UnityPoint Health–Proctor • Illinois Institute for Addiction Recovery

PARADIGM

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SPOTLIGHT

Michele Poskonka
LCSW, CRADC, PCGC, MISAII

Michele began her professional career as a school teacher, but she soon discovered that she was more interested in helping her students with their personal problems, and she decided to transition to the field of social services. Her first position in social services was with a community mental health organization where she primarily worked as a job coach for individuals with chronic mental illness and/or developmental disabilities. After graduating in 2008 with her master's degree in social work, Michele came to work as a substance abuse counselor for IIAR at Ingalls Hospital.

Through her work with the substance abuse population she has seen a great need for trauma informed care, and this need has inspired her to pursue additional trainings, including two modules in Gestalt equine-assisted therapy. In addition, Michele has recently been accepted into a Somatic Experiencing training program. Michele believes that trauma is often an underlying issue needing specialized treatment, and it has been her experience that clients can often benefit from alternative, non-traditional therapies.

Michele's passion is integrating both mental health and substance abuse treatment in order to provide clients with the best possible outcomes. In her free time, Michele enjoys reality TV, traveling, making art, and spending time with friends and family.

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FEATURES

DEPARTMENTS

CHALLENGES AND TRIUMPHS

IMPAIRED PROFESSIONALS

By Frederic G. Reamer, PhD

Recently I consulted on a compelling licensing board matter involving a mental health counselor. The counselor, Donna V., had served as clinical director of a specialized high school for struggling teens. Most of the school's students struggled with significant mental health challenges; many had a history of substance abuse.

One of the clients, Gabe, was an eighteen-year-old who had been expelled from his local public school because of behavioral issues. Donna and Gabe met weekly for counseling.

After several months, Donna and Gabe began to joke with each other casually; Donna believed that avoiding rigid boundaries with adolescent clients helps facilitate treatment. They exchanged some sexualized comments, especially when Gabe discussed his relationship frustrations and disappointments. At one point, Donna shared with Gabe that when she was his age, she too had difficulty navigating intimate relationships. At that moment, Gabe looked at Donna and told her that he hoped to be able to find a woman as kind and beautiful as Donna. Gabe grinned sheepishly and told Donna that at times he fantasized being in a relationship with Donna.

At the time, Donna, a young married mother of a toddler, was very vulnerable. Her marriage was falling apart and she was self-medicating with alcohol. Donna acknowledged that in her late teens she had been an alcoholic and has been in recovery ever since. That experience is what led her to become a mental health professional.

Donna responded to Gabe's comment by telling him that she found him very attractive, but that it was not possible for them to be in a relationship. Gabe impulsively leaned over to kiss Donna, who responded in kind. "I shouldn't be doing this," Donna said to Gabe. "But part of me wants to."

Within a week, Donna and Gabe's flirtation evolved into a full-fledged sexual relationship. Donna knew she had crossed the line, but felt out of control.

One afternoon, Gabe's mother overheard Gabe talking on his cell phone with Donna as they were arranging a tryst at her home. Gabe's mother confronted him; Gabe disclosed the affair. Gabe's mother called the school's director and shared the disturbing information. Gabe's parents then filed a formal licensing board complaint and lawsuit alleging that Donna violated her state's ethics-related licensing regulations and engaged in professional malpractice. After a protracted process that took months, the state licensing board concluded that Donna was an impaired practitioner and revoked her license. The lawsuit settled for $265,000 in damages.

The Nature of Professional Impairment

The good news is that relatively few mental health professionals are impaired. The bad news is that a significant number of professionals are impaired, and they cause great harm to clients and, ultimately, their own careers.

Historically, impairment in the helping professions has been a taboo subject. The reality, however, is that every profession—medicine, law, nursing, psychology, dentistry, social work, addictions, pastoral counseling, and education, among others—has been littered with impairment-related challenges throughout their respective histories. Only recently have the major professions begun to shed bright lights on this daunting challenge.

In the 1970s and 1980s various professions began to pay increased attention to the problem of impaired practitioners (Reamer, 2015). In 1972, for example, the Council on Mental Health of the American Medical Association released a statement that said that physicians have an ethical responsibility to recognize and report impairment among colleagues. In 1976 a group of attorneys recovering from alcoholism started Lawyers Concerned for Lawyers to address chemical dependence in the profession, and in 1980 a group of recovering psychologists inaugurated a similar group, Psychologists Helping Psychologists (Coombs, 2000; Kilburg, Nathan, & Thoreson, 1986; McCrady, 1989). In 1981 the American Psychological Association held its first open

forum on impairment at its annual meeting (Stadler, Willing, Eberhage, & Ward, 1988).

More recently strategies for dealing with professionals whose work is affected by problems such as substance abuse, mental illness, and emotional stress have become more prevalent and visible. Professional associations and informal groups of practitioners are convening to examine the extent of impairment among colleagues and to organize efforts to address the problem (Reamer, 2015).

Both the seriousness of impairment among practitioners and the forms it takes vary. Impairment may involve failure to provide competent care or violation of the ethical standards of the profession. It may also take such forms as providing flawed or inferior treatment to a client, sexual involvement with a client, or failure to carry out professional duties as a result of substance abuse or mental illness.

Unfortunately, there are no precise estimates of the prevalence of impairment among helping professionals. Given the stigma associated with impairment, it is difficult for researchers to gather valid and precise data. That said, there are several classic studies—most of which were conducted in the 1980s—that shed some light on the subject. For example, the *Impaired Social Worker Resource Book*, published by the National Association of Social Workers (NASW) Commission on Employment and Economic Support (1987:4), states, "Social workers have the same problems as most working groups. Up to 5 to 7 percent of our membership may have a problem with substance abuse. Another 10 to 15 percent may be going through personal transitions in their relationships, marriage, family, or their work life." A 1992 survey sponsored by the NASW Indiana Chapter found that of impairments reported among social workers, 26 percent were alcohol or drug related. Results of a survey of NASW members in New York City found that 43 percent of respondents reported knowing a colleague with a drinking or drug abuse problem (Stoesen, 2002).

Prevalence studies conducted among psychologists suggest a significant degree of distress within that profession. In a study of 749 psychologists, Guy, Poelstra, and Stark (1989) found that 74.3 percent reported "personal distress" during the previous three years, and 36.7 percent of this group believed that their distress decreased the quality of care that they provided to clients. Pope, Tabachnick, and Keith-Spiegel reported that 62.2 percent of the members of Division 29 (Psychotherapy) of the American Psychological Association admitted to "working when too distressed to be effective" (1987:993). In their survey of 167 licensed psychologists, Wood, Klein, Cross, Lammers, and Elliott (1985) found that nearly one-third (32.3 percent) reported experiencing depression or burnout to an extent that interfered with their work. Wood et al. also found that a significant portion of their sample reported being aware of colleagues whose work was seriously affected by drug or alcohol use, sexual overtures toward clients, or depression and burnout. In addition, evidence exists that psychologists and psychiatrists commit suicide at a rate five to six times higher than that for the general population (Farber, 1983).

In an interdisciplinary study, Deutsch (1985) found that more than half of her sample of social workers, psychologists, and master's-level counselors reported significant problems with depression. Nearly four-fifths (82 percent) reported problems with relationships, approximately one-tenth (11 percent) reported substance abuse problems, and 2 percent reported suicide attempts. In a comprehensive review of a series of empirical studies focused specifically on sexual contact between therapists and clients, Pope (1988) concluded that the aggregate average of reported sexual contact is 8.3 percent by male therapists and 1.7 percent by female therapists.

Causes of Impairment

Several studies report a variety of forms and sources of impairment among mental health professionals. Guy et al. (1989) and Thoreson, Miller, and Krauskopf (1989) found clinicians reported diverse sources of stress reported in their lives, including their jobs, illness or death of family members, marital or relationship problems, financial problems, midlife crises, personal physical or mental illness, legal problems, and substance abuse.

Research suggests that distress among clinicians generally falls into two interrelated categories: (a) environmental stress, which is a function of employment conditions (actual working conditions and the broader culture's lack of support for the human services mission) and (b) professional training and personal stress, caused by problems with marriage, relationships, emotional and physical health, and finances. With respect to psychotherapists in particular, Wood et al. (1985) note that professionals encounter special problems from the extension of their therapeutic role into the non-work aspects of their lives (such as relationships with friends and family members), the absence of reciprocity in relationships with clients (therapists are "always giving"), the frequently slow and erratic nature of the therapeutic process, and personal issues that are raised as a result of their work with clients.

A recurring theme in cases involving practitioner impairment is the challenge of professional boundaries (Reamer, 2012; Zur, 2007). Particularly in cases involving sexual involvement with clients, practitioners typically display confusion about what constitutes appropriate boundaries between themselves and their clients and about the need to clearly delineate the practitioner's and client's involvement in each other's lives (Celenza, 2007; Syme, 2003). The combination of an impaired practitioner and vulnerable client can be disastrous. In these instances both parties are more likely to be confused about, or will simply ignore warning signs and risks related to, inappropriate involvement that may take the form of sexual contact, socializing, or business involvement unrelated to treatment.

The most extreme boundary violations involve sexual misconduct. Based on his extensive experience with vulnerable and offending therapists, Simon (1999) argues that boundary violations are often progressive and follow a sequence, or "natural history," that leads ultimately to a therapist-client sexual relationship, as they did in the case involving Donna and her client Gabe. Although the sequence is not always linear, the general pattern is common.

continued on page 6

continued from page 5

Responding to Impairment

There is limited research on the extent to which impaired practitioners voluntarily seek help. Guy, Poelstra, and Stark (1989) found that 70 percent of the distressed clinical psychologists whom they surveyed sought some form of therapeutic assistance. These findings contrast with those of Wood et al. (1985), who found that only 55.2 percent of clinicians who reported problems that interfered with their work (substance abuse, sexual overtures toward clients, depression, and burnout) sought help. Two-fifths (42 percent) of all those surveyed, including impaired and unimpaired professionals, reported having offered help to impaired colleagues at some time or having referred them to therapists. Only 7.9 percent of the sample said they had reported an impaired colleague to a local regulatory body. Approximately two-fifths (40.2 percent) were aware of instances in which they believed no action was taken to help an impaired colleague.

