taught in the first class start with simple needs. Examples of such words being taught were:

Milk– The action for this sign is like milking a cow. Make a fist and squeeze and relax. There is no vertical motion; it is just like squeezing an udder. Show this sign immediately before and after drinking.

Eat– To make this sign, touch the tip of your thumb to the tip of your fingers and tap your mouth. Make the sign whenever food is offered, as well as while eating and when finished eating.

Make-up sessions were provided to mothers who had other obligations precluding program participation, such as a doctor's appointment or court appearance. At the completion of the overall program, mothers were given a small monetary award and

a certificate of completion. Interestingly, by the third session, one of the mothers shared that her daughter was already using gestures from ASL. The daughter observed another child at the facility doing something she did not like and gestured in ASL to her mother *"not nice."* Moreover, some mothers shared what they learned with others in the facility who were not in the program. The spontaneous sharing of learning not only created an opportunity to practice the skills they had learned, but also generated appreciable program enthusiasm.

As an example of co-creating knowledge in the classroom, we were stumped during the occasion of a class when a mom remarked that her baby's signing looked like "gang signs." Several moms heartily agreed that watching their baby sign also reminded them of gang signs. Because we did not want to react negatively to this mother's observation, we chose to use this observation to illustrate how children learn. The instructor shared how infants are constantly learning from their environment and that they mimic what they hear and see. The instructor stressed the importance of being good role models in the appropriate use of language and gestures.

Where Do We Go From Here?

The program is relatively simple in design and low-cost, making it easy for program administrators to incorporate into existing rehabilitation programs. To maintain the ongoing practice of this new parenting skill, the staff of the rehabilitation facility can also be trained in the use of ASL. This would give the mothers additional opportunities to practice their newly-learned communication and parenting skills and provide them with positive reinforcement for what they have learned. Expanding the length of the daily classes could provide the participants and educator the ability to have deeper discussions around parenting skills, ASL, and enhancing children's learning.

Participating mothers demonstrated a reduction in anxiety by virtue of participating in the ASL intervention classes (Kissel et al., 2014). We must be mindful that ID/SA mothers perceive themselves as a failing parent and parenting difficulties increase when trying to end a drug dependency (Coyer, 2001; March of Dimes, 2006). As high levels of stress can influence the way a woman approaches parenting (Velez et al., 2004), there is a pronounced need to teach parental skills to help reduce the anxiety from these stresses (Coyer, 2003). Learning new parenting skills can increase a recovering mother's self-esteem, alleviate self-contempt and deepen the affective bond with her child (Bauer, 2003). These new skills help the mother deal better with the often intense and counter-productive feelings of guilt and shame related to self-perceptions of being a failure as a parent (Coyer, 2003). The ASL program provides each participant an opportunity to successfully complete a wide range of parenting tasks and create the mastery experiences necessary to increase both her sense of parental efficacy and the belief that she too can be an effective, responsive parent.

Residential treatment programs for ID/SA mothers specifically addressing women's needs have been decidedly beneficial, as they facilitate mother-infant interactions, improve communication skills, and increase the mother's knowledge of self-care and relaxation (Porter & Porter, 2004). One noteworthy method of fostering positive mother-child interactions and bonding could be the addition of parenting enhancement skills to existing rehabilitation programs (Porter & Porter, 2004). Higher parenting efficaciousness can lower the mother's vulnerability to stress and the anxiety caused by such stress; thus, teaching useful parental skills may help reduce anxiety (Coyer, 2003). Infants exposed to ID/SA in utero are more likely to suffer from language difficulties and speech development issues. Interventions such as the ASL parenting program may hold promise for facilitating better mother-child communication especially among developmentally-delayed children, allowing infants and young children to better express their needs without frustration. Such programs support building the effective mother-child affective bonds so necessary for the development of the child's trust, curiosity, exploration and all-important learning (Kissel et al., 2014; Reio, 2012).▼

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LIONS and TIGERS and BEARS, OH MY!

AN EXAMINATION OF ROLES AND ETHICS

By Mark Shields, LPC, CRAADC and Scott Breedlove, MRSS-P, MARS

Self-Disclosure, Dual Relationships and Setting Boundaries are common topics that an instructor may cover during a typical ethics training. For years, behavioral health professionals have shared common beliefs and practices that provide comfortable guidelines for professionals to adhere to when signing and agreeing to abide by a code of ethics. However, in the last few years, a noticeable change has occurred. Training sessions are bringing a diverse group of individuals together who may work within the same field of behavioral health, but have traveled different paths to this destination and bring with them different beliefs, perceptions and opinions.

The current substance use disorder recovery field includes multiple service practitioners with varying degrees of qualifications. Counselors, community support workers, peer and faith-based recovery support providers have unique service functions but share similar roles creating the opportunity for role confusion (White, et al, 2004).

Each practitioner seeks to create a therapeutic relationship characterized by warmth, respect and empathy. The effectiveness of the behavioral health practitioner depends on the quality of the therapeutic relationship. This interpersonal relationship is powerful—being either incredibly healing or incredibly harmful. Minimum guidelines of conduct are created by a professional code of ethics, and it provides objective feedback to allow the professional and others to measure conduct. These guidelines between acceptable and unacceptable behavior may vary slightly based on the role an individual serves in the treatment and recovery process. A professional clinician uses education and training to create therapeutic interactions promoting goal directed behavioral change. A community support worker arranges and coordinates services, resources and supports. The peer relationship is unique in that it draws on the personal recovery experience to inspire hope, confidence and direction, (White, et al, 2004) while the faith-based relationship builds and repairs the clients' spiritual resources.

In 1852, William Booth started his evangelistic ministry career, which eventually blossomed into what we now know as the Salvation Army (salvationarmyusa.org, 2015). Today faith-based ministries provide a variety of recovery support services such as housing, transportation, life skills education, spiritual counseling and coordination of care. Faith-based providers believe a spiritual transformation is key to sustainable recovery. Faith-based recovery support service ministries are often independent organizations or may be sponsored by church congregations. Faith-based recovery ministries sponsored by church congregations are often able to leverage church infrastructure and resources in order to be financially self-sufficient and operate efficiently.

Spiritual counseling explores problems and conflicts from a spiritual perspective and may involve

1. establishing or reestablishing a relationship with a higher power;
2. developing personal connectedness with a spiritual, religious or faith-based entity;
3. acquiring skills needed to cope with life-changing incidents;
4. adopting positive values or principles;
5. identifying a sense of purpose and mission for one's life;
6. achieving serenity and peace of mind;
7. finding life purpose;
8. overcoming emotional, social, mental or physical obstacles; and
9. putting pain and grief into perspective.

Dual Relationship May Create Dilemma

Clergy provide spiritual counseling to individuals who are or may become members of the local congregation and providing these services to church members or potential church members can present particular ethical challenges. One such example is that churches depend on financial contributions and tithes of the local congregation, as well as give financial and other types of aid to those with needs. This can create a dilemma concerning what contribution expectations are placed on the member receiving services and what type of financial or other aid can a church provide this member. Questions as to whether or not a dual relationship has been created and whether or not the member is being financially exploited are raised.

