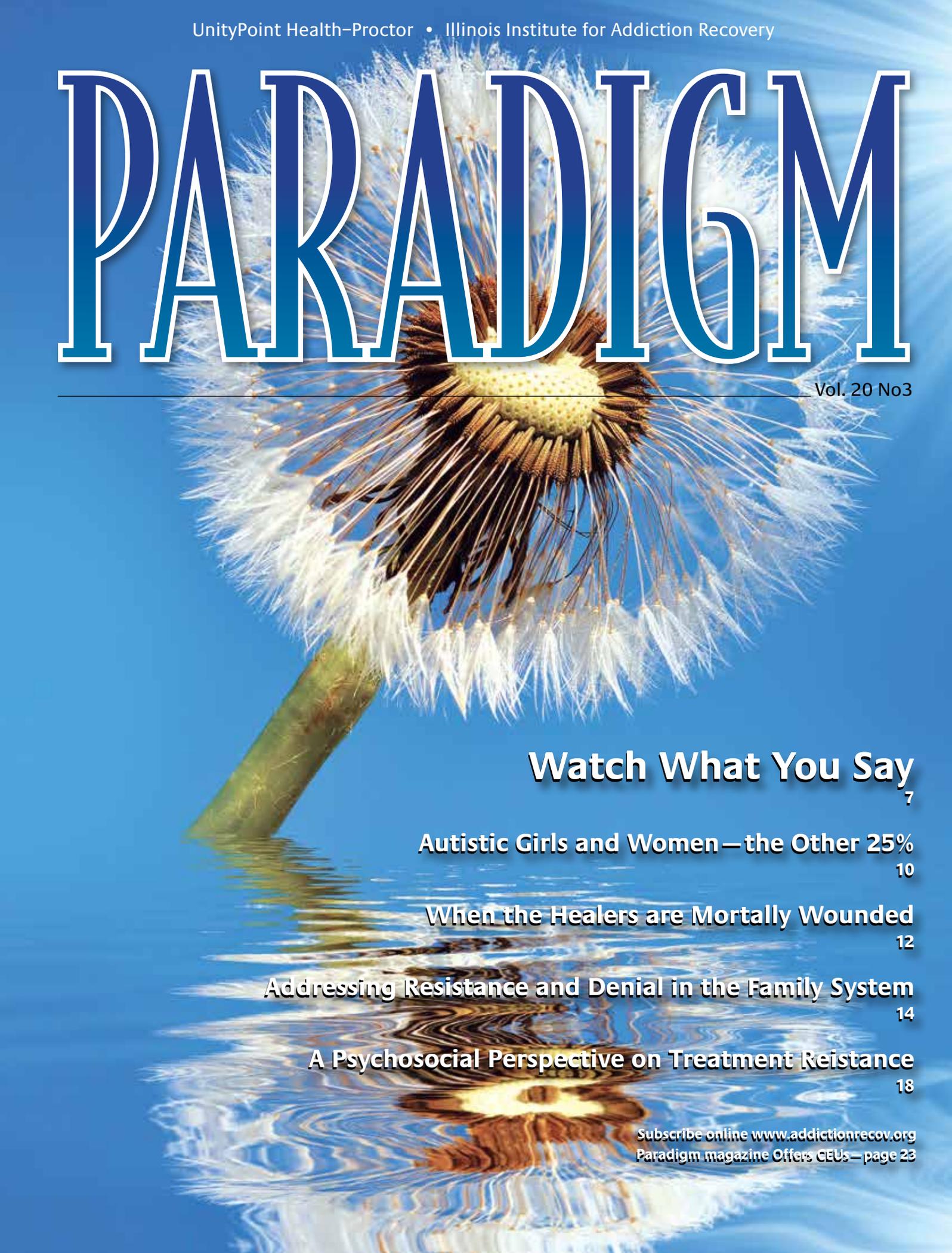


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SPOTLIGHT



Brittany Ott
MS, CADC

Brittany is a corporate services clinician at Illinois Institute for Addiction Recovery (IIAR) through UnityPoint Health Methodist-Proctor. Brittany received her master's degree in clinical-counseling psychology from Illinois State University in 2010. She is also licensed as a certified alcohol and drug counselor.