Professionals' reluctance to seek help and the reluctance of their colleagues to confront them about their problems may be due to various factors. Professionals may be hesitant to acknowledge impairment within their ranks because they fear how practitioners would react to confrontation and how such confrontation might affect the future relationships of colleagues who must work together (McCrady, 1989; Wood et al., 1985). Thoreson et al. (1983) also argue that impaired professionals sometimes find it difficult to seek help because of their mythical belief in their infinite power and invulnerability. Also, because many psychotherapists are in private practice, the reduced opportunity for colleagues to observe their unethical or inept practice exacerbates the problem.

In a valuable study by Deutsch (1985), a diverse group of therapists who admitted to personal problems gave a variety of reasons for not seeking professional help, including believing that an acceptable therapist was not available, seeking help from family members or friends, fearing exposure and the disclosure of confidential information, concern about the amount of effort and cost required, having a partner who was unwilling to participate in treatment, failing to admit the seriousness of the problem, believing they should be able to work their problems out themselves, and believing that therapy would not help.

To protect clients and minimize the risk of litigation and disciplinary action, practitioners must devise ways to prevent impairment and respond to impaired colleagues. Consensus is growing that a model strategy for addressing impairment among professionals should include several components (Reamer, 2015; Schoener & Gonsiorek, 1988; Sonnenstuhl, 1989). First, ways to identify impaired practitioners are needed. Professionals must be willing to assume some responsibility for acknowledging impairment among colleagues.

Second, a practitioner's initial identification and documentation of a colleague's impairment should be followed by exploration of the causes and by what Sonnenstuhl (1989) describes as "constructive confrontation." Third, once a practitioner decides to confront the impaired colleague, the practitioner must decide whether to help the impaired colleague identify ways to seek help voluntarily or to refer the colleague to a supervisor or local regulatory body (such as a licensing board).

Assuming the evidence is sufficient to support a rehabilitation plan, the impaired practitioner's colleague, supervisor, or licensing board should make specific recommendations. The possibilities include close supervision, personal psychotherapy, and treatment for substance abuse. In some cases a licensing board may need to impose some type of sanction such as censure, probation, limitations on the professional's practice (for example, concerning clientele that can be served), or loss of license. Whatever action is taken should be monitored and evaluated.

The various helping professions have become increasingly aware of the possibility of impaired practitioners within their ranks. In recent years, the professions have become more cognizant of the prevalence and causes of impairment and taken assertive steps to respond meaningfully. Indeed, honest acknowledgement and constructive response to impairment is an essential element of what it means to be a profession.

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WHEN RECOVERY INCLUDES CHILDREN

By Debra Alessandra

For the last several decades we have come to understand families in recovery, using terms such as dysfunctional, troubled, addictive, and impaired. This writer prefers to describe them as stressful family systems. The task becomes how to offer new alternatives, new insights, and new skills to children and families in distress (nacoa.org, 2011).

In families with addictive behavior, adjustments are made to tolerate the stress of their circumstance. Small adjustments become more engrained habits, and over time they become an automatic response to the extent that it goes unnoticed (Kinney & Leaton, 1987). A person's ability to be mindful of these dynamics can bring a greater level of personal freedom because once the pattern is recognized, a person can learn how to disengage by considering common reactions and responses. The cycle that limits healthy relationships can be stopped, and healing the family dynamics can begin (Black, 1999).

Many compare a family system to a mobile, a suitable metaphor for the interactions between family members: when one part shifts, all parts shift. This mimics the response of families with addiction. A person with addiction upsets the stasis of the mobile and everyone adjusts to accommodate him or her. Unfortunately, the typical response to stress constricts the options of the members (Satir, 1972).

Open vs. Closed Families Compared

The more a family experiences stress the more rigid their behavior becomes. Based on each member's inherent temperament and natural inclinations, stress sets a pattern of behavior that becomes engrained. Over time, the ability to exercise options in response to circumstances and alternative behaviors shrinks. A significant feature of a closed family is the depth to which communication suffers. Members are caught in a rigid set of rules, controlled by fear and the need for conformity, and conclude "it's better not to talk about this."

In contrast, the open family system encourages and allows each member's perspective. A flexibility exists which allows members to experience safety, love, and mutual trust. The family has an interest in learning and growing, and they are able to explore solutions and find alternate responses, navigating issues while maintaining individual dignity.

No family is entirely closed or open. Depending on the stress and the length or duration of the stressor, families move in and out of expansion and constriction. The more prolonged and severe the stress, the less fluid the system (Hanley Center at Origins, 2015).

How Children Respond

Children under stress behave in a manner which secures their need for safety and ultimately survival. When exploring family systems, four major roles have been studied in depth, but several more noticeable patterns of behavior have been identified. The four basic roles are often referred to as, the Hero, the Scapegoat, the Lost Child, and the Mascot. Others have included terms like the Caretaker, the Placater, and the Adjuster (Black, 1999; 2006).

The Hero

Some children have a natural inclination to succeed. They find solace in being the brightest and the best. Awards, accomplishment, good grades, and a measure of positive reinforcement set the stage to enact this challenging position. Driven by the search for perfection, the burden is great to exceed the most recent level of success. Goal planning and

continued on page 8

continued from page 7

organization along with self-reliance are attempted at a young age and often continue. A family can avoid their need for healing by pointing to the elevated status of the responsible, upstanding child: "We can't be too bad. Look at the success of this child."

The Scapegoat
Other children react in the opposite fashion. The problems of negative behavior create a cycle of trouble: trouble in school, trouble with the law, and trouble in relationships. This child broadcasts his anger and announces the issues in the family by defying authority, resisting conformity, and drawing attention to the family by acting out their fear and confusion. When a child extracts negative attention, the family comes together in his or her behalf. They avoid their deeper problems by focusing on the child's misbehavior and miss the cry for help it may mask. By focusing on the rebellious, self-destructive nature of this child, others avoid addressing their own issues.

The Lost Child or Adjuster
Another way children handle stress is to remove themselves from the upset. These children learn to entertain themselves: reading, drawing, and playing alone. Physical and emotional distance suits their temperament. Despite the protective intention, this behavior severs the bonds children need. The child who isolates and withdraws allows the members to conclude, "At least we don't have to worry about him or her." The lack of connection ends up imprisoning the child in a self-imposed safe, but lonely existence.

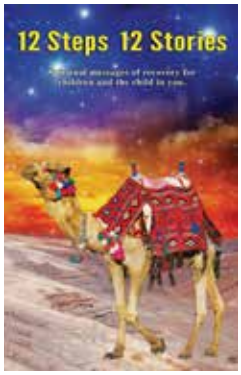
The Mascot
To avoid intense feelings, some children deflect the tension in the home with humor. They learn to joke and make light of painful circumstances. This provides relief to the family and includes a measure of positive attention. The child whose comedic impulse keeps others from addressing significant family issues provides distraction and further enables a family as it avoids challenging situations: It is difficult to discuss issues and laugh at the same time.

The Placater
Caring for other children or taking on parental responsibilities often emerges to quell the fear and chaotic nature of a stressed family. These children are sensitive and giving. Quick to notice the emotional status of others, they try to compensate by their own actions or behavior. They seek to manage their stress by stepping up to tasks which stretch their developmental ability. The child who takes up parental responsibilities and care-taking duties can forestall a crisis. They cushion the adults from the consequences of falling short in their parental responsibilities.

A New Path for Parents

When one family member embraces the rewards of recovery, the value of addressing the needs of children becomes clear. Embracing recovery as a parent includes examining the impact of addiction on children. Parents must note their vulnerabilities and strengths, and be honest and digest the truth: children are hurt by addiction. Significant improvement can occur within a family once awareness, acceptance, and a commitment to change takes hold (Black, 2003). To avoid the topic of addiction or recovery fosters the unhealthy lack of communication, with the pervasive silence creating significant discomfort. When approaching younger children one must search for appropriate services. "Who can help discuss the pain we have experienced?" "Is there a counseling center, a therapist, an agency, a treatment center, a community center and/or group that will help?" "What materials can I explore that might be helpful to my children and my family?" How might I nurture my children and offer a more stable environment?" "How have my children been hurt and what can I do to break the cycle of stress in their lives?" (Partnership for Drug-Free Kids, 2016)

Recovery is an ongoing process and children must be guided in their recovery as well. Pressure to move on without regard to the impact of addiction deters their healing progress. Presenting new ways of coping when circumstances shift can help children learn and develop meaningful life skills like problem solving and navigating change (Strengthening Families Program, 2016). By allowing children to identify, acknowledge and express their feelings, they will learn to share their feelings, build their confidence and self-esteem (Moe, 2007).



The Use of Story: A Softer Approach to Healing

A strong parent-child relationship is the single most significant prevention factor and indicator of family cohesion. Family bonding between parents and children during recovery can be strengthened through emphasis on parent-child communication (drugabuse.gov, 2003). Parents who talk early and often in developmentally appropriate ways open the door to establishing security and trust. Stories are one way to offer healing and help to children and the people who love them. Interactive books provide families in recovery with a simple yet meaningful way to approach topics that may be difficult. The carefully chosen story offers an easy opening to discuss the characters and the issues they face. This identification reduces their isolation and the often long-held impression that they are the only ones struggling with a difficult problem.

Through the use of story children learn the value of perseverance in the face of difficulties. Additionally, they learn to appreciate the importance of being open minded as they hear how each character explores and attempts their own unique solution. This validates two key points; (a) others have similar problems and, (b) sometimes solutions to these problems take time and effort.

A little extra time to integrate the story concepts can make a big difference. Reading combined with talking, drawing, writing and interactive questioning, helps parents and their children connect and explore the language of feeling and expression. Some suggestions for parents include:

- Searching for the right book and/or proper story which suits the child's temperament, age, gender, and level of maturity.

- Reading the material first to become comfortable with the way the information is presented. Then decide whether the child will respond to the characters in the stories.
- Keeping a small collection of related books written for children to address their needs.

A Recovery Book for Children: *12 Steps 12 Stories*

The book, *12 Steps 12 Stories* (Alessandra, 2013) can break the uncomfortable silence that often surrounds addiction and recovery. These 12 age-appropriate stories give adults an opportunity to help children feel comforted, valued, and included when parents are in recovery. Each story helps parents and/or other caregivers to:

- introduce the 12 key components in a recovery-based lifestyle;
- communicate on a child's level;
- alleviate the confusion children often feel;
- encourage children to talk openly; and
- share their most precious resource: time with children.