In 1935, Bill W. helped Dr. Bob S. get sober and the foundation of a person in recovery helping another peer in the recovery process was born (AA, 2015). Training, credentialing and employing a peer recovery coach is a relatively new principle in the recovery field. Mutual self-help support groups have traditionally been financially self-supported through member donations. Peers are valued because of their personal experience and ability to relate, helping others through sharing their lived experience in addiction and recovery. Peer recovery coaches

develop supporting relationships, provide a connection to a peer group, model recovery behavior, advocate for needed services and empower the consumer to make successful life choices. Peer recovery coaching is relational, can be delivered in multiple venues, and is provided by a peer with a lived experience. Professional peer recovery coaching roles are relatively new to the behavioral health system and may overlap with existing counselor and community support functions leading to the possibility of role confusion. A peer recovery coach is not a sponsor, counselor, nurse, psychiatrist, or clergy (White, et al, 2004). Peer recovery coaching may include

1. helping consumers connect with other consumers and their communities in order to develop a network for information and support;
2. sharing lived experiences of recovery, sharing and supporting the use of recovery tools, and modeling successful recovery behaviors;
3. helping consumers to make independent choices and to take a proactive role in their recovery;
4. assisting consumers with identifying strengths and personal resources to aid in setting and achieving recovery goals; and
5. conducting recovery management check-ups over time, and assessing victories, strengths, challenges, and setbacks. (Missouri Division of Behavioral Health, 2014)

The peer recovery coach might need assistance determining how to relate as a peer while maintaining boundaries. Typical counselor ethical codes and expectations may not be appropriate for this new role. New ethical codes must be created and new ethical trainings delivered by competent trainers who can "speak" the language of lions and tigers and bears, all at the same time. Quality ethics training and supervision is vitally important in helping peer coaches be successful in their new role within a recovery system. This role has the potential for more opportunities of dual relationship issues such as sexual intimacy, socialization outside of official duties and financially exploitive situations.

Community support work connects the consumer to health and wellness resources empowering community integration and self-determination. Community support work is typically a one-on-one service with the consumer and typically occurs in the home and community. Community support work is practical and life skills oriented and may include

1. locating, referring, arranging coordinating and advocating for services and resources;
2. providing experiential training in life skills and resource acquisition; and
3. re-engaging clients following absence. (Department of Mental Health, 2005)

Ethical issues include privacy, confidentiality, financial exploitation and other dual relationship boundaries.

Standard Guidelines Promote Client's Recovery

Counselors have long placed a high value on experience, education, credentialing, licensure, evidence or science based results. The credentialed or licensed professional counselor has supervised experience, training and education.

Counseling includes

1. assessing and exploring identified problems and their impact on functioning;
2. verbal and non-verbal techniques, methods or principles for influencing behavior change; and
3. examination of thoughts, perceptions, attitudes, emotions, motivation and behaviors to promote improved functioning and recovery. (Department of Mental Health, 2005)

The professional counseling relationship is clearly defined and usually time limited, however, counseling is always conducted in a private setting and has the most hierarchical relationship. Some clients are emotionally vulnerable and easily exploited.

Why is "do no harm" not enough? Why do we need a complex set of ethical principles and codes that are specific to provider roles? Human beings have a remarkable capacity for self-deception.

Even the most experienced and stable behavioral health practitioner would be more vulnerable to boundary and ethical mistakes when they are experiencing a crisis in their personal life such as divorce, significant loss, illness and loneliness.

Counselors, community support workers, faith-based professionals and peers need standard guidelines that provide direction and guidance within the job functions they perform. Care must be taken to clearly define unique and common key service functions to prevent role confusion and practicing outside of the accepted scope of practice for that role. A code of ethics and supervision provides the objective feedback professionals need. At first glance, the response to a room full of lions and tigers and bears might be "Oh My!" However, with the appropriate training and ethical guidance, this team of diverse professionals provides the greatest opportunity for successful recovery in the clients we serve.▼

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LESSONS LEARNED ABOUT DENIAL in Persons with SERIOUS MENTAL ILLNESS

What we are dealing with here is anosognosia—a neurological syndrome that leaves patients unaware that they are ill.

By Xavier Amador, PhD

When I was a child, my older brother Henry was my hero. Our father died when I was just shy of 3 years old, and Henry—though only eight years older than me—did a lot to fill his shoes. We were very close and he taught me many important lessons in life, including the importance of being honest with yourself. Henry was always very insightful and responsible. But all that seemed to change after his first hospitalization for schizophrenia. He seemed suddenly to become defensive, in denial, and irresponsible.

After that first hospitalization, and many more that followed in the first few years of his illness, I learned an important lesson: My natural instinct to confront denial head-on didn't help and more often led to disaster. Whenever I discovered that he had once again stopped taking his medication—he never saw it as "his" back then—I would ask him why. Our conversations went something like this:

"I'm okay now. I don't need it anymore," he explained.
"But the doctor said you're probably going to have to take this medicine for the rest of your life. You can't stop taking it!"
"He didn't say that."
"Sure he did! I was at the family meeting, remember?"
"No. He said I had to take it while I was in the hospital."
"Then why did he give you a supply of medicine to take home?" I argued, trying to prove him wrong.
"That was just in case I got sick again. I'm fine now."
"No. That's not what he said."
"Yes, it is."
"Why are you being so stubborn? You know I'm right!" I said.
"You're the one who needs help, not me!"

With every dose of "reality"—*my* reality, not his—I tried to give him, Henry countered with more denials. And with every go-round we both became angrier and angrier. Our once trusting and respectful relationship became one marked by distrust and a surprising lack of respect on both our parts. As you will read below, for professionals working with persons with all kinds of serious mental illnesses (SMI) a relationship characterized by mutual respect and trust is key to many things including the person's attitudes about treatment, their satisfaction with their healthcare provider, and their ability/willingness to take medicine reliably. Although there is not nearly as much research on family members, my personal experience is the same holds true for family relationships (Amador, 2012; Day, et al, 2005).

Before I turn to that research and other relevant findings, one more comment about my relationships with my brother is in order. Because I didn't understand the root cause of his longstanding denial I thought he was being stubborn and immature. My accusations and threats to prove him wrong made him angry and defensive. My natural instinct to confront his denial was completely ineffective and made things worse between us. The end result was that he usually walked away from such arguments.

In 1989, when I first started doing research on the problem of poor insight into having a mental illness, there were fewer than 10 studies in the research literature. Today, there are close to 300! There has been an explosion of new research on this problem, and we have learned a great deal. I would like to share the two most important lessons that I—and the field—have learned in that time.

It's Not Denial

Research shows that about 50% of persons with schizophrenia (about 1.5 million in the U.S.) do not know they have an illness, and this unawareness does not improve with education, time, or treatment (Amador, Strauss, Yale, & Gorman, 1991; Amador & Andreasen, 1994; DSM-IV-TR, 2000; DSM-V, 2013). I purposely did not use the term "denial" in the previous sentence because this problem is not denial. Denial is a coping strategy, a way we deal with painful knowledge. People in denial know something deep down inside (unconsciously), but they lie to themselves about it. But the research indicates that this is not what we are dealing with when, after months and years of evidence, the person still does not believe she or he is ill. What we are dealing with here is anosognosia (AH-no-sog-NO-sia)—a neurological syndrome that leaves patients unaware that they are ill (Amador, Strauss, Yale, & Gorman, 1991; DSM-IV-TR, 2000; DSM-V, 2013).