Brittany began her career as a counselor for Chestnut Health Systems. She then transitioned to a counseling position at IIAR, where she enjoyed assisting patients in learning to identify and accept their addiction and build tools for lasting recovery. She recalls that some of the most encouraging and uplifting moments occurred when the team would receive a phone call or card indicating that a past patient earned several months to several years of sobriety. In her current role as a corporate service clinician, Brittany enjoys assisting individuals who struggle with addiction by coordinating treatment services. In addition, Brittany strives to build community awareness of the disease of addiction to reduce stigma and offer treatment solutions.

In time away from work, Brittany can be found boating, reading, shopping, or spending time outside.

For the past 10 years, the Illinois Institute for Addiction Recovery has been celebrating recovery while supporting the Ameel Rashid Scholarship Fund through the annual recovery walk. Recovery Walks! 2016 will be held on Saturday, September 24 from 10 am – 2 pm at the UnityPoint Health-Proctor campus.



Recovery Walks! 2016 is a day of celebration and fun. This family-friendly event includes a delicious lunch, live music with The Corn Wolves, face painting by Stephanie Doss, balloon art by Doug Smith of The Unique Twist and a silent auction. At noon, participants step off together for a leisurely walk on the

paved walking trail while celebrating recovery. The registration fee also includes a Recovery Walks! T-shirt. Those wanting to identify themselves in recovery and be part of the color guard can choose a special T-shirt, the color of which will indicate their years in recovery: a green T-shirt signifies 0-9 years in recovery, a blue T-shirt for 10-19 years, and an orange T-shirt 20-29 years. Those in recovery for 30+ years will wear a gold shirt. It is such a moving experience to see the "sea of color" walking the track and knowing that each color represents that recovery is possible.

All proceeds from this event go toward the Ameel Rashid Scholarship for Addiction Recovery. Dr. Rashid was instrumental in starting the Addiction Recovery Center, and was one of the medical directors for many years. He established this scholarship fund, as he saw firsthand what happens to individuals who want to change their lives but simply run out of money to do so. This fund helps those individuals obtain the treatment they desperately need so they can break the cycle of addiction and make their lives better and more productive.

For more than 35 years, the treatment professionals at the Illinois Institute for Addiction Recovery have touched the lives of thousands affected by the disease of addiction. It provides treatment with dignity and respect to the patient and their family, that literally changes lives. September is National Recovery Month, dedicated to creating awareness and breaking stereotypes about addiction.

For more information about the IIAR or donating to the Ameel Rashid Scholarship Fund, contact Amanda Doman at (309) 691-1055. To register for Recovery Walks! 2016, visit the website at www.addictionrecov.org.



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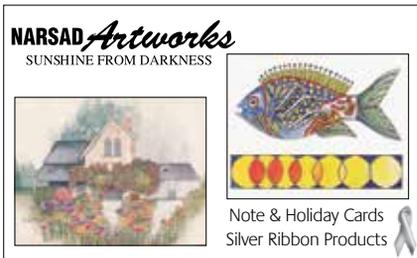
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By Ralph E. Carson, RD, PhD

It sounds almost silly that something as simple as a hug could combat the negative consequences of chronic stress. Could something as fundamental as a warm, loving embrace reverse the detrimental effects of excess cortisol? What scientific evidence supports the notion that a firm heartfelt squeeze to the upper back and shoulders triggers a release of chemicals that calm the brain?

A chemical called oxytocin (OXT) is released when there is an open and honest communication or heartfelt hug. Usually it involves a romantic partner, family member, or a trusted acquaintance. Often the opportunities to embrace are around tragedies, grief, celebrations, social occurrences, or friendly greetings. Extending a warm sincere hug teaches you to let go of the present moment and connect with your heart. It signifies a universal communication of caring, and is an act of both giving and receiving.

Oxytocin itself is synthesized in the neurosecretory cells of the supraoptic nucleus or paraventricular nucleus of the hypothalamus. When stimulated, oxytocin travels from the hypothalamus to the posterior pituitary where it is stored in secretory vesicles. Once activated, the oxytocin is released to projections in the brain where it is distributed to the pleasure center, the center of arousal and executive center. The peripheral sites where oxytocin receptors flourish are the heart, sexual organs, kidneys, adrenals, intestines, pancreas, lungs, thymus and fat cells.