The following excerpt from *12 Steps 12 Stories* relates the tale of Edd, a dog who had a strong compulsion to persist in pursuing something dangerous and potentially life threatening. The story begins with an introduction to Edd's problematic behavior.

Edd, the dog, lived on a very busy street. He loved to watch the cars whiz by. His family trained him to stay in the yard. One day he thought, "I wonder if I can make it across the street?" He had no idea how this simple question would change his whole life. Even though he knew the danger, he thought, "I can do it."

Off he ran.

Perhaps it was a touch of defiance or maybe the thrill of something new. "This sure is exciting!" he panted when he reached the other side.

That night as he lay in his dog bed, Edd felt better than ever. He grinned as only a dog can. "This is fantastic!" He tried to convince himself that it was okay. "Heck, all dogs run across the street sometimes. Why not me?"

Edd puts himself in danger while minimizing his behavior. He denies the effects of his actions, and the negative impact on his family members. Edd makes efforts to control himself to no avail. Finally he admits defeat and recognizes his powerlessness. He teaches children the first step in solving any problem is acknowledging a problem exists.

Follow-up conversation may include comments and questions such as:

We all have habits. Some of them are good for us like brushing our teeth or reading a story before bedtime. Sometimes they are not good for us like picking a scab or grind our teeth. Have you ever had a habit you could not stop? Maybe it was as simple as sucking your thumb or biting your fingernails. Edd's habit was more serious than thumb sucking or nail biting. Even though he tried to manage it, he could not. It could have cost him his life.

Conclusion

Awareness of the impact of addiction on children is crucial to the health of a family system. Efforts to share information and promote conversation serve to address the needs of children in stressful family systems. Parents who work a program of recovery learn to model healthier behaviors. Their inclusive actions support children and help create a more comfortable home environment. Parents who encourage open communication can make great strides in the hard fought battle for a sense of stability and safety in their home.

Debra Alessandra *is an educator, consultant, counselor, and author of two children's self-help books. She has a double major in sociology and elementary education. Alessandra combined her work as a teacher with her work in the drug and alcohol field to create* 12 Steps 12 Stories: Spiritual Messages of Recovery for Children and the Child in You, *(Star Sapphire Press, 2013) designed to help children understand the recovery process through simple spiritual stories. Her second book,* The Magic of Roots and Stars: A Tale of Strength and Hope, *(Star Sapphire Press, 2015) offers strength and hope to children who live with someone other than their biological mother. Alessandra currently presents a family dynamics program to those affected by addiction, in which she places special emphasis on the needs of children living in stressful family systems. To learn more go to www.12steps12stories.com or www.TheMagicofRootsandStars.com.*

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HORSES HEALING THE HEARTS
of children of substance addicted parents
Changing lives...one horse, one child, one day at a time.

Children are the future. They are the next generation that will step up to change lives and make a difference in the world.

A child's life at home has a massive impact on who the child will grow up to be. The heartbreaking reality is that many children do not have an emotionally healthy upbringing. Unfortunately, many children currently reside in homes with at least one alcoholic family member, which can significantly impair their mental, physical, and emotional abilities.

Children of Alcoholics (COAs) face a difficult challenge. The parents are focused on their addiction—a brain disease which encompasses their every thought and behavior. Consequently, their children receive very little time and attention. Neglect, abuse and trauma resulting from witnessing violent episodes leave these children with neurological and emotional deficits. Too often these circumstances result in a pattern of addiction that can last many generations.

Additionally, children living with a non-recovering alcoholic tend to score lower on measures of family cohesion, intellectual-cultural orientation, active-recreational orientation, and independence. They also usually experience higher levels of conflict within the family (National Association for Children of Alcoholics, 1998).

There are almost 28 million children living with at least one alcoholic parent today, and 11 million of those children are under the age of 18 (National Association for Children of Alcoholics, 1998). It's no secret that a child's nurturing has a huge effect on the person they will become, and their innate desire to be cared for is one that is often not fulfilled as a COA. Not surprisingly, one-third of alcoholics have or had a parent who was an alcoholic (National Clearinghouse for Alcohol and Drug Information, 1991). Thus, COAs are four times more likely to become alcoholics as adults, continuing the vicious cycle (National Association for Children of Alcoholics, 1998).

Many people and organizations are actively trying to end the cycle of alcoholism and improve the lives of COAs around the world. One influential woman in particular has found a unique approach to accomplishing her mission of bettering the lives of children—involving horses as members of the team to help these children learn to trust and feel again.

Lizabeth Olszewski founded Horses Healing Hearts, an organization that offers help and support to COAs through horses and peer-to-peer mentoring. Olszewski is able to relate to these children on a meaningful level, as her stepfather and mother were alcoholics during her childhood. Her stepfather became sober when she was 12 years old, and he was transformed into an inspirational mentor. He became Olszewski's confidant and guiding eye, and would forever change her life when he suggested that she visit his sister, her aunt in Pennsylvania.

Lessons Learned from Observing Rescued Horse

During her time in Pennsylvania, Olszewski learned that her own mother was suffering from cirrhosis of the liver and the doctors gave her six months to live. She lived every day in fear that it would be her mother's last. Olszewski attributes her hope and strength during that difficult time to her aunt's rescued mustang, Jonathon. They formed a strong connection, and it was at that moment Olszewski realized the power of healing through horses.

"My aunt had rescued a young mustang and spent a lot of time developing and bonding with him," Olszewski explained. "That was the first time I ever really was involved with horses. I saw this horse, and I saw all these parallels—between his scars on the outside and mine on the inside. He survived and went on to accomplish great things; I hoped I could have the same fate. I knew I wanted to be with horses and use them to make a difference for me and for others."

Building upon her experience writing excerpts about her past and volunteering with therapeutic riding programs Olszewski knew she could use horses to help COAs. In September 2009, Olszewski launched Horses Healing Hearts (HHH) in Wellington, FL. It remains the only organization geared specifically towards empowering children of alcoholics/addicts in this capacity. The program seeks to alleviate the pain and burdens these children endure on a daily basis, and to steer them in a new direction from the decisions of their parents by modeling and teaching healthy behavior. HHH may be the only place where these children feel comfortable to open up and share their true feelings without shame and fear of judgment.

Horses Healing Hearts is a non-profit organization that instills in children lifelong coping skills, confidence, and responsibility through riding and caring for horses in a physically and emotionally safe atmosphere. One fourth of the children who participate in the program have either one parent in jail or have experienced the loss of a parent due to suicide, overdose, or disease resulting from alcoholism. Because of this, some children



struggle with making decisions, have a low self-esteem and tend to be either overly trusting or highly mistrustful.

The philosophy of Horses Healing Hearts is rooted in prevention. Olszewski explained, "We firmly believe that if these children have exposure to, and an opportunity to emulate, a positive role model, they have a much better chance at being a successful adult who can handle stress and problems in healthy ways instead of trying to numb them with drugs or alcohol. When this happens we break the generational cycle of addiction that is so prevalent."

The team at Horses Healing Hearts wants to stop the vicious cycle of alcohol addiction in its tracks and alter the statistics. Because children of alcoholics are four times more likely than non-COAs to develop alcoholism, intervening with early prevention education is critical to breaking the cycle. (National Association for Children of Alcoholics, 1998). This fact holds true whether children are biological children of alcoholic parents or adopted children who grow up with the daily influence of alcohol in the home, demonstrating that alcoholism is influenced by environment and genetics, or by a combination of both (Alcoholism Statistics, 2013).

Utilizing horses in a therapeutic manner can have healing benefits. The published study, "Randomized Trial Examines Effects of Equine Facilitated Learning on Adolescents' Basal Cortisol Levels," demonstrates with statistical significance the positive effects that horse therapy has on happiness and overall well being of the child in the study (Pendry, Smith, & Roeter, 2014).

Sponsors, Ambassadors Lend Valuable Support

Horses Healing Hearts operates out of sponsor barns located in areas close to Wellington, FL, home to world-class equestrian athletes and top horse shows. Sponsors barns are located in Boynton Beach, Boca Raton, and Delray Beach. Each week, more than 50 children are served from the greater Palm Beach County community.

Olszewski works tirelessly every day to bring awareness to the cause of Horses Healing Hearts, alongside global ambassadors who are prominent members of the equestrian community. These ambassadors include two-time Olympic Silver Medal show jumping rider Lisa Jacquin, internationally successful six-goal polo player Sugar Erskine, professional polo player Jeff Blake, Olympic Gold Medal show jumper Peter Wylde and international dressage rider Marco Bernal.

Horses Healing Hearts has grown from helping two children at its inception to accommodating over 50 children today, some as young as six years old. Each weekend, children are taught valuable skills like setting goals, establishing and maintaining boundaries, teamwork, dealing with emotions in a healthy manner, and the importance of routines. They master concepts from the National Association of Children of Alcoholics, and can share their feelings if they feel comfortable. Sometimes, art therapy is implemented to facilitate emotional response.

The first part of each session consists of peer-to-peer counseling, overseen by a state certified addictions professional. Afterwards, a child educator tailors an age-appropriate lesson from the *Children's Program Kit: Supportive Education for Children of Addicted Parents* curriculum, a SAMHSA product which was published by the Department of Health and Human Services. Groups are no larger than 6 to 10 children, allowing for an intimate setting where children can get the attention they usually don't receive at home.

Each child learns the proper protocol for safely handling horses, and how to groom and tack up a horse prior to their private riding lesson. Since most of these families lack financial resources, the majority of the youth clients receive services at no cost. Means to operate Horses Healing Hearts come from generous donors, grants, and fundraisers.

As far as goals for the future of Horses Healing Hearts, Olszewski said, "Our goal is to have Horses Healing Hearts affiliates nationwide." Olszewski's aim is to continue helping as many children of addicts as possible. "I understand this is a life-long challenge that will far surpass me. But every time we see one of the children beam with pride because they can now handle a horse, or use a skill they learned with a great outcome, we are inspired to keep fighting this insidious disease through education, mentoring, and the incredible gift of the horses' intuition. We also realize it will be long and costly, but that's to be expected. I know these resilient and intelligent children will prevail. They are survivors who I hope will carry on this legacy of helping others through horses."

To learn more about Horses Healing Hearts or how you can help with donations of money or time, log on to HHHUSA.org or email Liz Olszewski at liz@hhhusa.org or call (561) 713-6133.