According to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR), "A majority of individuals with schizophrenia lack insight ... Evidence suggests that poor insight is a manifestation of the illness itself, rather than a coping strategy ... comparable to the lack of awareness of neurological deficits seen in stroke, termed anosognosia." (DSM-IV-TR, 2000, p. 304)

As cochair of the last revision of the *DSM-IV* text on schizophrenia, I was asked to propose changes that would better reflect scientific consensus. Every change considered had to be peer-reviewed by other scientists. The quote above reflects scientific consensus in the field (as of 1999) that poor insight is common in schizophrenia and is linked to executive (or frontal lobe) dysfunction. In the seven years since this update in the *DSM*, many new studies have replicated this finding.

The workgroup on *DSM-V* (our current diagnostic manual in psychiatry) asked me to review the literature again and submit the text for the same section. Here is what the research tells us today:

> Unawareness of illness is typically a symptom rather than a coping strategy. It is comparable to the lack of awareness of neurological deficits following brain damage, termed anosognosia…This symptom is the most common predictor of nonadherence to treatment. It has been found to predict higher relapse rates, increased number of involuntary treatments, poorer psychosocial functioning, aggression, and a poorer course of illness. (DSM-V, 2013, p. 101)

If you believe that the person you are trying to help has anosognosia for schizophrenia, rather than denial, then you should not say that this person "refuses to acknowledge he is ill." That would be like accusing someone of refusing to stop being delusional or hallucinating. We don't do that because we understand that these are symptoms of the disorder and not the person's choice. Armed with this knowledge and some additional research, you can become much more effective at convincing someone who has anosognosia—someone with poor insight—to accept treatment and services.

Relationships are the Key

Too often, people with anosognosia for schizophrenia feel that we (I am speaking here both as a therapist and as a family member) are their enemies. From their perspective we are not allies because we keep trying to convince them of something that they know, with certainty, is not true. In this context it is not surprising that the relationship often deteriorates and becomes adversarial. However, once you understand that the mentally ill person's refusal to accept treatment typically results from a brain dysfunction that is beyond his control, you will see why you shouldn't take it personally or blame him for what appears to be deliberate denial. In fact, from this person's point of view it is common sense to refuse treatment. If we take the psychoeducational, or medical model, approach and tell the person (again and again) that they are ill, we will only drive them further from the people and help we believe is needed.

Research on the "therapeutic alliance" across a wide range of disorders finds that it predicts the effectiveness of treatment and positive treatment outcomes (Amador, 2012; Day et al, 2005). In one study published in the *Archives of General Psychiatry* the investigators studied 228 patients with either schizophrenia or schizoaffective disorder and found that "the quality of the relationships during acute admission [was] an important determinant of patients' attitudes toward treatment [more positive] and [better] adherence to medication" (Day, et al, 2005). This is one of many studies that find the same thing: the therapeutic alliance is a powerful predictor of who will accept treatment and stay in treatment. It is more important than the experience of side effects or many other factors studied. And relationships matter in this way even when the patient has anosognosia for mental illness.

This research begs the question: How does one develop a strong therapeutic alliance? One way to answer that question is to look at studies of interpersonal techniques that have been found to improve treatment adherence. Motivational interviewing, developed more than 30 years ago to help people with substance abuse problems accept treatment, has been well studied and can be very effective in helping people who do not understand they have a mental illness accept treatment and stay the course. In fact, in their review of 20 years of research aimed at improving medication adherence in persons with schizophrenia, a Columbia University psychologist and her colleagues found that "although programs utilizing family therapy and psychoeducation were common in clinical practice, they were typically ineffective [at improving medication adherence, or compliance]." Instead "those programs that utilized [elements] of motivational techniques were effective…" (Zygmunt, Olfson, Boyer, Mechanic (2002); (Paillot, 2009)

In 1998, in collaboration with Aaron T. Beck, I developed a six-session inpatient intervention aimed at improving insight into illness and medication adherence in patients with schizophrenia. This therapy based on motivational interviewing and cognitive therapy did not appear to improve insight as we had hoped at the time, but it did improve the therapeutic alliance. From this experience I pulled together a more simple intervention which added elements of Carl Roger's client centered therapy into the program which was then boiled down to its core communication tools aimed at improving the alliance, turning adversaries into

continued on page 22

By Kirk Moberg, MD, PhD and Philip Scherer, CADAC, NCGC II, MISA II, CIP

Process Addictions

An Overview

It is not an understatement to say that the understanding of process addictions as a group is at its infancy.

Process addictions, also called behavioral addictions, constitute a group of disorders that are characterized by an inability to resist an urge to engage in a particular activity. These activities include gambling, sex, shopping/spending, Internet utilization, Internet and video gaming activities, eating disorders, and possibly tanning (Grant, Kim, & Odlaug, 2009; Karim & Chaudhri, 2012; Warthan, Uchida, & Wagner, 2005). They share some significant commonalities with substance use disorders, some of which include the experience of anxiety or excitement preceding the activity and pleasure during the activity (Grant, Potenza, Weinstein, & Gorelick, 2010). The American Society of Addiction Medicine (ASAM) recognizes process addictions in its formal addiction definition as follows:

> *Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors [emphasis added] (2011).*

Before proceeding further it is helpful to review what is known and not known regarding process addictions:

- There is a lot more known about substance use disorders than process addictions.
- Gambling disorder is the best understood process addiction.
- There is evidence for a variety of neurotransmitters involved.
- Like substance use disorders, process addictions make use of mesolimbic and mesocortical neural pathways.
- Parkinson's disease provides an interesting lens through which to study at least some of the process addictions.
- There are a variety of treatment modalities for process addictions.

It is not an understatement to say that the understanding of process addictions as a group is at its infancy. In fact, it is not clear they constitute a real grouping. In the *DSM*-5 they are separated into a variety of different sections. For example, binge eating disorder is under eating disorders, kleptomania is in impulse control disorders, Internet gaming disorder in Section III—which means it is still being studied to determine if it is a true disorder—and gambling disorder is grouped with the substance use disorders, which makes it the only disorder so grouped. Nevertheless, there are sufficient similarities on clinical and neurochemical grounds that suggest a common etiology.

Clinical Themes

Shared characteristics of these disorders include continued participation in the behavior despite adverse consequences, diminished control, cravings, and a hedonic quality during the performance of the behavior. Other clinical findings that are similar to substance use disorders include adolescent- or young-adult-onset, chronic relapsing patterns, a significant spontaneous remission rate, tolerance, and a dysphoric state when abstaining. However, there is no evidence of physiologic withdrawal symptoms.

An interesting clinical phenomenon is "telescoping," a term that refers to an accelerated progression of addictive disorder when the onset occurs later in life. This has been observed in women with gambling disorder when comparing the progression of their disease to men. Interestingly, it has also been described in alcoholism and other drugs such as cannabis, opioids, and cocaine. However, this finding was not confirmed in a recent study possibly due to the observation that younger cohorts are initiating drinking earlier in life.