Oxytocin engages brain circuits that make us care about others, even including people we haven't previously met. The smallest suggestion that someone would like to connect with us begins the release of OXT. When one makes a personal connection with another person, OXT is released in that person's brain.

An important role for oxytocin is its ability to mitigate stress and hence OXT is often referred to as the antithesis of cortisol (Tops, Buisman-Pijlman, Boksem, Wijers, & Korf, 2012; Keating, Dawood, Barton, Lambert & Tilbrook, 2013). Stress can compromise the immune system, making one more susceptible to colds and flu. Research supports that there are fewer incidents of such illnesses when there are a greater number of social interactions. A person isolated from society may experience an increase of cortisol and inflammation (Steptoe & Wardle, 2005).

With all the great attributes assigned to oxytocin, many may wonder if it is available in pill form. Unfortunately, like any protein, OXT is rapidly broken down in the gut by enzymes and not absorbed as oxytocin, but as individual amino acids. There is evidence that OXT taken as a nasal spray can be absorbed in its original state through the mucous membranes that line the respiratory tract. This may be acceptable, however some question whether OXT can cross the blood-brain barrier (BBB) once it is in the bloodstream. Although it is questionable if nasal OXT spray crosses the BBB, autistic adults did find help in judging facial expressions within 15 to 20 seconds. (Aoki et al., 2015).

Release of Oxytocin Reduces Consequences of Stress

Remarkably, hugs have been shown to raise oxytocin and as a result to lower cortisol. The common embrace employed in social support produces low cortisol levels (Heinrichs, Baumgartner, Kirschbaum, & Ehlert, 2003). Combine hugs with social support and you create a synergistic effect which inhibits the hypothalamic-pituitary-adrenal stress cycle by lowering the series of hormones (CRF, ACTH, NOR) that trigger negative emotions. This cascade of events concludes with the output of cortisol which is responsible for many of the negative physical consequences of stress. Hugs activate OXT and as a result counter the repercussions of cortisol.

Other avenues that contribute to increase oxytocin include having a good cry and practicing self-compassion. Oxytocin is one of the hormones that is secreted in response to self-care, vulnerability and self-kindness. Anything that creates a sense of being cozy, loved, peaceful, connected or trusting will contribute to an increase in OXT.

Placebo effect is based on a belief in the act of being treated and belief in the effectiveness. Volunteers given a whiff of oxytocin nasal spray and then told the cream they were testing contained a powerful pain reliever believed that the trial produced an analgesic effect. The explanation was that the oxytocins made the participants have more trust in what they were told (Kessner, Sprenger, Wrobel, Wiech, & Binge, 2013). When you look in a caregiver's eye and sense that they are really reflecting concern for your health and well-being, you tend to be more susceptible to a positive treatment outcome. This is what good empathetic doctors are capable of providing.

The actions of OXT in stabilizing emotional upheaval is based on its influence on many other neurochemicals (Dölen, Darvishzadeh, Huang, & Malenka, 2013) such as serotonin, endorphins, and dopamine (Field, Hernandez-Reif, Diego, Schanberg, & Kuhn, 2005). OXT strengthens the immune systems, reduces inflammation, and improves longevity. It also slows the aging process and has been linked to reducing wrinkles. Oxytocin peaks naturally about five hours after falling asleep. It is highly influenced by your normal circadian rhythms and is beneficial in creating a safe, sleep-like environment.

The physiological explanation for the benefits ascribed to hugs begins with egg-shaped pressure centers within the skin. We are made aware of sensory receptors in the skin when we touch a hot stove or are stuck by a pin. The impulse is instantaneously sent to the pain loci in the CNS through the spinal cord. In contrast, pleasant touch prompts Pacinian corpuscles to send electrical currents through the vagus nerve to the pituitary for the release of oxytocin (Forsell & Åström, 2012; Field et al., 2005). Pain responses are instantaneous (milliseconds), but with hugs, the communication is slower (4-5 seconds) because the C-nerves are non-myelinated (Morrison et al., 2011; Löken, Evert, & Wessberg, 2011). This vagal involvement produces a balance of the parasympathetic nervous system with the sympathetic nervous system and a reduction in blood pressure and heart rate. There is muscular relaxation and an increase in circulation that soothes aches, relieves tension and reduces pain. Eventually, oxytocin's activation of the orbital frontal cortex improves attachment, heightens compassion, and ushers in feelings of

contentment. The cumulative effect will induce and improve sleep which contributes significantly to overall health and well-being. Understanding the mechanism of healing and the application of kind touch explains some of the healing benefits of therapeutic massage (Morhenn, Beavin, & Zak, 2008).