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CANNABIS USE

Neuropsychiatric Effects of Early Onset
(Adolescent Onset)

By Jerrold Pollak, PhD, ABPP, ABN

Introduction

Cannabis is the second most widely consumed substance by adolescents after alcohol (Lisdahl, Wright, Medina-Kirchner, Maple, & Shollenbarger, 2014). About seven percent of adolescents between the ages of 12 and 17 have used cannabis in the previous month (SAMHSA, 2014). Most adults who use this drug on a regular basis initiated use in their adolescence typically before the age of 18 (Large, Sharma, Compton, Slade, & Nielssen, 2011).

Consumption through the adolescent years has been associated with a broad range of adverse medical, psychosocial and neuropsychiatric consequences (Hall & Degenhardt, 2009).

This article reviews the research literature pertaining to early onset use of cannabis as a risk factor for several concerning neuropsychiatric outcomes: cognitive/neuropsychological impairment; anxiety/depressive mood symptoms and the onset and trajectory of symptoms of bipolar disorder and psychosis. Articles with an emphasis on literature reviews (including meta-analyses) were obtained through PubMed, which have appeared over the past ten years, approximately. Key phrases included in this search: early onset cannabis use and neuropsychiatric symptoms; adolescent onset cannabis use; cannabis use and cognitive impairment.

Definition

Early onset use is defined in most of this literature as frequent (often daily) use of cannabis starting in early adolescence, typically by the age of 15 and which continues into the young adult years. Some studies, though, define early onset use as the consumption of cannabis beginning between the ages of 12 and 18.

Cognitive/Neuropsychological Functioning

Two recent reviews of the literature concluded that adolescent cannabis users exhibited a wide range of cognitive/neuropsychological difficulties, notably problems with complex attention, verbal memory, executive functioning and information processing speed (Lisdahl et al., 2014; Volkow et al., 2016). A recent separate study (not cited in these reviews) found a significant reduction in verbal memory over a 25-year follow-up period among users, some of whom began cannabis use in their later adolescence (Auer et al., 2016).

Anxiety and Depressive Disorders

Based on a literature review a modest association was found between early onset and sustained cannabis use and the development of depressive mood symptoms (Degenhardt, Hall, & Lynskey, 2003). More recent literature though, reflects mixed findings or a lack of a clear relationship between cannabis use and anxiety and/or depressive mood symptoms (Bechtold, Simpson, White, & Pardini, 2015).

A meta-analysis of studies, which investigated the relationship between cannabis use and anxiety disorders, concluded that there was a relatively low positive association between cannabis use (including cannabis use disorder) and anxiety as well as mixed anxiety-depression among persons not in formal mental health or substance abuse treatment. Cannabis users, even those without a diagnosis of cannabis use disorder, were somewhat more likely to have a clinical diagnosis of one or more anxiety disorders. However, this study did not specifically address the possible differential impact of adolescent versus later onset use on the timing, frequency, duration or severity of anxiety and/or depressive mood symptoms (Kedzior & Laeber, 2014).

Bipolar Disorder

Severity of cannabis use was found to be a fairly good predictor of age of onset of bipolar symptoms. Onset of bipolar symptoms among adolescent users was, on average, in the late teenage years among adolescents with a cannabis use disorder. In contrast, minimal users or adolescents with no history of use did not become symptomatic, for the most part, until their early twenties. A significant "dose response effect" was noted with frequent to steady use associated with an earlier emergence of symptoms (Lagerberg et al., 2014).

Prodromal Psychosis and First Episode Psychosis

With a few exceptions (e.g. Bechtold et al., 2015) literature reviews offer good support for a significant association between adolescent age onset cannabis use, (especially early onset consumption by the age of 15) and a younger age of onset of prodromal and first episode psychotic symptoms in later adolescence and young adulthood (Bagot, Milin, & Kaminer, 2015; Paruk & Burns, 2015).

A meta-analysis found that onset of psychotic symptoms was nearly three years earlier, on average, for steady adolescent users of cannabis than for adolescents with no history of use (Large et al., 2011). Di Forti and her colleagues reported that among adolescents who engaged in daily use of high potency cannabis (cannabis containing increased levels of THC) the onset of psychosis was six years earlier when compared to adolescent non-users (Di Forti et al., 2014).

A number of studies also offer good support for a salient "dose response effect," i.e., adolescents with a pattern of more intensive and frequent use over time were found to be at increased risk for the development of psychosis and, in particular, were more likely to have a greater number and a broader range of positive psychotic symptoms (Bagot et al., 2015; Paruk & Burns, 2015). This finding appears to be more salient among adolescents with earlier onset use in their teenage years (by the age of 15) related, perhaps, to the finding that earlier onset users are considerably more likely to be daily and persistent consumers of cannabis into their young adult years which results in greater exposure to cannabis over time (Di Forti et al., 2014).

A vulnerability to psychosis in adolescence may contribute to this at risk profile. In this regard, adolescent cannabis users who were identified as at clinically high risk for psychosis had a higher rate of conversion to first episode psychosis within one year of the development of prodromal symptoms when compared to clinically high risk adolescents who did not use this drug (Kristensen & Cadenhead, 2007).

Bagot et al. (2015) reviewed the literature on the relationship between cannabis use prior to the age of 18 and the age of onset of prodromal as well as first episode psychotic symptoms by the mid-twenties. This review reached the following conclusions:

- Earlier age of initiation as well as greater frequency and duration of use is highly associated with earlier onset of both prodromal psychosis and first episode psychosis.
- Earlier onset of use as well as frequency and duration of consumption are strongly associated with the frequency and severity of positive psychotic symptoms, response to treatment and poorer outcomes.
- There is evidence for and against a clear association between earlier onset use and frequency of use and the number and severity of negative psychotic symptoms when comparisons are made with adolescents with no history of cannabis use.

A quite recent literature review offers additional support for these linkages between cannabis use in adolescence and psychosis (Volkow et al., 2016).

Conclusions

There are a few studies which have not found clear associations between adolescent onset cannabis and adverse neuropsychiatric sequelae (e.g. Bechtold et al., 2015). Still, there is a more substantial research base which supports clear and consistent links between adolescent onset of cannabis use (so called "early onset use") and a number of undesirable neuropsychiatric outcomes later in adolescence and in young adulthood. The occasional findings which support the null hypothesis may reflect differences in study design.

The more frequent finding of important linkages between adolescent onset use and neuropsychiatric symptoms remains salient after adjustment is made for confounding variables: demographic factors, pre-morbid neurocognitive and mental health status and pre-existing and co-occurring substance use. These outcomes also do not appear to reflect the impact of publication bias.

More specifically, adolescent onset use is strongly associated with acquired multi-domain neurocognitive impairment which often persists into adulthood, particularly for continuous consumers, based on psychometric assessment and supported by informant ratings.

Consumption initiated in the teenage years (especially in early to mid- adolescence) is also implicated in the earlier onset as well as the development of a broader range and more pronounced symptoms of psychosis in adolescence and young adulthood. Additionally, earlier onset use has been linked to the earlier emergence of bipolar symptoms.

Adolescent onset cannabis use may also serve as a risk factor for depressive mood symptoms later in adolescence and the young adult years. Overall, however, findings remain mixed and inconsistent regarding this association. There is insufficient information, relevant to early onset cannabis use as a risk factor for the development of anxiety disorders, to reach a firm conclusion regarding this issue (Paruk & Burns, 2015).

Persistent and intensive cannabis use beginning in early to mid-adolescence appears to create a concerning synergy which places some teenage consumers at significantly enhanced risk for one or more problematic neuropsychiatric outcomes later in adolescence and in their young adult years when comparison is made to occasional or non- users and/or teenagers who initiate cannabis use later in adolescence or as young adults. In particular, a "dose response effect" has been demonstrated in a number of studies: Heavier and more regular consumption through adolescence (especially among earlier onset users) is associated with negative outcomes. These include an earlier onset, higher incidence and more pronounced psychotic symptoms as well as earlier onset bipolar symptoms.

Higher potency preparations, together with earlier onset use and persistent and intensive consumption, appear to be emerging as a set of factors which confer an enhanced risk of psychosis and, perhaps, other neuropsychiatric difficulties, notably neurocognitive impairment, beginning in adolescence and which continues into the young adult years (Lisdahl et al., 2014).

Collectively, research findings strongly suggest that early and mid-adolescence may constitute a sensitive period for brain development such that onset of persistent and substantial cannabis use, especially with high potency cannabis, during these phases of adolescent development may have more deleterious neuropsychiatric consequences than comparable use later in adolescence or in the young adult years particularly for a substantial minority of teenagers (Di Forti et al., 2014; Lisdahl et al., 2014).

Most importantly, this would include adolescents that are considered "psychosis prone" based on family history, genetic factors, neurobiology and/or psychosocial influences. This vulnerable subgroup appears to be more inherently susceptible to

continued on page 22

continued from page 13

the negative effects of cannabis when it comes to the emergence of psychosis and other neuropsychiatric conditions through young adulthood.

Directions for Research

Additional research is needed to further clarify the interplay and relative importance of the factors cited above regarding susceptibility to an array of alarming neuropsychiatric outcomes among a significant minority of adolescent cannabis users. These include age of initiation of use, frequency, quantity and duration of use and potency (Volkow et al., 2016).

In particular, further study is warranted to bolster support for what may well be a causal relationship between cannabis use and a broad range of recurrent as well as persistent neuropsychiatric symptomatology. The research literature offers little support for the reversed temporal relationship, namely that the appearance of neuropsychiatric symptoms in adolescence typically precedes and/or triggers the onset of cannabis use at least when it comes to psychotic symptoms (Myles, Myles, & Large, 2015). Clearly, however, this does not rule out that the onset of psychotic and/or other neuropsychiatric symptoms in adolescence may act as a risk factor for more intensive and chronic cannabis use as a coping mechanism to manage the emergence of these symptoms.

There should as well be further investigation of the potency of cannabis as an important risk factor for the onset, persistence and severity of neuropsychiatric symptoms, particularly psychosis, given the evidence for increased use of stronger preparations by adolescents in recent years and the dramatically increased incidence of psychosis among older adolescents and young adult users of high potency cannabis (Di Forti et al., 2015).