Neuroanatomy and Neurochemistry

Gambling disorder has the most robust literature base of the process addictions at the present time, and therefore it is a useful model from which to study the remaining process addictions with respect to neurobiology. Although there are a variety of neurotransmitters implicated, the role of dopamine appears central to the process. This neurotransmitter is released in response to the exposure to addictive drugs in certain parts of the brain to produce a euphoria or reward. Similarly, it is released in those with gambling disorder as a function of reward expectation and gambling severity, but not necessarily with the task of gambling itself.

There is an interesting clinical phenomenon that has been recognized with respect to dopamine. Some patients with Parkinson's disease or restless legs syndrome—and who are being treated with dopamine agonist medications, especially those that stimulate the D2 and D3 receptor subtypes—develop a variety of process addictions even if they have not exhibited those behaviors in the past. These include gambling, hypersexuality, binge eating, compulsive shopping/spending, skin picking, and pathological Internet use. This is additional evidence of the importance of the role of dopamine. Interestingly however, investigators have observed that both dopamine agonists and antagonists have been linked to gambling behaviors. Other likely neurotransmitter candidates include glutamate (compulsiveness and cognitive inflexibility), endogenous opioids (pleasure and urges), serotonin (impulse control), norepinephrine (arousal and excitement) and cortisol (stress).

The mesocortical and mesolimbic circuits, pathways that mediate processes involved in substance use disorders, also appear to be central to the process of repetitive behaviors in process addictions. These circuits include structures that mediate reward (ventral tegmental area and nucleus accumbens), memory (amygdala and hippocampus), coordination of behavior and movement (substantia nigra and dorsal striatum) and executive function (prefrontal cortex). These pathways can be "hijacked" by addictive drugs and presumably by impulsive or addictive behaviors as well.

Psychological Treatment

The evidence base for treatment for various process addictions ranges from clinical trials to case reports with an emphasis on the latter. Cognitive behavioral therapy (CBT) has shown promise for gambling disorder. This therapy specifically targets the cognitive distortions associated with a disorder. With respect to gambling, the patient is taught to restructure such distortions as the near-miss fallacy, gambler's fallacy, and chasing one's losses as well as other superstitions such as the illusion of control over random events and the value of talismans such as lucky numbers, colors or articles of clothing. Yet another technique that is being increasingly used to treat gambling disorder is mindfulness.

CBT has also shown promise for the treatment of compulsive buying, sexual addiction, and binge eating disorder. Its evidence is limited to case reports in the treatment of Internet addiction and kleptomania.

Medication Assisted Treatment

Although there are no medications approved by the Food and Drug Administration (FDA) for the treatment of any process addictions, there are a variety of medications used "off label." Randomized clinical trials exist that support the use of the opioid antagonists naltrexone and nalmefene for the treatment of gambling disorder. At present this class of drugs would be considered first line therapy, especially for those with a family history of alcoholism, co-occurring substance use disorder or particularly intense gambling urges. Some additional data supported medications to treat gambling are N-Acetyl Cysteine, a glutamate modulator; fluvoxamine, a selective serotonin reuptake inhibitor (SSRI); carbamazepine, a mood stabilizer; lithium, for those with bipolar disorder and gambling disorder; and amantadine, a medication used to treat Parkinson's disease.

Bullock and Potenza (2012) published an excellent review article summarizing the clinical trials of medications studied to date and the reader is referred to that article for further details. They also provide an algorithm to guide the treatment of those with gambling disorder. Those who are reluctant to try medications could attempt a trial of N-Acetyl Cysteine. If an individual is experiencing urges or cravings to gamble or has a co-occurring substance use disorder, consideration of an opioid antagonist is appropriate. An SSRI trial is reasonable if the patient is experiencing anxiety or depression. If they are experiencing mania or hypomania, lithium is an excellent adjunct.

continued on page 18

Sexualized Transference in Older Adults

By Sarah Mourra, MD

Of all the transferences that emerge in the consultation room, sexual feelings are by far the least talked about and the most challenging for therapists to manage. When sexualized transference occurs in work with older adults, these challenges are amplified. As the population ages, more older adults will require or seek out mental health treatment, and effective recognition and management of this issue will be an inevitable part of treatment.

Sexual transference expressed by older adult patients does not differ dramatically from younger adults, other than involving unique barriers to its recognition and management. As in younger adults, it can range from aggressive lustful longings to intimate and tender feelings. Some have made the distinction between *erotic transference* (in which the patient understands their fantasies as unrealistic and does not present a barrier to further work) and *eroticized transference* (in which the patient has an irrational preoccupation with the clinician and makes overt demands for sexual fulfillment, avoiding insight into the transference) (Ladson, 2007). However, the overall challenge with erotic transference lies in both the patient and the clinician recognizing it as a distraction or a disguise for a wide range of affective experiences, as well as unresolved developmental difficulties and interpersonal conflicts (Bridges, 1994). For this reason, it presents an opportunity for clinicians to address underlying issues that may be at play.

Erotic transference possesses many underlying meanings. Sexual feelings may provide a way for patients to defend against feelings of dependency or passivity, particularly when the age gap between the therapist and the patient creates a reversal of power dynamics that the patient feels uncomfortable with. Additionally, focusing on lustful or "falling in love" feelings is an effective defense against dealing with grief over the loss of a loved one, which many older adults confront. It may also serve as a method of combatting loss of sexual potency or physical strength and beauty (Nemiroff & Colarusso, 1985). For older adults who have experienced traumatic experiences in childhood related to a caregiver who may have perpetrated sexual abuse, the experience of being cared for and being sexual may become conflated. For patients who have fears of intimacy, and for whom the process of growing to trust the therapist triggers these fears, expressing sexual feelings in a manner that repels the therapist may lessen feelings of vulnerability (Bridges, 1994).

Many barriers impair recognition of these underlying dynamics. For instance, many clinicians have difficulty acknowledging older adult sexuality, often due to avoiding awareness of the intimate lives of parents and grandparents in their own families. Some theorists have suggested that this triggers Oedipal issues, which prevent practitioners from considering sexual attraction coming from someone who resembles a parental figure (Bridges, 1994). Additionally, due to having lived through different life roles, older adults have the capacity for a myriad of transferences, which may surprise clinicians. Indeed, Patricia King has theorized that older adults have a complex experience of age—which involves experiencing the self psychologically (the age they feel), biologically (their physical appearance and health) and chronologically (the age they actually are) (King, 1980). Management of sexualized transference must consider all of these factors.

Clinicians should also note that media and pop culture influences strongly perpetuate barriers to acknowledging sexual feelings in older adults. Many films and television shows portray elders as either asexual or hypersexual, with very few portrayals in between. This may contribute to restrictive societal perceptions of sexuality in older adults and more intense or ambivalent responses from clinicians when this emerges (Gussaroff, 1998). Therapists must also consider that for many older adult patients, their "real" objects (spouses, parents, friends) may have passed away, enhancing the therapist's role as both a transference object and a real object (Bridges, 1994). It is not unusual for a patient to express that seeing the clinician is often one of the few "outings" or moments of human contact during the week. In this context, the patient's expression of sexual feelings may create worries about dependency and feelings of suffocation on the part of the clinician, leading to distancing behaviors.