Human beings all need to be loved, appreciated and made to feel special. This should be imbedded in us from our earliest experiences and continued throughout life. The feelings we experience in establishing a strong self-esteem are not only communicated through others, but also through acts of self-compassion and taking pride in ourselves. When we connect with these positive insights, the brain releases oxytocin. An individual may be in need of an oxytocin fix if he or she was raised in family that was lax in forming strong bonds, did not encourage or provide love, but instead created distance by shaming, criticism and abuse.

In order to enter a person's space and engage in physical contact it is necessary to know when it is appropriate and if the contact—such as a hug—will be reciprocated. The ability to know if such an action is safe and the other person trust this gesture will take attunement. For most individuals, this skill arises from reading the facial expressions and body language that provide the signal that it is safe to hug (Cserjési, Vermeulen, Lénárd, & Luminet, 2011; Castro, Davies, Hale, Surguladze, & Tchanturia, 2010). Those who are unaccustomed to making such decisions because of frightening past experiences and trauma often possess dysfunctional face reading skills. Therefore it would be challenging and uncomfortable to ask this person to give or receive a heartfelt hug.

Thus, the brain signals social recognition through facial expressions which are reflections of the level of oxytocin (Guastella, Mitchell, & Mathews, 2008). Even a pet that is attached to its owner will demonstrate increased oxytocin in their urine (Nagasawa, Kikusui, Onaka, & Ohta, 2009). Strangers or aggressors increase the firing of the arousal center that initiates a defensive or avoidance behavior and thereby activating the release of cortisol (MacDonald et al., 2013; De Dreu et al., 2010). There are many occasions where the hug or the person giving the hug are inappropriate, and individuals need to acquire those skills that set appropriate boundaries.

Oxytocin's Role in Eating Disorders Examined

Research has shown that oxytocin reduces binge eating and cravings as well as the use of illicit drugs and alcohol (Mitra et al., 2010; McGregor & Bowen, 2012). In reverse, high intakes of sugar reduce the activity of oxytocin and lead to overeating. This practice is further encouraged for people undergoing treatments for alcohol, drugs and compulsive disorders who benefit from participating in safe and responsible hugging routines on a regular basis.

It was previously mentioned that oxytocin directly has an effect on fat cells. Oxytocin alone has been observed to reduce body fat as a consequence of slower fat accumulation and smaller fat cells (Eckertova, Ondrejčáková, Krsková, Zorad, & Jezová, 2011). There is also scientific support for OXT reducing gut inflammation, preventing insulin resistance and increasing metabolism (Yamauchi et al., 2001).

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Oxytocin has been associated with causing dieters to feel satisfied sooner and stay satisfied longer (Welch et al., 2009; Welch et al., 2010). It was stated earlier that oxytocin has an almost ubiquitous distribution which includes nerve fibers along the entire length of our gut (Welch et al., 2009). The contribution of oxytocin to appetite suppression may invoke gastric distention combined with delayed gastric emptying. Oxytocin reduces reward driven food intake in humans without interfering with normal hunger (Ott et al., 2013). As a result of oxytocin, there is a reduction in the number of calories consumed during snacking.

There is substantial research supporting oxytocin contribution to weight loss. There have been reductions in cortisol, binge eating, appetite, fat cell size and number, insulin resistance, and inflammation. There is also an increase in metabolism. The accumulated studies highlight the importance of the oxytocin system in the pathogenesis of obesity (Gajdosechova, 2014).