Implications for Clinical Practice

The findings of the studies cited above strongly suggest that delaying the age of onset of cannabis use and lowering the frequency and duration of use in the teenage years may forestall or even derail the development of psychosis and other pernicious neuropsychiatric outcomes among at least some "at risk" adolescents. Healthcare professionals who treat adolescents, in particular, younger teenagers and/or those deemed to be psychosis prone based on history and screening assessment, should strongly encourage abstinence or in cases of significant ongoing use recommend aggressive treatment to discontinue or sharply decrease consumption especially of high potency cannabis.

Reduction and/or cessation of use may have beneficial effects following the onset of psychosis (Schoeler et al., 2016) as well as salutary effects on neurocognition (Lisdahl et al., 2014).

Hopefully, reduction of risk would, at a minimum, push back the age of onset of psychotic and other neuropsychiatric symptoms by a least a few years for a substantial number of early onset users. Earlier onset of neuropsychiatric symptoms, notably bipolar and psychotic symptoms, is associated with a poorer prognosis. Therefore, forestalling symptom onset by even a few years is likely to buy valuable time for identity consolidation and opportunities for psychosocial, academic and vocational skill development which may reduce the probability of persistent functional disability.

Conclusions

Cannabis use remains an important public health problem for adolescents and young adults (Large, 2016). Healthcare professionals should continue to raise awareness about the neuropsychiatric consequences of adolescent onset cannabis (especially use involving high potency preparations earlier in adolescence) in the face of powerful socio-cultural trends like the movement to legalize cannabis use for recreational use. This movement appears to overlook the evidence- based harm of this substance and undermines the perception of its risk by teenagers. Legislation to legalize cannabis for recreational use should mandate a legal age of 21 and also place strict controls over the strength of cannabis which can be purchased.

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Social Anxiety or INTROVERSION

Socially Avoidant Behavior
assessment and treatment

By Kathy HoganBruen, PhD

Maya was born in the US and raised in Maryland by a single mother who had come to the US from the Philippines. Maya and her mother had a structured life: Maya would go to school, walk home by herself and, always a diligent student, focus on her homework while she waited for her mom to return from her job as a medical technician. The two of them would cook dinner together, and then watch their favorite TV shows. Weekends they liked to go for hikes at the nearby state park. Maya's mom didn't date or socialize much other than a weekly card game with neighbors.

Similarly, Maya hung close to home, with only the occasional shopping or movie outings with a few girlfriends. Maya would hear kids at school talk about parties, football games, and school clubs. It didn't seem unusual to her that she wasn't part of that life; she had her own life, and she really needed to focus on her schoolwork. Maya wasn't sure if she was happy, as that wasn't a question she was ever taught to ask. She knew she was getting good grades and helping take care of her mom, which seemed to be enough.

Accepted at a prestigious university, Maya went to college more committed than ever to working hard. But in college, her old routine of class and homework no longer felt satisfactory. Maya began noticing that she wasn't part of the socializing on her hall, or the parties everyone seemed to be planning. Maya began to feel a bit down and realized maybe she should reach out to some of the other students. But she had a hard time approaching them, thinking she was awkward and had nothing to say. Feeling discontent and wondering if something was wrong with her, she shared some of these feelings with her academic advisor who encouraged her to set up an appointment with me.

At our first visit Maya reported spending a lot of time alone, missing home and her mother, not connecting with other students, and feeling lonely. She wasn't unhappy per se, but she knew her life looked different from the other students' lives, and she felt something was missing. She didn't report hopelessness, or a lack of pleasure in things she used to enjoy. She wasn't skipping class or staying in bed. Was Maya socially anxious—was fear of judgment or embarrassment keeping her from interacting with her peers? Or was Maya merely introverted, content with books and intellectual stimulation, not needing much in the way of interpersonal relationships?

As Maya revealed more of her personality, social experiences, and hopes for college and relationships, we came to the joint conclusion that the answer was muddled—she was indeed introverted, but she also was experiencing Social Anxiety Disorder (SAD). Maya was naturally drawn to quiet and solo activities, content to spend a day alone reading and taking a walk. But she was also lonely and desiring friendships, possibly even a romantic connection. Reaching out to others, or showing up at an activity in her dorm caused her to feel anxious, wondering things like, "Will people think I'm weird?" "What will I say?" and, "What if no one talks to me?"

Maya had gotten into a pattern early in life of saying "No, I've got to study" when social invitations came her way. Maya's mom had constantly stressed the importance of academic achievement, and the importance of "honoring her family" by being successful. But Maya wanted more in her life than school; she was beginning to feel jealous of the other kids who were having fun. She was feeling lonely and afraid of what other students thought of her. She didn't look like them or have a similar cultural background. It was fearing the judgment of others—the hallmark of SAD—that kept her from socializing.

Many Students Adapt to the New Reality of College Life

SAD wasn't as obvious with Maya as it often is with college students. Many students away from home for the first time struggle to initiate friendships and date, having been used to the ease of socializing with family and grade school friends who have been a constant in their life. While kids often fantasize

about reinventing themselves in college, the reality can be a lot harder. Without the structure of a seven-hour school day surrounded by the same classmates, kids are left on their own to form and foster friendships. For plenty of kids, this works out just fine—after all, selection bias would suggest like-minded students naturally gravitate toward the same schools. And with less class time and more social time in college, quick and easy friendships develop naturally for many students.

In her book, *Quiet: The Power of Introverts*, Susan Cain (2012) describes introversion as a personality trait in which an individual recharges his or her batteries with quiet time, as compared to extroversion, where batteries are recharged with socializing. She mentions the stigma introverts receive from our very extroverted society, as well as the fact that introversion and extroversion occur on a continuum—rarely is someone truly all one or all the other. While Maya cared greatly about her studies, and indeed felt refreshed after getting some down time with books following a stimulating class lecture, there was more to the picture. As humans, we're biologically and genetically driven to be social creatures; historically, our mere survival (e.g., finding food, raising children) has depended on our ability to group with others.

Seeing Maya, I was hesitant to slap the "SAD" label on her and pathologize her naturally quieter state. But, according to Maya, there was something missing for her at school. It's one thing to avoid big keg parties when you'd rather 'Netflix and chill.' But it's quite another to avoid parties out of fear or anxiety. If a client declines social invitations, I ask them, "If you weren't worried or nervous, what would you do?" to tease out social anxiety from introversion. They're usually easily able to answer it. Many clients, right at the onset of treatment, say, "I WISH I could ask someone on a date, or sit down next to a stranger in the dining hall and start talking, or jump into a group conversation at a party the way I see others do." Maya was different. It took her a while to reach the conclusion that it might be nice to have some friends in the dorm or, ask people in class to form a study group.

Certainly, from a "statistical deviance from the mean" perspective, Maya would have been diagnosed with SAD, as she was an outlier in college based on how little social contact she had with others. But beyond deviance, diagnosing SAD requires assessing two essential features—level of distress, and interference with functioning. In other words, someone could appear to have SAD, but merely be introverted; and it depends on an individual's own experience of being quiet versus what others expect of him or her. With regard to distress, Maya reported mild unhappiness and a low level of loneliness. At first glance, Maya's functioning wasn't greatly affected by anxiety—she was still attending classes and doing quite well academically—but she wasn't actively participating in college life outside the classroom. Perhaps most importantly, Maya's cognitive processes reflected a fear of others' scrutiny. As such, Maya was an example of a student who, at first glance, might appear to be introverted, but mentally healthy, but under closer scrutiny, was evidencing SAD.

A Rich Inner Life, But Failing to Launch into Adulthood

The question, "Is this SAD, introversion, or both?" came up again when Tony, a 22 year-year-old recent graduate of a demanding liberal arts college, walked through my door. Tony was very quiet in our first session, answering my questions with as few words as possible. It struck me as unusual, as others in his age cohort tend to chat more freely, sometimes without ever really honing in on their specific issues. While brought to therapy by his father, Tony wasn't there against his will, and his brevity didn't reflect oppositionality. In fact, Tony was quite reflective and thoughtful. While Tony was respectful and cooperative, it was almost as if my questions punctured his solitary bubble, forcing him into a social sphere he preferred not to inhabit. Tony appeared to me as someone who truly enjoyed his inner world—and I, with all of my questions, was taking him from that place where he was content. But there was a problem; Tony was still unemployed, a year after graduation, and with no apparent explanation.

When asked about his interests and hobbies, Tony shared a level of sophistication well beyond what most employed young adults experience. His computer programming and intellectual pursuits, including the study of languages, music, and neurology, filled his days. He helped out at home and didn't get in anyone's way—to a fault, as Tony spent much time alone in his room. He communicated with friends online, including a couple he had met through a fantasy club at college, but he didn't have much in the way of in-person human contact.

When it came to jobs, Tony just wasn't interested. His inner life was a rich one, and working in a social environment wasn't appealing. He reported being happy with the small number of friends in his life. On the surface, this could appear to be an issue of social anxiety—a young and talented college grad, unemployed and holed up in his room without any social life. But what was missing was the hallmark fear of judgment, humiliation or embarrassment. While his dad was concerned, Tony was okay with who he was and how he spent his time. Rather than fearing what others thought of him, he was rather unconcerned. (His social skills were fine, he laughed with me, and seemed to be emotionally in sync, ruling out an autism diagnosis).

But the reality was that Tony had in front of him the developmental task of needing to launch into adulthood with paid employment. He was able to use therapy to identify and overcome obstacles to employment and set goals related to job applications. Perhaps even more importantly, Tony learned about introversion and how it affected him, and how to reduce the associated stigma he felt for being quieter and more inward than others might want from him. Tony came to celebrate his quieter nature and all that it allowed him to accomplish, including important contributions online. He also learned ways to "pop his personal bubble" and participate in a more social world, even if it was against his nature, and reap the benefits. He worked on knowing his limits and communicating them, while pushing himself to be a bit uncomfortable for a bigger purpose, such as paid employment. Tony's therapy proved useful, but proved not to be about SAD as originally anticipated.