Physical Touch May Prompt Sexual Transference

Cultural factors are also important for clinicians to consider. The culture of geriatric psychiatry in general tends to employ touch far more than general adult psychiatry. This is partly due to data indicating that for patients with sensory or neurological impairments, or with dementia, physical touch can be reassuring and soothing (Hawranik, Johnston, & Deatrich, 2008). Other aspects contributing to this include positive familial countertransference toward older adults, as well as actual or perceived loneliness and need for physical comfort. However, this lower threshold for touch in the therapeutic setting with older adults may also be an indicator of clinicians unintentionally subscribing to the stereotype of older adults as asexual or "harmless." Nevertheless, integrating physical touch into patient care may become challenging when sexual transference emerges in the therapeutic encounter. For this reason clinicians should carefully consider the risks and benefits of using physical touch in an older adult patient.

Co-morbid cognitive dysfunction presents perhaps the largest challenge in managing sexualized transference in older adults. Geriatric psychiatry's strong focus on monitoring for disinhibited behavior or hypersexuality as indicators of cognitive impairment may lead clinicians to use these diagnoses as a method of unintentional avoidance. Additionally, memory loss may be a result of dynamic conflict and situational stress, rather than impending dementia (Nemiroff & Colarusso, 1985). However,

clinicians must also recognize brain change effects such as frontal lobe disinhibition, agnosia leading to misidentifications, and loss of ability to understand context. These cognitive impairments often co-occur with the patient's psychological experience and reaction to brain disease, which may include sexual feelings or behavior. Making this determination requires close observation of the person's behavioral patterns in a variety of contexts, including reports from family members and caregivers. Even in patients with more prominent dementia and inappropriate sexual behaviors clinicians must consider psychological factors such as boredom, lack of physical closeness, or need for control and mastery of a situation (Robinson, 2003). In a study involving inappropriate sexual behaviors in a nursing home population, only 40% of perpetrators had cognitive impairment, indicating that other factors must be considered in the course of management (Harris, 1998).

Ignoring sexual feelings, or setting harsh limits around expression of feelings in the therapeutic setting can be hazardous. These actions can cause isolation, shame, guilt and withdrawal in both the therapist and the patient (Nemiroff & Colarusso, 1985). Clinicians experiencing guilt over admonishing a patient for expressing sexual interest may overinvest in therapy to compensate, including extending session time or reducing fees. This behavior may send conflicting signals to the patient and complicate matters further (Bridges, 1994).

Effectively dealing with and managing sexual transference in older adults involves three steps: Conceptualizing, Containing and Managing. Conceptualization requires obtaining supervision from superiors, colleagues or peers if needed, and identifying the variety of factors that may be at play. These include assessing the clinician's physical and emotional safety, psychological and transference factors, degree of cognitive impairment, environmental and cultural factors, and countertransference.

Setting Limits, Normalizing Feelings May Be Helpful

Containment primarily involves containing one's own reaction, which may involve anxiety, alarm, disgust, withdrawal or even reciprocation (Hillman & Stricker, 2001). Clinicians should recognize that, unless physical and emotional safety is at risk that they may not need to act right away. Setting an empathic limit is often useful, which depends heavily on the characteristics of the patient and the therapist. Often simply observing the behavior can bring it into the patient's conscious awareness (Ladson, 2007). For behaviors or comments that threaten physical or emotional safety, clinicians may want to emphasize that treatment needs to be a safe space for the patient to get the treatment that they deserve, and that psychotherapy is a verbal treatment that does not involve physical contact (Bridges, 1994).

Normalizing feelings can also be helpful. An example of this would be a statement like: "It is often normal to have sexual feelings that come up in our treatment together as we have done a lot of work on intimate and difficult things. It often takes a lot of courage to talk about these feelings. I would like to explore how these feelings may relate to what is going on in your life right now." Other statements such as "I am wondering if there is someone else in your life who you felt that way about at one time or another" can help shift the focus towards the underlying meaning of these feelings and how they relate to the patient's experience. Comments like "maybe I make you think about the kind of relationship that you would like to have?" can help the patient associate to current unmet needs and affective experience.

Management means moving forward and working through feelings as they come up, while continuing to obtain supervision. In older adults, as cognitive impairment may progress or occur, clinicians should periodically reexamine their conceptualization of the case and underlying contributing factors. Maintaining the delicate balance between a curious and empathic stance and setting boundaries is key.

For psychiatrists who work primarily in a supervisory role on a team, being able to recognize and manage erotic transference is key. Often, patients may develop sexual feelings towards a member of a team, causing conflicts among other team members (Berman, 2010). Psychiatrists can be helpful in identifying these dynamics and educating other care providers about their management. Recognizing these issues can greatly impact care for patients at all levels of functioning.

In conclusion, it is key for providers to recognize that sexual feelings are like any other strong affect that emerges in treatment, and that sexual feelings in older adults present unique challenges that, if understood, can enrich the therapeutic experience. Frequently, unmanaged or unrecognized countertransference in work with older adult patients can manifest as ageism, or the determination that patients are "not appropriate" for treatment. Awareness on the part of the clinician can avoid these pitfalls, and better serve the needs of this special population.▼

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continued from page 15

Other process addictions do not have the strength of evidence to support them with the same degree of confidence. This is primarily due to small sample sizes, placebo response rate, and dropout rates. However, some evidence exists although in some cases it is limited to case reports. The following is a list of disorders matched with medications that has shown a potential for success:

- Trichotillomania (naltrexone)
- Hypersexuality (naltrexone)
- Kleptomania (naltrexone)
- Compulsive shopping/spending (citalopram)
- Hoarding (paroxetine)
- Binge eating (topiramate, orlistat, zonisamide, atomoxetine)
- Internet gaming (escitalopram)

Who's at Risk?

There are many risk factors to be considered in determining those most at risk for developing a process addiction problem. An existing substance abuse problem is often found with those suffering from pathological gambling, sexual addiction or another process addiction (Bourget, Ward, & Gagne, 2003). Other factors may be trauma, preexisting psychiatric issues (Petry, 2006), poverty, age, gender, and poor impulse control.

A preexisting substance abuse problem is by far the number one correlate with people suffering from a process addiction. This is not to say that one causes the other, but to point out that many sufferers of say, disordered gambling or sexual addiction also will present with another addiction problem. Neglect and abuse issues in childhood are linked to negative life experiences as adults that in turn may include addiction issues (Moore & Jadlos, 2002). Gambling as a means out of poverty can lead to a disordered gambling problem (Welte, Barnes, Wieczorek, Tidwell, & Parker, 2004). Young males are more likely to develop a disordered gambling problem as opposed to young females, but that changes as people age; in older adults it is the female who is more likely to experience problems with disordered gambling (McCormack, Jackson, & Thomas, 2003) or shopping and spending money.

Conclusion

Although there is still a lot left to be learned regarding process addictions, it seems clear that there are many similarities to the substance use disorders. Congruencies in natural history, clinical characteristics, neurochemistry, and neuroanatomy argue for a common source for all. A comprehensive treatment program that offers of psychological and medication interventions would intuitively bring about the best outcome although for many of these disorders there is no evidence to prove that assertion. A variety of medication assisted treatment strategies is helping us understand the relevant neurotransmitters and an understanding of the underlying neurobiology helps us develop new medications.▼

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Counseling for Medication-Assisted Recovery

Tools and Tips

By Gary Blanchard, MA, LADC1

For years, addiction treatment was provided in dedicated treatment programs; medication was not a usual component of treatment. With the recent introduction of medications like Suboxone, Zubsolv, and Vivitrol for opiate dependence and now Campral and Vivitrol for alcohol dependence, treatment has begun to shift from dedicated addiction treatment facilities to the physician's office. This shift presents new challenges to addiction treatment professionals.