If there is a therapeutic benefit from hugging, the main contribution would be the reduction of cortisol (Light, Grewen, & Amico, 2005). However, it becomes confusing when one is asked to quantify the hugs. Though not entirely evidenced based scientifically, from the few observations and reports mentioned in the scientific press, we might make some broad recommendations. The number of hugs per day that provides good therapeutic value averages around 12; but some therapy experts have suggested as few as eight will suffice. The time frame ranges from a few seconds to 20 seconds, but 9 1/2 seconds

seem best because it takes 4-5 seconds for the message to reach the brain and oxytocin secretion peaks in about 8-10 seconds thereafter. To achieve the same effect from handholding will take 10 minutes. The increase in oxytocin could almost be considered as instantaneously. The effect on lowering cortisol seems to be evident within an hour. The benefits seem to take place only if the hug is heartfelt and the exchange is between people who trust each other and share mutual feelings. Recipients will have sent similar signals that they want and give permission to share an embrace.

Dr. Ralph E. Carson has been involved in the clinical treatment of obesity, addictions and eating disorders for over 40 years. His unique background in health science and medicine (with degrees from Duke University and Duke University Medical School) coupled with nutrition and exercise (bachelor's degree from Oakwood College and PhD from Auburn University) has prepared him to integrate neuropsychobiological intervention and proven psychotherapeutic treatment. He is currently Vice President of Science and Innovation for the Eating Recovery Center's CORE Program for weight management and binge eating disorders, and consultant for the Pinegrove Behavioral Health and Addiction Center in Hattiesburg, MS. Dr. Carson has consulted with numerous addiction and eating disorder treatment centers and has been a speaker at various conferences and workshops. He has also set up several eating disorder programs and corporate wellness programs. Dr. Carson is an active board member of the International Association of Eating Disorder Professionals (IAEDP). He has authored several popular books on nutrition, lifestyle practices, good health and the brain: *Harnessing the Healing Power of Fruits and the recently published The Brain Fix: What's the Matter with Your Gray Matter?* Dr. Carson may be contacted at recarson@bellsouth.net.

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By David Mee-Lee, MD

WATCH WHAT YOU SAY

how language shapes attitudes

If you work in the addiction and mental health treatment world, it is common to refer to “substance-abusers” and “substance abuse” treatment. Even the federal government still clings to the terminology of the National Institute of Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Drug Abuse (NIDA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). The American Society of Addiction Medicine (ASAM) has for years discouraged the use of “substance abuse,” asserting that people, not substances are abused. In addition, calling a person a “substance abuser” carries the baggage of stigma associated with “child abuser,” “sex abuser,” or “elder abuser.” It is time to watch what we say and look again at the terminology we use to describe the people we serve and the treatments we provide. This is not about political correctness. This is about attitudes that perpetuate stigma and discrimination and affect how we treat people and the quality of services we offer.

Increased Scientific Attention About Language and Stigma

Bill White and John Kelly, in an interview in 2013, discussed the impact of terminology used in addiction treatment. Bill White is a long time champion for recovery and has for many years alerted us to the terminology we use. He asked Dr. Kelly, an associate professor at Harvard Medical School and associate director of the Massachusetts General Hospital in Boston, about the role language plays in social and professional stigma attached to addiction. Dr. Kelly shared some of his research, saying

I decided to investigate this scientifically to see whether describing someone as a “substance abuser” compared to describing someone as “having a substance use disorder” influenced people’s perceptions of personal blame and responsibility for their problem, how safe they were to be around, and whether they should receive treatment or punishment.

Dr. Kelly conducted an experiment that randomized more than 500 doctoral-level clinicians to receive a vignette describing an individual involved in a drug court situation, who was supposed to appear before the judge again. The vignette was identical except in half of the vignettes, the individual in violation of the court mandate was described as a “substance abuser” and, in the other half, he was described as “having a substance use disorder.” These well educated clinicians, many of whom were addiction specialists, viewed the person described as a substance abuser significantly more punitively, as having greater personal responsibility and being more to blame for his problems, and as less deserving of treatment. (White, 2013; Kelly, Dow, & Westerhoff, 2010).

Language and stigma is not confined to addiction treatment. The same kinds of attitudes have been shown to exist in mental health. Granello and Gibbs studied undergraduate students, adults in a community sample, and professional counselors and counselors-in-training. They used an instrument that measured people’s attitudes towards individuals with diagnosable mental illness. What they found was that when individuals were described as “mentally ill” it evoked attitudes of authoritarianism (treating people as if needing more control and discipline); social restrictiveness (needing to be more isolated from the rest of the community); and less benevolence (less sympathetic, kind feelings and less willing to be personally involved with the individual). In contrast, when the instrument described individuals as “people with mental illness,” there was increased tolerance, benevolence and acceptance of people as being part of the community needing help and assistance rather than control and isolation from others (Granello & Gibbs, 2016).