Tony's case illustrates the importance of a good functional analysis, looking at the "A, B, Cs"—the antecedents, behaviors, and consequences of the social avoidance. In the case of Maya, avoiding social contact helped her feel safe and preserved her sense of self; if she didn't expose herself to anyone, she would be free from their judgment. The antecedents to Maya's avoidant

continued on page 18

continued from page 15

behavior were the experiences with her mother—observing and learning from her mother's own socially avoidant behavior, as well as explicit warnings from her that people could be mean and harsh. Similarly, being in a new social environment (college) without the benefit of years of social skills practice put Maya at a disadvantage. As a result of Maya's avoidant behavior, she was missing out on developing meaningful relationships, dating, and having fun at college. Worse, Maya was feeling bad about herself, not understanding why she wasn't like the others

CBT Leads to Understanding SAD Diagnosis

Using cognitive behavioral therapy (CBT), I worked with Maya individually, and subsequently in a group format. In both modalities, psychoeducation went a long way—helping Maya to understand SAD, correcting the"I'm just shy" myth, and making the case for exposure therapy where Maya would face her fears by engaging in increasingly challenging social situations. Learning that 12% of all individuals will suffer from SAD at some point in life (Kessler et al., 2005), helped Maya not to feel alone, as well as to see this as a problem that needed addressing. Compared to people suffering from other diagnoses, those with SAD are less likely to seek treatment, often believing it not to be serious (Kearney & Trull, 2015).

I asked Maya to keep a daily thought record of situations where she felt anxious, tracking her physical and emotional symptoms, level of anxiety, automatic thoughts, cognitive errors, thought rebuttals, and associated behaviors. After practice together in sessions, Maya recorded an experience where she was called on in class by a professor and immediately felt nervous, started to sweat and felt a pain in her stomach. She rated her anxiety level a 7 out of 10, and reported thoughts of, "I'm going to say something stupid," "The students will think I'm an idiot" and, "The professor will think I don't deserve to be at this college." She was able to see the distortion in her thoughts and identify that she was "fortune telling," "mind reading," and "name calling" (Burns, 1980). After challenging her cognitive distortions, Maya was able to come up with rebuttals she could rehearse to ready herself for the next anxiety-provoking situation in class.

I urged Maya to cross out loaded language, substituting in better word choices. For instance, she put a red "X" though "idiot" and tried out a range of alternative words, completing the sentence, "Students will think I'm a/an _____" with "student," "introvert," or "fashionista." Maya was able to turn around "I'm going to say something stupid" to "I'm not sure what I'm going to say," "I don't typically say 'stupid' things," "Who knows, I could say something brilliant!" and, "Whatever I say, I'm contributing to the class discussion, a valuable part of college." With regard to what the professor would think, Maya recognized that she was falling into the trap of trying to read his mind. Identifying her fear that the professor would think she didn't belong at the college gave us an opening to explore the broader theme of "not belonging" that kept popping up in treatment. Using the "downward arrow" technique (Burns, 1980), I repeatedly asked Maya, "And if that were true, what would be so bad about that?" Through that exercise we were able to uncover two core beliefs—that she felt "lesser" than others, and that she felt she had to be smart to be valuable. With those core beliefs uncovered, we could explore, challenge, and ultimately replace a lot of what was driving the social anxiety. Rather than walking around with the entrenched belief that "I'm only valuable if I'm smart," Maya was eventually able to think and truly believe, "my value as a human is inherent in my being alive, regardless of my IQ or grades."

Maya made great gains through psychoeducation, cognitive restructuring, and revising her core beliefs. But for the meat of CBT for SAD—behavioral exposure—I referred Maya to a social anxiety group that I facilitate for young adults. On day one Maya was exposed to many of her fears—talking in front of others, opening herself up to the judgment of others, and sounding "stupid," to name a few. Maya was asked to set specific behavioral goals and create a "fear and avoidance hierarchy," listing from easiest to hardest the social situations she wanted to tackle, along with her levels of avoidance and anticipated anxiety.

In group, Maya addressed her lower ranked social situations by role-playing specific scenarios with other group members—e.g., initiating a conversation with a girl on her hall, asking a classmate to get coffee, and going back to her original thought record, making a "stupid" comment in class. With the other participants, Maya practiced specific social skills that had gotten rusty—e.g., making direct eye contact during conversation; saying, "Thank you" when given a compliment; shaking hands with sweaty palms; and interrupting a group conversation. In addition to the exposure exercises and social skills practiced in group each week, Maya chose an exposure higher on her hierarchy to tackle for homework, often the very thing she had just role-played. With rehearsal under her belt, and thought rebuttals in her head, Maya was able to move through her hierarchy, exposing herself to fear, but being rewarded with a gradually increasing social life. As group progressed, Maya reduced, and ultimately eliminated her safety behaviors (e.g., routinely sipping from a water bottle in social situations). She considered the pros and cons of using relaxation strategies and deep breathing during the exposures. Ultimately, what Maya took away from group was that no matter what came up physically or emotionally, she could stay put and handle it, that she could tolerate all aspects of the anxiety, and that it was worth it.

Maya's therapy, like Tony's, included a component to address introversion, routinely reflecting on the question, "If I didn't have anxiety, would I want to do X?" to tease apart anxiety avoidance from an introverted nature. Maya came to know the difference between her introverted self that needed some recharging with quiet time; and her socially anxious self that needed a kick in the pants to be with people even if it meant being temporarily uncomfortable.

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Old Wisdom

How Early Clinicians Launched Patients Into Recovery

By Jeff Jay, BS, CAP, CIP

This year I'll celebrate 30 years of full-time employment in the addiction treatment field. But my journey started five years earlier, when I entered treatment myself as a hopeless alcoholic and drug addict in 1981. At that time, I had no thought of a clinical career—or any career, for that matter. I didn't believe life was possible without mood altering chemicals, and I didn't know the first thing about the medical aspects of addiction, beyond the experience of withdrawal.

In those days, there was a seamless interface between the medical/treatment professionals and the Twelve Step community. The professionals realized their engagement with the patients would be finite, so it was critical to help patients make a strong connection into the recovery community, where support was ongoing and free. I still marvel at the common sense introduction I received into the disease concept and the profound effect it had on me.

I'd shown up at an urban hospital with a bleeding ulcer, a bleeding colon, and transient neuropathy of the legs. At the ripe old age of 26, I was crippled by my disease and unable to make rational choices. In fact, it was only a last-minute family intervention that saved me from suicide.

The first night in the hospital was horrible. There was a frail old alcoholic in the bed next to me who was delirious, and I think he may have died in the middle of the night. A few hours after lights out, a squad of nurses and doctors ran into the room and started working on him furiously. I kept my head turned away with my eyes closed. It sounded like gruesome things were happening. Sometime later the room went quiet and they wheeled him out. I never saw the old man again.

The next day I had a visit from the head doctor on the ward, Dr. William Keating, who had decades of experience in alcohol and drug treatment. I was a punk kid sitting on the side of the bed, shaking and sweating and feeling terrible. I was wearing a blue hospital gown that tied up ineffectively in the back. Dr. Keating strode into the room with authority, a big, powerful black man with a white coat, a stethoscope and a clipboard. It was like God himself coming in to take charge. He pulled up a chair, got in my face, and called out like he was trying to wake the dead. And maybe he did.

"Boy!" he said. I almost jumped out of my skin. "Boy," he said, "you've got a disease. You're not responsible for what you've done."

"Great," I said to myself.

"But you're responsible for what you do now."

"Sh-t," I said to myself.

"Your disease is incurable," he said, "the most we're going to be able to do is put it in remission. We're going to give you a program to follow: Twelve Steps. You follow that program and the disease will stay in remission. You stop following that program and the disease is going to kick you in the ass again." Then he stood up and walked out.

I didn't know what he was talking about. I didn't know anything about alcoholism or AA or anything else, but I was suddenly alert, even in the daze of detox, and I tried to ponder his statements. As the hours and days went by, Dr. Keating's brief prognosis and prescription echoed in my mind, like operating instructions for a new life.

I still think of him as a giant, but when I saw the good doctor again some days later, I was surprised to find out he wasn't a big man with a booming voice. Rather, he was an older gentleman, short and trim, who moved with energy and purpose. He had a deep reservoir of what he called "hog trough philosophy," a collection of home-spun stories that he poured out in lectures to the assembled patients. I loved his "keep it simple" approach, and I hung onto his words, convinced he had a solution that just might work. In the months that followed, everything Dr. Keating said proved right.

I spent ten days detoxing in that hospital, and then I was transferred to a 28-day residential treatment program an hour away. I was in better physical shape than when I arrived, and I went willingly. But within a day or two I was off on an emotional

roller coaster, pleading to leave treatment every chance I got. I was glad to be there one minute and determined to leave the next. The staff would get me calmed down and then I'd want to leave again. Somehow, I kept agreeing to give it one more day and ultimately got past the worst of the mood swings. But my brain still spun at an alarming rate, churning out thoughts that were pure sabotage. Food helped, along with physical exercise, which led to the gift of sleep.

Small Steps Result in Progress

I brought my shallow grandiosity into the group therapy sessions, either telling war stories of cross-country binges or needlessly complicating the basic concepts of recovery. Part of me wanted to take the simple wisdom to heart, but my pride was too great and my stake in intellectual fashion was too deep. I couldn't imagine the smart set subscribing to slogans like "Easy Does It" or "Let Go and Let God," and I wasn't buying it, either. I'm sure the counselors saw me racing straight for a relapse, but I was glad to entertain the other patients with my stories. Only rarely did I catch sight of my insanity, my loneliness and my fear, and I had no more idea what to do with those things than I would a newborn baby.

Most of the lectures were boring, so I was delighted when Dr. Keating came to visit the treatment center as a guest lecturer. The patients were transfixed by his energy, and we all drew strength from his confidence. He talked about keeping "first things first," and taking the small actions necessary to get through the day.

"Do you want to go downtown?" he asked. "Then get off the couch, check the bus schedule, walk to the corner, get on the downtown bus, put the fare in the box, take a seat and ride." He looked around the room to see if we got the point. "But you have to get off the couch!" he said, slapping the podium.

"Do you want to recover?" he asked. "Get off the couch, check the meeting schedule, go to the meeting and listen to other alcoholics who have stopped drinking. Then do what they tell you to do."

His "hog trough philosophy" was very attractive to me. Although he was a physician, he challenged us to reject people who merely studied addiction academically and instead advised us to follow people who'd conquered it personally. "Would you want to learn how to skin a mule from somebody who only read about it in a book?" he asked. "Or would you want to learn from a muleskinner?"

Bill Keating wasn't in recovery from any addiction himself, but like many doctors of that era, he had great faith in Twelve Step programs. He knew there was nothing in medicine to cure the insanity of addiction, but he saw that somehow alcoholics were able to help each other in the structure of the meetings. The leaderless groups were straight forward, good humored and unselfish. What could be better? Dr. Keating's effectiveness as a healer was grounded in his ability to persuade us to put our swollen brains on the shelf and follow the program.