Traditionally, there is very strong sentiment that those engaged in Medication-Assisted Recovery (MAR) programs are not really in recovery. This attitude can be seen in professional treatment as well as in the self-help community. One of the first things that we, as addiction treatment professionals, need to ask ourselves is whether we accept, or can accept, the premise of MAR. As newer medications are placed on the market, more people will opt for this approach. If a clinician is able to change his or her attitude to accept that medication can play a role in recovery, he or she is in a position to have a tremendous impact. If the clinician is not able to accept MAR then he or she should continue to concentrate on working within the drug-free treatment community to have an impact there.

A frequent criticism of MAR is that the client is simply exchanging one drug for another. This is true of some medications currently being used; some of the newer medications, however, especially those still in development and testing, are focused on balancing brain chemistry rather than preventing withdrawal and craving. In any case, the use of medication may be the best way to first bring a person into the recovery process. There is no wrong door to the treatment process.

Fear of withdrawal and its physical effects is a prime motivator for continued use of mood-altering substances even after the negative consequences of use outweigh any benefit that the drug provides. For many, the idea that a prescribed medication can eliminate the need to use illicit drugs is enough to bring them into treatment. If, in becoming involved in a MAR program, they are also exposed to the idea that continued recovery also requires work, skills, and support, the person is more likely to succeed in treatment. In order for clients to get this message there is a need for trained addiction counseling professionals who are willing and able to work with the client while they are engaged with their prescriber and are taking medication.

Another attitude or belief that the addiction professional must face is the idea that the ultimate goal of all clients should be total abstinence from all mood-altering substances. While that goal is ideal, the fact is that many of our clients, in both drug-free and MAR programs, do not come to us with a goal of total abstinence. If the client is faced with a forced choice to accept a goal of total abstinence or to leave treatment, many will choose to leave treatment, even if they have entered treatment under compulsion. The job of the addiction treatment professional is to meet the client and help focus on immediate goals, and from there aid in moving toward a goal of total abstinence.

Abstinence and Recovery Not Identical

Many clients in MAR programs feel that the medication will remove the cravings for use, thus eliminating the problem. Research, however, shows that in addiction, just as in the treatment of mood disorders, the combination of medication and therapy is the most efficient treatment. It is the role of the

continued from page 19

Ultimately, the goal is for the client to be just as successful in the maintenance phase of recovery as he or she was in the action phase.

clinician to help the client recognize the difference between abstinence and recovery. The idea that simply abstaining from substance use equates to recovery is all too common. Often the client and his friends and family see abstinence as the goal. They fail to recognize that abstinence can be fleeting without a change in attitudes, beliefs, and behaviors.

Another common client belief is that one particular substance is the problem; if they can stop using that substance, then it is acceptable to continue use of other mood-altering substances. Thus, the client's goal may not agree with the goal of the treatment professionals. Other times the client's goal is not cessation of the drug of choice but simply controlling the use. This is less common in MAR, but does come up from time to time.

Frequently, clients involved in MAR have had previous experiences in addiction treatment programs and have made assumptions about the treatment they will receive from us. If they have ever taken part in a drug-free program while taking medication to assist recovery, they may very well expect to be judged and possibly rejected. They may feel that the clinician will want to exert his or her treatment plan rather than work with the client's wishes. They may feel that the clinician has nothing to offer if the clinician hasn't had the same experiences. While this challenge is the client's, we as clinicians can help him or her meet this and find success in recovery.

The growth of Medication-Assisted Recovery has expanded treatment options and moved treatment out of specialized addiction treatment facilities into the doctor's office. As a result, people who seek medication for recovery find themselves out of touch with those who can provide the cognitive and behavioral support they also need in order to be successful.

Some prescribers understand the need for a combination of medication and counseling, but others do not. It is the job of addiction counselors and other professionals to reach out to prescribers and to form therapeutic alliances that help to assure that recovery becomes a reality.

Creating Alliance with Prescribers an Effective Approach

It would be nice to believe that physicians who choose to prescribe medications that assist in recovery would seek out area professionals, but that is not always the case. The addiction counselor needs to reach out to prescribers and to form alliances with them. The pharmaceutical companies often provide websites that list physicians who are trained to prescribe medications that treat addiction. I have reviewed those lists and sent information to the prescribers about my services, and requested a chance to meet with them to discuss how we can work together to help their patients succeed in recovery. Some doctors like to have someone who will come to their office to allow their patients to make one trip for both services. Others prefer to have the patient go to a different facility. I have worked with some physicians who believe that all of their MAR clients should have counseling; others feel counseling is only needed if the patient continues to use alcohol or other drugs. I have found it is good to begin working with the doctor in the way he or she prefers; as we form an alliance I am better able to convince the prescriber to reconsider our approach to more effectively help the person in treatment.

In an ideal world, everyone who comes to us for treatment would come with an understanding of their problem and a deep-felt determination to change. In fact, many, if not most, of the people I have seen for treatment come under some type of compulsion. The reason may be legal problems, family pressure, employment problems, or some other outside force that has the person presenting for treatment before they have determined the need for treatment. In MAR, it is quite common for the person to decide that they want to control addiction to one substance but not be committed to abstinence from all mood-altering drugs. While this does not mean that treatment is impossible, it does make it difficult.

If a client who enters our office does not feel he or she has a problem, it may be difficult to get them to fully engage; without engagement, change will not come about. Our first job, therefore, is to work with that person in a way that might lead to a decision to make lifestyle changes.

It is important for a clinician to recognize the process and stages of change. It is here that an understanding of the Stages of Change model and learning about the various Motivational Interviewing and Motivational Enhancement Therapy techniques becomes necessary. More information on this is readily available from many sources; I highly recommend *TIP 35, Enhancing Motivation for Change in Substance Abuse Treatment*. This guide is focused on the use of Motivational Enhancement Therapy for substance abuse treatment and is available free of charge through SAMHSA.

Cognitive/Behavioral Therapy (CBT) is another highly effective tool for treatment of addictions and is quite compatible with MAR. Albert Ellis, the developer of Rational Emotive Behavior Therapy (REBT), has applied these techniques to addiction treatment, as did Jack Trimpey, founder of Rational Recovery.

An important part of the counseling process in MAR is to provide recovery skills that will allow the person to avoid relapse not only while on medication but also once the medication has

been eliminated. Personally, I like to refer to this as building continuing recovery skills rather than as relapse prevention as it gives the person in treatment a focus on success rather than a focus on not failing.

Among the recovery skills that are vital for people in MAR are improved communication, the ability to be aware of and to express feelings, self-awareness, connection with positive people, and recognizing recovery barriers and planning to overcome them. It is vital that those in MAR programs realize that recovery is more than not taking a drug; it is creating a new outlook on life and developing a whole new way to live.

Transition Timing a Collaborative Effort

This leads us to the transitioning process. Most of the physicians who prescribe medications to assist recovery see these medications as a short-term intervention. While some see medications as a tool for maintaining recovery, the general view seems to be that medication is a good way to help the person become stable enough to develop the skills needed for long-term recovery without medication.