Richard Saitz, MD, newly appointed editor of the *Journal of Addiction Medicine* (JAM), focused in his first editorial on

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terminology. *JAM* is the journal of the American Society of Addiction Medicine (ASAM) and Dr. Saitz wrote “we hope to set a standard for clear, scientific, nonstigmatizing language.” This goal he said was

about accuracy, clear communication of addiction science, and about helping to assure high-quality clinical care. Use of stigmatizing language can actually worsen the quality of clinical care. Words matter. Thus, herein, we propose that in our field and in this journal, we use precise respectful clinical terminology. This will include “person first” language (e.g., patient with alcohol use disorder, not addict or alcoholic). We recommend avoidance of “abuse”..... and always avoidance of “abuser” (Saitz, 2015).

Moving Towards Strength-Based Words That Promote Recovery

In the Washington State Certified Peer Counselor Training Manual there is a succinct list emphasizing that language matters. The manual advises:

When we talk about mental illness, the words we choose are very important. Respectful language can promote recovery and reduce stigma. A poor choice of words can have the opposite effect. Consider the following word choices:

- *Person* instead of patient
- *Challenge* instead of failure
- *Opportunity* instead of crisis
- *Life experience* instead of history of illness
- *Strengths* instead of weaknesses
- *Recovery path* instead of cure
- *Acceptance* instead of blame

The words on the left are positive and have a sense of power to them. They engender hope and possibility. The words on the right are negative. Words can go a long way in facilitating someone’s recovery and combating stigma within and outside of the mental health system. (Module 3: Core Principles of Recovery & Resilience, p. 37, 2009).

Harris and Felman (2012) provided their list of how language that is commonly used within the mental health system can often be improved. The following are examples of simple, practical ways to reframe the conversation in recovery-oriented ways.

Rather than these words:	Use words that promote recovery:
1. Refused	1. Declined/Repeatedly said no
2. Resisted	2. Chose not to/Disagreed with the suggestion
3. Client believes that...	3. Client stated that...
4. Delusional	4. Experiencing delusional thoughts
5. Paranoid	5. Experiencing paranoid symptoms
6. Decompensate	6. Experiencing an increase in symptoms
7. Manipulative	7. Seeking alternative methods of meeting needs
8. Noncompliant	8. Not in agreement with the treatment plan/ Difficulty following treatment recommendations
9. Unmotivated	9. Bored/Has not begun
10. Suffering from...	10. Has a history of...
11. Low functioning	11. Has difficulty with...

Person First Language

People-first or Person First language has evolved out of the disability rights movement that started in the 1970s and has

encompassed people from the fields of education, physical health, intellectual development not just addiction and mental health. The goal is to avoid attitudes that dehumanize people by separating the condition or diagnosis from the identity of the person. The diagnosis comes second to the person rather than the person taking on the identity of their diagnostic label or condition. For example, John is not a stutterer, but a person who stutters. Kathy is not a drug addict and a schizophrenic, but a person with addiction and schizophrenia. Some people in treatment have an emotional outburst and take on the identity of their diagnostic label: “What do you expect? I’m bipolar!” as if that absolves them of responsibility to address their outburst. “The term people-first language first appears in 1988 as recommended by advocacy groups in the United States. The usage has been widely adopted by speech-language pathologists and researchers.” (Accessed on Wikipedia, February 13, 2016).

In a document from the Washington State Department of Social and Health Services published August 2, 2010, but for which the Division of Behavioral Health and Recovery could not find the original author, a useful table of terms was introduced:

The table on the following page contains examples of the terms that we have traditionally used to describe people and/or their behaviors. These terms place judgment and blame on the individual and generalize their actions. It is much more helpful to describe the specific situation that a person is facing than to use generic and punitive clinical terms.

Conclusion

Whether you work in addiction, mental or physical health settings, or a non-clinical environment, like community or social services, criminal justice, child protective services or prevention, language matters. It can bring you closer to the people, or keep you separate. It can empower them to embrace recovery and wellness, or keep them stuck in a victimized pathology-oriented identity. Notice what you say and how language shapes not only our own attitudes, but also those of the people and families we serve.