Old Wisdom Complements Current Understanding of Addiction

Today, clinical staff have even more to offer newly recovering addicts. Professionals can provide clearer and more detailed information about addiction as a brain disease, as opposed to a series of bad choices. These discussions can go a long way in alleviating shame, and helping patients understand why they should follow treatment recommendations, instead of their own labile thinking. Further, professionals can help patients understand the mechanism of denial and unmanageability, and how decisions regarding substance use are shunted from the pre-frontal cortex (where they belong) to the limbic brain, where addiction lives. These discussions are fascinating, and help patients understand why their actions didn't always follow their intentions.

The old wisdom of Dr. Keating and the clinical staff helped to bridge the understanding of science into pragmatic action plans for me as a patient. They were concrete in their language, and clear in putting the responsibility on me to take control of my recovery. Of course, this is still the primary dilemma in the treatment of all chronic illnesses: the patient must ultimately take control of the process. How best to inspire that, how best to induce that "vital spiritual experience" that leads to fundamental and global change, is perhaps not the special purview of science.

In 1981, I wasn't much for following directions. I was proud, stubborn, and determined to get my own way. For an addict, this mindset is often fatal, or at least a first-class ticket to relapse. But with the slightest kindling of faith —in Dr. Keating, the counselors, and the program they laid out for me—I began following the directions, and listening more deeply. New ideas started to form, and I wondered if the old cliché could be true: "Today is the first day of the rest of your life." This maxim was framed on the wall of the hospital ward, and as syrupy as it seemed, some part of me wanted it to be true. Could the Twelve Step groups really give me a fresh start?

They did. The "one day at a time" philosophy was cumulative, like compound interest at the bank. Slowly but surely it paid dividends that got bigger over time. This was true, in part, because the people in recovery could offer much more than the clinicians; namely, experience, love, and thousands of hours of their own personal time. I can never begin to repay the debt I owe them. So I focus on the newcomers.

Today I'm grateful for Dr. Keating's old-school wisdom. By patching me up and pointing me in the direction of the solution, he empowered me to take control of the process, even as I had to surrender to the reality of my addiction. I learned that truth often resides in paradox, and that acceptance opens the door to change.

Jeff Jay *is a clinical interventionist, certified addictions professional and author. His work has appeared on CNN,* The Jane Pauley Show, *PBS, Forbes website and professional journals. He has served as president of the Terry McGovern Foundation in Washington, DC, and on the boards of directors for the Michigan Association of Alcohol and Drug Abuse Counselors, Dawn Farm, and the Employee Assistance Professionals Association of Greater Detroit. He currently serves on the advisory board of Jefferson House, in Detroit, MI. Jeff is the co-author of the best-selling book* Love First, *(Hazelden, 2008) and also co-author of* At Wit's End: What You Need to Know When a Loved One Is Diagnosed with Addiction and Mental Illness *(Hazelden, 2007).*

The rest of Jeff Jay's story is told in his new book, Navigating Grace *(Hazelden, 2015), which is partially quoted above. Read more about Jeff's work at lovefirst.net.*

Malingered Psychosis

By Phillip J. Resnick, MD

Malingering is defined in DSM-5 as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs."

Malingering can be categorized into (a) pure malingering, (b) partial malingering, and (c) false imputation. When an individual feigns a disorder that does not exist at all, this is referred to as *pure malingering*. When an individual has actual symptoms but consciously exaggerates them, it is called *partial malingering*.

All malingerers are actors who portray their psychoses as they understand them. Malingerers often overact their part. Malingerers sometimes mistakenly believe that the more bizarrely they behave, the more psychotic they will appear.

Approaches to Detecting Malingering

Clinicians should be particularly careful to ask open-ended questions of suspected malingerers and let evaluees tell their complete story with few interruptions. Inquiries about hallucinations should be carefully phrased to avoid giving clues about the nature of true hallucinations. Clinicians may feel irritation at being deceived, but any expression of irritation or incredulity is likely to make the malingerer more defensive.

Inpatient assessment should be considered in difficult cases of suspected malingering: Feigned psychotic symptoms are difficult to maintain 24 hours a day. After completing a detailed examination, clinicians may decide to confront an evaluee with their suspicions. The suspected malingerer should be given every opportunity to save face. Once malingering is denied there is a risk that it will be harder to admit later. It is better to say, "You haven't told me the whole truth," than, "You have been lying to me" (Inbau & Reid, 1967).

Detailed knowledge about actual psychiatric symptoms is the clinician's greatest asset in recognizing simulated illness. Therefore, to find characteristics that help divide true from malingered symptoms, the phenomenology of genuine hallucinations will be reviewed. To evaluate the possibility of malingered hallucinations, the clinician must consider the characteristics of true hallucinations.

Key Points

- **Knowing the detailed phenomenology of genuine symptoms helps the clinician to identify faked symptoms.**
- **Non-psychotic genuine hallucinations should not be mislabeled as faked hallucinations.**
- **Malingered hallucinations are often described as more intense than genuine hallucinations.**
- **Having genuine schizophrenia does not preclude faking an exculpatory hallucination.**

Malingered Hallucinations

Before distinguishing genuine from true hallucinations, the clinician should differentiate between psychotic and non-psychotic hallucinations. Non-psychotic hallucinations usually have a childhood onset with a median age of 12, whereas psychotic hallucinations begin at a median age of 21. Non-psychotic hallucinations are often attributed to family members, spirits of dead people, or guardian angels, rather than real people such as Secret Service, police or malevolent neighbors (Larøi et al., 2012).

Persons reporting hallucinations with any atypical features should be questioned in great detail about the nature of their symptoms. Both psychotic patients (Goodwin, Alderson, & Rosenthal, 1971) and patients with schizophrenia (Small, Small, & Andersen, 1966) show a 76% rate of hallucinations in at least one sensory modality. The reported incidence of auditory hallucinations in patients with schizophrenia is 66% (Small et al., 1966). Eighty-two percent of hallucinating patients describe hallucinations in more than one modality (McCarthy-Jones et al., 2014). The incidence of visual hallucinations in persons with psychosis is estimated at 24% (Mott, Small, & Andersen, 1965) to 30% (Small et al., 1966). Hallucinations are usually (88%) associated with delusions (Lewinsohn, 1970).

Auditory Hallucinations

Goodwin et al, (1971) described the following characteristics of auditory hallucinations. Both male and female voices were heard by 75% of the patients in their study. About two thirds

continued on page 20

continued from page 19

of hallucinating subjects could identify the person speaking (McCarthy-Jones et al., 2014). The content of hallucinations was accusatory in over one-third of the cases.

Auditory hallucinations usually consist of single words or phrases, especially early in the disease process. Hallucinated voices tend to become more complex over time, from single words to entire sentences. The number of voices heard also increases (Leudar, Thomas, McNally & Glinski, 1997). The syntax of long-standing auditory hallucinations is usually in complete sentences, and mirrors the syntax typically used by the evaluee (Nayani & David, 1996). In affective disorders, the content of the hallucination is usually mood-congruent and related to delusional beliefs (Asaad, 1990).

Schizophrenic hallucinations tend to consist of personal insults, abuse, and derogatory comments about the patient or the activities of others (Larøi et al., 2012). Nayani and David (1996) reported that the most commonly encountered hallucinations were simple terms of abuse. Female subjects described insults conventionally directed at women suggesting promiscuity. Men described male insults such as those imputing homosexuality.

About one third of persons with auditory hallucinations reported that voices asked them questions. Voices never sought information such as "What time is it?" or "What is the weather like?" Instead they asked chastising questions such as "Why are you smoking?" or "Why didn't you do your essay?" (Leudar et al., 1997).

Leudar et al. (1997) found that most patients in their study engaged in an internal dialogue with their hallucinations. Many were able to cope with chronic hallucinations by incorporating them into their daily life as a kind of internal advisor. Interestingly, sometimes their hallucinated voices would insist on certain actions after the patient refused to carry them out. The voices would rephrase their requests, speak louder, or curse the patient for being noncompliant. In contrast, malingerers are more likely to claim that they were compelled to obey commands without further consideration.

Hallucinated voices are usually perceived as benign, benevolent, or malevolent. Malevolent voices evoke negative emotions (anger, fear, depression, anxiety). Patients often respond by arguing, shouting, non-compliance, and avoidance of cues that trigger malevolent voices. Benevolent voices usually provoke positive emotions (amusement, reassurance, calm, happiness). Patients often respond by elective listening, willing compliance, and doing things to bring on their benevolent voices.

A common myth in detecting faked hallucinations is that if someone replies that they hear their voices in one ear or the other, they are faking. This myth is belied by the fact that when asked to place a finger on the part of the head that they could locate their voices, 71% of genuine hallucinators selected a place close to one ear (Hoffman, Varanko, Gilmore, & Mishara, 2008). In persons with genuine auditory hallucinations, 71% were able to recall the first time they heard voices (Hoffman et al., 2008).

Persons suspected of feigning auditory hallucinations should be asked what they do to make the voices go away or diminish in intensity. Genuine patients are often able to stop auditory hallucinations when their schizophrenia is in remission, but not during the acute phase of their illness (Larkin, 1979). Schizophrenic hallucinations tend to diminish when patients are involved in activities. Patients with genuine malevolent hallucinations usually develop some strategies to decrease them (McCarthy-Jones & Resnick, 2014).

The suspected malingerer may be asked what makes the voices worse. Eighty percent of persons with genuine hallucinations reported that being alone worsened their hallucinations (McCarthy-Jones & Resnick, 2014). Voices were also made worse by listening to the radio and watching television (Leudar et al., 1997). News programs were particularly hallucinogenic.

Some malingerers may allege that their hallucinations went away after one or two days of treatment with antipsychotic medication. The first time a psychotic patient is given antipsychotics, the median length of time it takes for hallucinations to completely clear is 27 days (Gunduz-Bruce et al., 2005). In persons treated for schizophrenic hallucinations after one month, their voices became less loud and less distressing (Schneider, Jelinek, Lincoln, & Moritz, 2011). After six months of antipsychotics, they heard their voices less frequently and felt that they had more control of them. They also recognized they were self-generated (Schneider et al., 2011).