The timing for this transition must be a cooperative process. The prescriber obviously has a lead role in this; he or she is, after all, the one with the most knowledge of the medication and medical requirements for the transition. Counselors have an important role in helping the physician evaluate the client's readiness to support recovery without medication. The client also has an important part to play, since he or she is the one who is undergoing the physical changes and insuring that the recovery continues.

In many cases, the prescriber may have a general rule for the length of time for medication. It may not always agree with the counselor's timeline or the client's timeline. I have seen some people try to transition too soon; they have not yet developed the skills to maintain recovery without the medication. Other times the client may be afraid to let go of the security that the medication provides. The counselor's job is to help the client assess readiness and to make good decisions regarding their care.

It is, perhaps, inevitable that we will not always agree with the physician on the correct timing of the client's transitioning. That is to be expected. There are ways that this can be handled that will not have a negative effect on the needed balance of the physician/counselor/client relationship.

First of all, any disagreement between the doctor and the counselor must be handled outside of the client's view. The client must feel that his or her treatment providers are a reliable team. We must also present concerns in a rational way that offers solid reasoning about the client's likelihood to succeed. Remember that the counselor's job description includes the ability to present goals in measurable terms. If we can do this, it is easier for the physician to weigh our input and to better respond to that input.

As I continue to work with doctors, I find that my interactions with them grow and improve. Many medical doctors are not used to working with counselors, and many counselors are not used to dealing with doctors. After time I find that we build mutual understanding and respect and there are fewer times that we disagree.

As addiction counselors we have specialized knowledge and are professionals in our field. The same can be said for doctors. It can be easy to have ego clashes when two professionals have an overlap in treatment. Both must recognize that the needs of the patient overrule the need for the professionals to be "right."

Once the team decides on the right time for the client to move from medication, they must help the client develop a continuing recovery plan. Much of the responsibility for this rests with the counselor and the client.

The continuing recovery plan should include several things. First, the client should be able to identify his or her recovery tools. That tool box should contain a variety of resources to meet a variety of situations. The client should be able to identify potential triggers for relapse and should have plans in place to deal with them. The client should have support in place and know who to contact in case of impending relapse.

The client and counselor should also establish a period of time for continued sessions after the medication is discontinued. There should be a minimum number of sessions set with the understanding that the number could be extended if the client feels the need or desire to do so. It is important that the client be discouraged from discontinuing medication and counseling at the same time as that may increase the possibility of relapse. The doctor may want to have some follow-up with the client after the medication is discontinued; that should be arranged between the client and the doctor.

Ultimately, the goal is for the client to be just as successful in the maintenance phase of recovery as he or she was in the action phase. This goal can be best met if the team of the client, counselor, and the physician is working together efficiently.

Medication to assist the recovery process has come a long way. Physicians and addiction counselors can view one another as competitors, or they can work together to improve the lives of those caught in the web of addiction. We need to acknowledge that, while our focuses may differ, our ultimate goal is the same. If we can also accept that there are different ways to treat addiction, and that clients have many different needs that require different approaches, we are one step closer to making success in recovery a reality for all. The time for division is over; we need to work as a team to help those in need.▼

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continued from page 13

allies and helping persons with SMI accept treatment and stay the course (Amador, 2012).

This *communication program*, called LEAP—for Listen-Empathize-Agree-Partner—can be learned by nearly anyone interested in helping someone with poor insight, or anosognosia, accept treatment (Amador, 2012; Paillot, 2009; Ihm, 2009). In fact it has been taught to tens of thousands of healthcare professionals, family caregivers and even law enforcement personnel worldwide (see www.LEAPinstitute.org).

The first step when using LEAP is to stop trying to convince the person he or she is ill. Instead, the goal is listen and respect the person's point of view by actively reflecting it back to them. The importance of listening without judging or reacting to what the person says cannot be overstated. So when a person with schizophrenia talks about the alien transmitter in his brain as the reason he does not need medication, the experience is respected and not contradicted. And the person's feelings about how they have been treated and misunderstood—the anger, depression, loneliness and fear are empathized with. "I would feel angry too if I were in your shoes and people kept telling me I needed medicine when what I really need is surgery to have the transmitter removed. Did I understand you correctly?" When you listen in this way, the person feels respected and befriended. The decision to accept treatment will have nothing to do with being ill but instead will hinge on his relationship with you. The research is clear: The key is to build a relationship in which the ill person feels listened to and respected, and trusts you. Consequently, you almost never give your opinion about the illness or treatment unless it is asked for. You learn how to listen to delusional beliefs (e.g., there's a CIA conspiracy against me) with respect and without telling the person it could not possibly be true.

When asked whether you believe such things to be true, you do not rush to give your answer because you know it will be hurtful; instead you try and respectfully delay giving your opinion. "I promise I will answer your question, but with your permission I would like to talk more about how to help you stay out of the hospital and find that job you told me you wanted. Would that be okay? When you finally do give your opinion, you use what I call the "Three A-tools" (Apologize, Acknowledge you could be wrong, and Agree to disagree). Start with an apology—because it will likely feel disappointing to the person—and a great deal of respect for the other person's point of view. For example: "You keep asking me whether or not I think the CIA is following you. I will tell you, since you asked, but I want to apologize because this will probably feel hurtful. I want you to know I could be wrong, I don't know everything and I just hope we can agree to disagree. I just don't see it the way you do. But I respect your opinion—I will not try and talk you out of it—and I hope you can respect mine."

After listening respectfully, refraining from giving your opinion, and then when you do give it you use the "A-tools," you look for areas where you agree, and partner on those. Perhaps it is to help the person stay out of the hospital, get a job, deal with the stress he is experiencing from the conspiracy, or get a full night's sleep. You partner on those things you can agree to work on together.

Your goal is to become a true ally (who thinks treatment might help with a range of problems, not just mental illness) and not get mired in the impasse that begins with your saying "You're ill and need treatment!" and ends with "I am not sick, I don't need help!" (Amador, 2012; Paillot, 2009; Ihm, 2009)

...YOU WIN ON THE STRENGTH OF YOUR RELATIONSHIPS, NOT ON THE STRENGTH OF YOUR ARGUMENT

The explosion of research on the problem of insight has taught me many things in the years since Henry first became ill. But mostly it has helped me to have a better relationship with my brother and to help him, and others like him, to accept treatment. By taking the LEAP approach we became friends and allies again. By not arguing and instead listening to him with genuine respect, I learned a great deal about my brother: I learned that he was never being stubborn or irresponsible when he refused treatment—he was suffering from anosognosia and simply following his common sense, which told him he shouldn't take medicine for an illness he didn't have. Among the lessons learned was that I would have done the same thing if I were in his shoes. Most important, by listening instead of arguing I learned that he never stopped being my hero. Today, I feel as proud and lucky to have had him as my brother as I did when I was a little boy.▼

Dr. Xavier Amador *is a visiting professor at the State University of New York and is the Founder/Director of the LEAP Institute, Peconic, NY (www.LEAPinstitute.org). He is the author of* I Am Not Sick, I Don't Need Help! How to Help Someone With Mental Illness Accept Treatment *(Vida Press, 2012) and* I'm Right, You're Wrong! Now What? *(Hyperion, 2007). Both of these books describe the research on anosognosia and how to use LEAP across a range of settings. These books have been translated into more that 14 languages. Dr. Amador has authored over 110 peer reviewed scientific articles, eight books and was co-chair of the Schizophrenia and Related Disorders Section of the DSM-IV-TR. He may be contacted by email at xavier.amador@leapinstitute.org.*

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2015

ILLINOIS INSTITUTE FOR ADDICTION RECOVERY TRAINING AND WORKSHOP SCHEDULE

This Educate Cafe Workshop series has been approved by IAODAPCA, LSW/LCSW, LPC/LCPC andf LMFT

To register contact Heidi Scuffham, Corporate Services Clinician at (309) 360-2571 or by email at hascuffham@yahoo.com.