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Worn Out Language	Language that Promotes Acceptance, Respect & Uniqueness	Comments
Max is mentally ill Max is schizophrenic Max is a bipolar Max is...	Max has a mental illness Max has schizophrenia Max has been diagnosed with bipolar disorder Max is a person with...	Avoid equating the person's identity with a diagnosis. Max is a person first and foremost, and he also happens to have bipolar disorder Very often there is no need to mention a diagnosis at all It is sometimes helpful to use the phrase "a person diagnosed with," because it shifts the responsibility for the diagnosis to the person making it, leaving the individual the freedom to accept or not
Alex is an addict	Alex is addicted to alcohol Alex is in recovery from drug addiction	Put the person first Avoid defining the person by their struggles
Rebecca is brain injured/damaged	Jane is a person with a disability	Put the person first Avoid defining the person by their struggles
Sarah is decompensating	Sarah is having a rough time Sarah is experiencing...	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Avoid sensationalizing a setback into something huge
Mathew is manipulative	Mathew is trying really hard to get his needs met Mathew may need to work on more effective ways of getting his needs met	Take the blame out of the statement Recognize that the person is trying to get a need met the best way they know how
Kyle is non-compliant	Kyle is choosing not to... Kyle would rather... Kyle is looking for other options	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Does Kyle agree with your plan?
Megan is very compliant	Megan is excited about the plan we've developed Megan is working hard towards the goals she has set	Being compliant means that someone is doing what they were asked or told to do. The goal of recovery-oriented services is to help the person define what they want to do and work towards it together. Someone being compliant does not mean that they are on the road to recovery, only that they are following directions.
Mary is resistant to treatment	Mary chooses not to... Mary prefers not to... Mary is unsure about...	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Remove the blame from the statement
Allie is high functioning	Allie is really good at...	Describe what it looks like uniquely to that individual—that information is more useful than a generalization
Jesse is low functioning	Jesse has a tough time taking care of himself Jesse has a tough time learning new things Jesse is still early in his recovery journey	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Avoid defining the entire person negatively based on the fact that he struggles in some areas
Michael is dangerous	Michael tends to become violent when he is upset Michael sometimes strikes out at people when he is hearing voices	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Remove the judgment from the statement Avoid defining the person by the behavior
Sam is unmotivated	Sam doesn't seem inspired to go back to work Sam is not in an environment that inspires him Sam is working on finding his motivation Sam has not yet found anything that sparks his motivation	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Avoid defining the person by the behavior Remove the blame from the statement
Andy is manic	Andy has a lot of energy right now Andy hasn't slept in three days	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Avoid defining the person by the behaviors
Kate is paranoid	Kate is experiencing a lot of fear Kate is worried that her neighbors want to hurt her	Describe what it looks like uniquely to that individual—that information is more useful than a generalization
Hailey is a cutter	Hailey expresses her emotional pain through self-harm Hailey hurts herself when she is upset	Avoid defining the person by the behavior Recognize the reason behind the behavior
Jordan has a chronic/persistent mental illness	Jordan has been working towards recovery for a long time Jordan has experienced depression for many years	Avoid defining the person by the behavior Recognize the reason behind the behavior
Jordan has a chronic/persistent mental illness	Jordan has been working towards recovery for a long time Jordan has experienced depression for many years	Avoid conveying a prognosis It is difficult to accurately predict an individual's prognosis and it only impedes their progress to define them as someone who will not recover (or will not be in recovery for a very long time) There is no need to address prognosis in describing a group of people or an individual
Tom is very difficult	Tom and I aren't quite on the same page It is challenging for me to work with Tom	Avoid making a judgment, which may be based on your dissatisfaction with the fact that the person has not met your expectations (which may be different from what he wants for himself)
Manipulative Grandiose In denial Passive aggressive Self-defeating Oppositional	These are often people's ineffective attempts to reclaim some shred of power while being treated in a system that often tries to control them. The person is trying to get their needs met, or has a perception different from the staff, or has an opinion of self not shared by others. And these efforts are not effectively bringing them to the result they want.	These are labels for strategies and perceptions we all have about ourselves, although possibly more subtle and effective. We all present information to achieve a desired result to some degree (manipulation). Or have an inflated opinion of ourselves, or are unable to see or agree with something presented to us by another.