Command Auditory Hallucinations

Command hallucinations are auditory hallucinations that instruct a person to act in a certain manner. Command hallucinations are easy to fabricate in order to support an insanity defense.

The majority of commands to commit dangerous acts are not obeyed. The examiner must be alert to the possibility that a defendant may fake an exculpatory command hallucination or lie about an inability to refrain from a genuine hallucination. Knowledge of the frequency of command hallucinations and the factors associated with obeying commands are helpful in looking at the authenticity of such claims.

Hellerstein, Varanko and Koenigsberg (1987) found in a retrospective chart review that 38% of all patients with auditory hallucinations reported commands; and that the content of command hallucinations was: 52% suicide, 5% homicide, 12% non-lethal injury of self or others, 14% non-violent acts, and 17% unspecified.

McCarthy-Jones et al. (2014) found that 76% of their patients said they were able to resist their command hallucinations. Junginger (1990) reported that patients with hallucination-related delusions and hallucinatory voices that they could identify were more likely to comply with the commands. Kasper, Rogers and Adams (1996) reported that 84% of psychiatric inpatients with command hallucinations had obeyed them within the last 30 days. Among those reporting command hallucinations in a second forensic population, 74% indicated that they acted in response to some of their commands during the episode of illness (Thompson, Stuart, & Holden, 1992).

Junginger (1995) studied the relationship between command hallucinations and dangerousness. He found that 43% of the subjects reported full compliance with their most recent command hallucination. People are more likely to obey their command hallucinations if (a) the voice is familiar, (b) if there

are hallucination related delusions (Junginger, 1990), and (c) if the voice is perceived as powerful (Shawyer et al., 2008). Compliance with commands is less likely if the commands are dangerous (Junginger, 1995; Kasper et al., 1996). A defendant alleging an isolated command hallucination in the absence of other psychotic symptoms should be viewed with suspicion. Non-command auditory hallucinations (85%) and delusions (75%) are usually present with command hallucinations (Thompson et al., 1992).

Visual Hallucinations

Persons with genuine visual hallucinations report that they are humanoid 70% of the time. A minority of visual hallucinations are animals or objects. Ninety-five percent of the time the visions are not something that the hallucinator has actually seen before. Over 80% of persons with visual hallucinations report that their response to their first visual hallucination was to be overwhelmed or fearful (Gaunlett-Gilbert & Kuipers, 2003).

Visual hallucinations are usually of normal-sized people and are seen in color; whereas alcohol induced hallucinations are more likely to contain animals (Goodwin et al., 1971). Visual hallucinations in psychotic disorders appear suddenly and typically without prodromata (Asaad & Shapiro, 1986). Psychotic hallucinations do not usually change if the eyes are closed or open. In contrast, drug-induced hallucinations are more readily seen with the eyes closed or in darkened surroundings (Asaad & Shapiro, 1986).

Visual hallucinations are volunteered much more often (46% vs. 4%) by malingerers than by genuinely psychotic individuals (Cornell & Hawk, 1989). Dramatic, atypical visual hallucinations should definitely arouse suspicions of malingering (Powell, 1992).

Suspect Hallucinations

Auditory Hallucinations

- Voices are unbearably distressing
- ack of strategies to diminish malevolent voices
- Hearing voices of animals
- Never hearing the same voice twice
- Voice only yells
- Voice sounds robotic
- Hearing only children's voices
- Hearing only female voices
- Hallucinated questions seeking information
- Allegation that all command hallucinations were obeyed
- Hallucinations not associated with delusions
- Stilted language reported in hallucinations

Visual Hallucinations

- Black and white rather than color
- Dramatic, atypical visions
- "Schizophrenic" hallucinations that change when the eyes are closed
- Only visual hallucinations in "schizophrenia"
- Miniature or giant figures
- Visions unrelated to delusions or auditory hallucinations

(Resnick & Knoll, 2008)

Conclusion

The detection of malingered mental illness is sometimes quite difficult. The decision that an individual is malingering is made by assembling all of the clues from a thorough evaluation of a person's past and current functioning with corroboration from clinical records, psychological testing, and other people. Clinicians must be thoroughly grounded in the phenomenology of the mental disease being simulated. Although the identification of a malingerer may be viewed as a distasteful chore, it is critical in forensic assessments. Indeed, clinicians bear a heavy responsibility to assist society in differentiating true disease from malingered madness.

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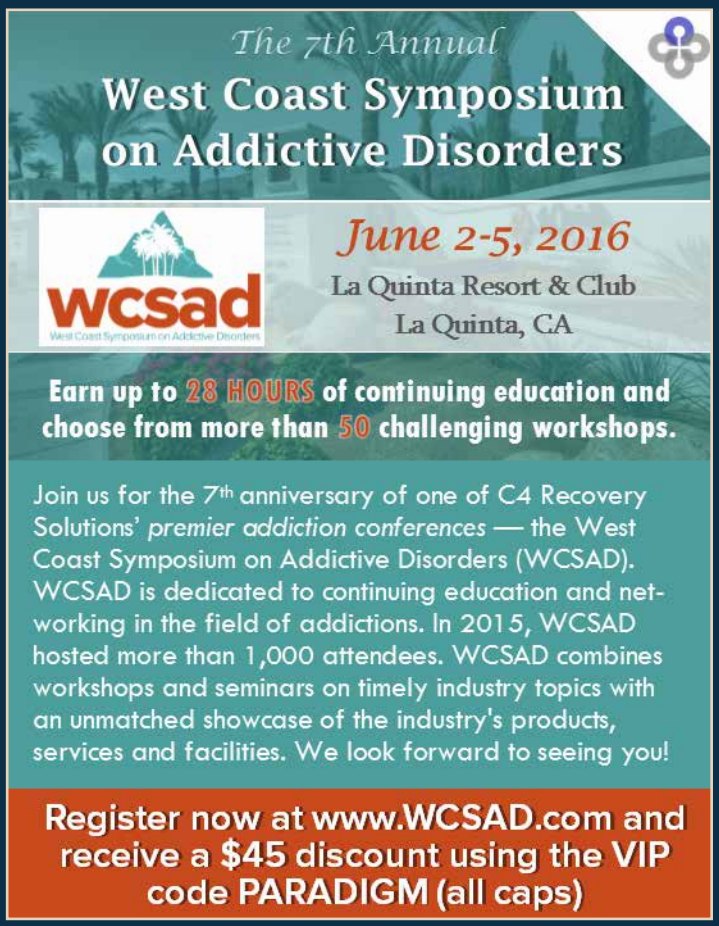

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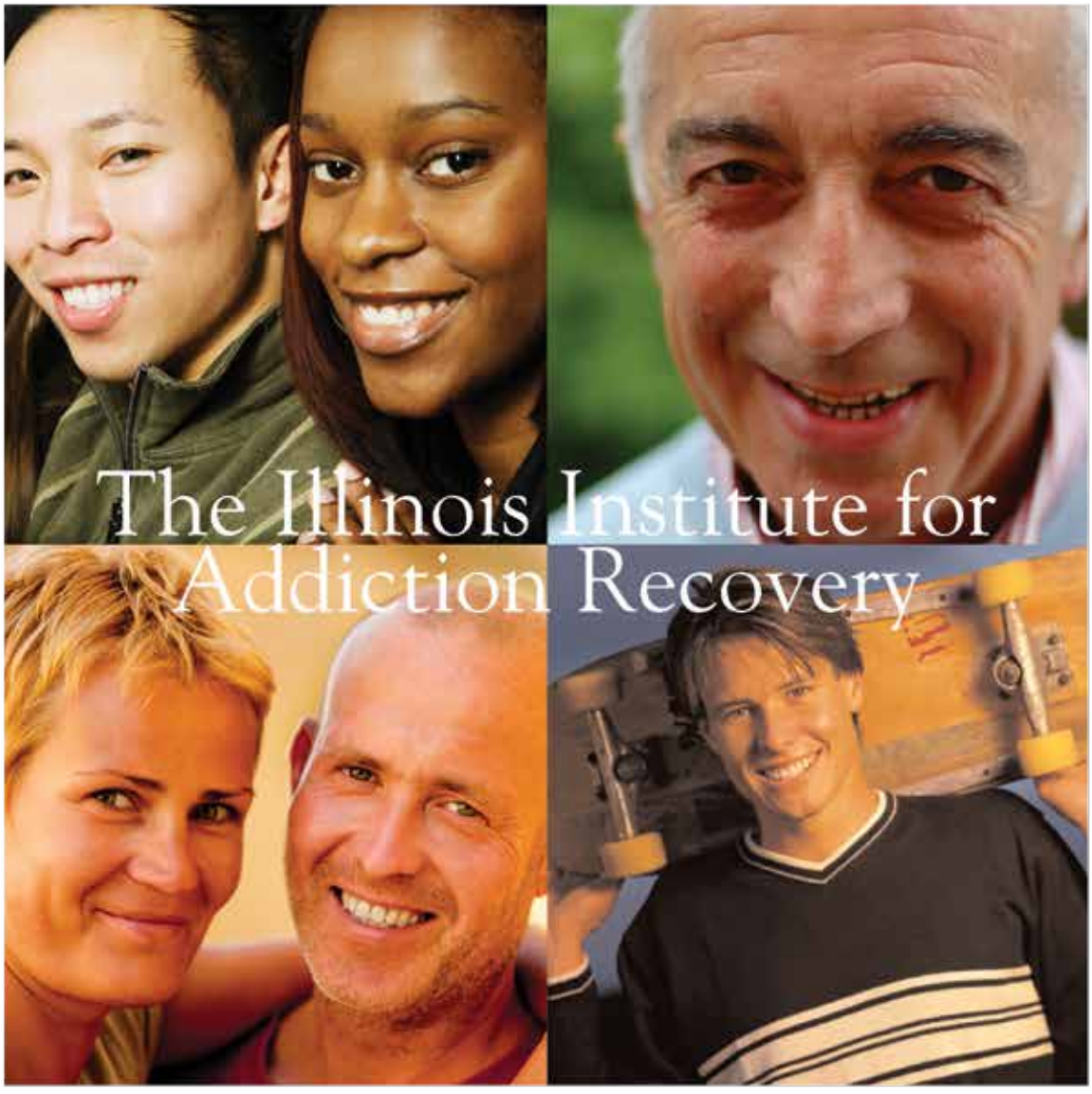

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