Educate Cafe Workshops

Presented by the Illinois Institute for Addiction Recovery Staff

No cost to attend. Participants will receive 2 CEUs.

April 24th
Overcoming Barriers to Treatment

Unfortunately the majority of the people that need treatment never get the help they need. This program looks at some of the many challenges we face as we strive to attain successful treatment outcomes. In this training we will discuss some promising and proven strategies to increase retention and treatment engagement.

July 31st
Helping to Heal the Hurt

Clients entering treatment bring with them a myriad and sometimes complex emotional and psychological issues. This program looks at the importance of concrete, brief interventions, utilizing collateral information, consultation and post inpatient referrals to group and individual counseling.

October 30th
Establishing Positive Peer and Social Networks: Building Bridges

The disease of addiction effects every area of the addicted person's life. This program looks at the support needed for people in the first 90 days and beyond. This training will explore the connection between resources, resiliency, and recovery-oriented systems of care (ROSC).

- Workshop: 8am – 10am
- 8 – 8:30am: Networking and Breakfast (provided)
- 8:30am – 10:00am: Presentation

- Workshop held on the campus of IIAR at UnityPoint Health–Proctor, Proctor Professional Building

CONTINUING EDUCATION UNITS

ILLINOIS INSTITUTE FOR ADDICTION RECOVERY AND PARADIGM MAGAZINE OFFER CEUS

The Illinois Institute for Addiction Recovery is now offering continuing education credits (CEUs) for the *Paradigm* magazine. 2 CEUs for $30.00 with completion of a post test. To obtain your continuing education credits visit http://www.addictionrecov.org/Paradigm/CEU/V1922015CEU.pdf.

THE JOINT COMMISSION

If you have concerns regarding your care, please contact our Patient Advocate at (309) 691-1065. If we cannot resolve your concern, you may also contact JCAHO, an independent, not-for-profit, national body that oversees the safety and quality of healthcare and other services provided in accredited organizations. Information about accredited organizations may be provided directly to the Joint Commission at 1(800) 994-6610.

Information regarding accreditation and the accreditation performance of individual organizations can be obtained through the Joint Commission's website at www.jcaho.org.

2015 Recovery Walks!

Save the Date

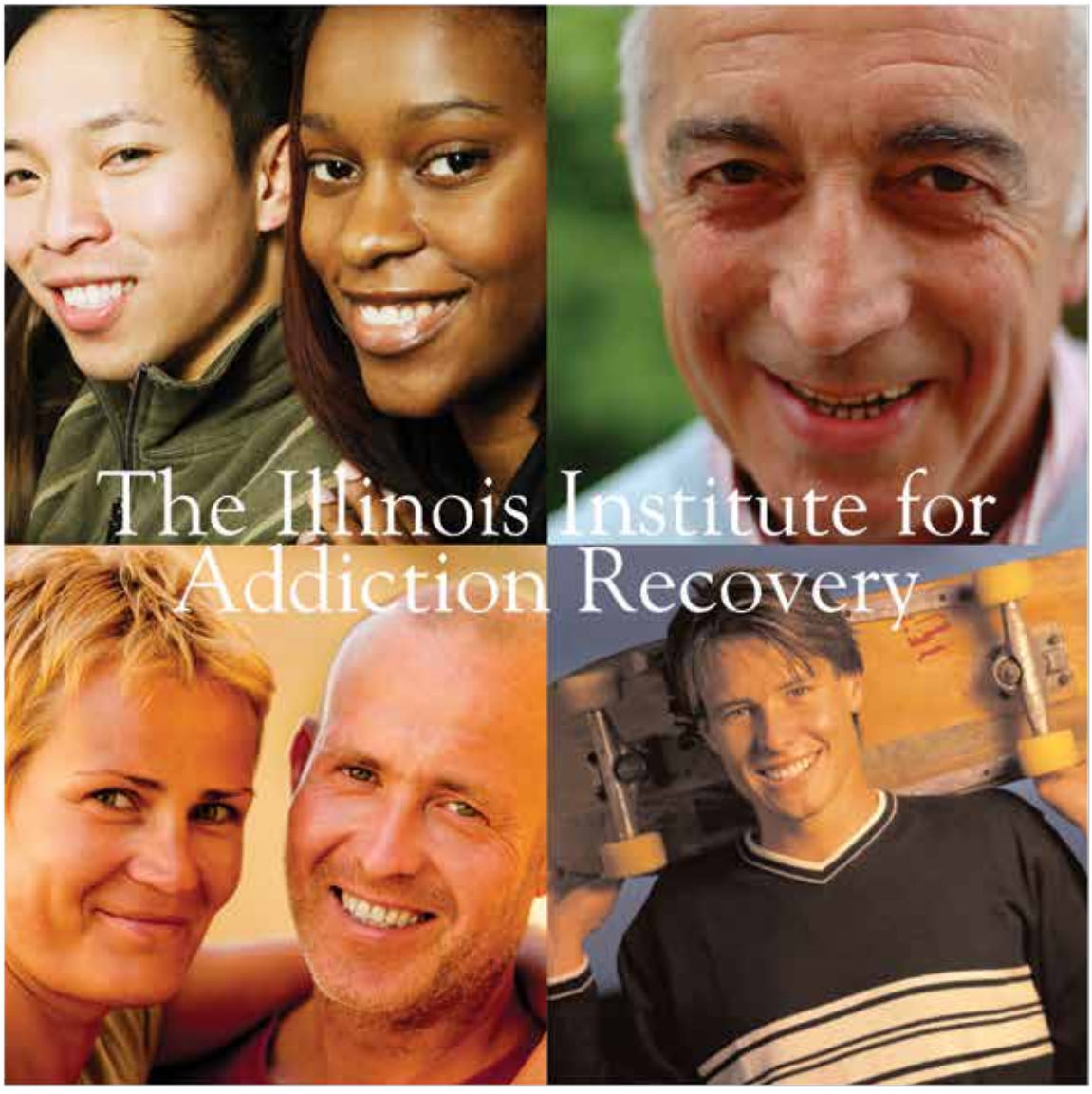
Saturday, September 26th

at the Campus of UnityPoint Health—Proctor

Proceeds benefit the Ameel Rashid Scholarship for Addiction Recovery

Putting troubled lives back together with comprehensive addiction treatment.

Our goal is to help those addicted achieve a lifestyle that is free from mood-altering chemicals and addictive behaviors, including alcohol, drug, gambling, food, sex, Internet, video game, and spending addictions.



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