Autistic Girls and Women

the other
25%



By Doris M. Greenberg, MD

According to the Centers for Disease Control and Prevention (CDC), it is estimated that Autism Spectrum Disorders now occur in about 1 in 68 males. For comparison, about one-fourth as many females have the same diagnosis. (Fombonne, 2005). The females have been “research orphans,” who are often excluded from medical trials and are just beginning to emerge in our medical consciousness. They often differ from the males, and because of this, they are often overlooked and under-diagnosed. Recently, there have been a number of books published about women and girls on the spectrum; some of the books have been written by women who were not officially diagnosed until their adult or late adult years (Kim, 2014). Some of these women are successful professionals, wives and mothers, and it is becoming apparent that some women with autism can fly under the radar, disguising their autism by carefully learning to imitate how “neurotypical” women behave.

Girls born with autism are quite diverse, as are the males. There is a group of girls and women who are severely autistic exhibiting severe speech and language deficits, intellectual deficiency, and severe behavior difficulties. They have been easy to diagnose and have been known to the medical community for a long time. The higher functioning women and girls are sometimes more difficult to diagnose than their male counterparts due to having fewer externalizing behaviors that make them stand out; often, they have a greater awareness of social conventions than the males with autism, and they may imitate and adopt social behaviors that make them look more typical (Lai et al., 2011). They are constantly playing a role, learning their parts by rote, covering up for the lack of intuitive social behaviors. This play-acting, however, can be exhausting. It is like being on stage constantly. Females may have concomitant depression and anxiety as a result of the stress of “playing typical.” They may be mothered by other girls and may look like they have a lot of friends, when they really are sitting on the periphery looking in at the behavior of the others. Teachers may miss the child’s social deficits, thinking the girl is fitting in with peers. The males may have few friends and are less likely to be included in a group of peers (Gould & Ashton-Smith, 2011). Girls may frequently be less hyperactive, and they may have interests they share with other girls like horses, other animals, and literature. They differ from their typical peers by the

intensity of their interests. Boys may lack any friends; girls on the spectrum may have a special friend, making it harder to diagnose their autism (Gould & Ashton-Smith, 2011).

Puberty Brings Additional Challenges

The stages of a child’s life are challenging for the females on the spectrum. Change is always difficult for autistic people. There is comfort in “same old, same old.” Suddenly, children enter puberty, a time of enormous change. This time of life is difficult for typical children without autism, but when the body is changing, hormones are raging, and courtship rituals become important, autistic adolescents and young adults face stress and anxiety. Autistic girls and women are often socially naïve and can be victimized (Attwood, Hénault, & Dubin, 2014). They may dislike being touched, being intimate, and reciprocating feelings. It may be daunting to understand flirting and its subtleties. They may not be able to sustain a relationship and may miss the subtle cues of intimacy. If a girl has sensory difficulties with touch, sexual relationships may be difficult or impossible. Similarly, some autistic women are too forceful and may hurt their partners unintentionally (Steward, 2014).

The Internet has been both a godsend and a curse for autistic girls and women. The chat rooms for girls and women on the spectrum have been helpful for social networking without requiring face to face conversations, which may be very difficult for this group. On the other hand, sex education obtained from the Internet may come from pornographic sites, and these sources may exaggerate and distort sexual behaviors, which, if adopted by the women who visit them, may lead to catastrophic and disappointing results. It is very important that parents and teachers address sexual behaviors and normative conduct with children, adolescents and adults on the spectrum and steer them away from unsavory sources (Attwood, Hénault, & Dubin, 2014).

When girls begin having menses, care and hygiene are important subjects for discussion. Some of the young women will not be able to care for their own periods; progesterone implants can prevent periods for years at a time and prevent pregnancy in this vulnerable group. Appropriate modesty, sexual safety, and appropriate responses to flirting, dating, and engaging in sexual

behavior are best learned from knowledgeable adults rather than peers or the Internet. These girls may need to have instruction regarding avoiding suggestive dressing, avoiding sexual posturing, and learning the intent of sayings like, "I want to sleep with you," not to be taken literally as a sleepover (Steward, 2014).

Leaving home and going to college is another big milestone in the lives of girls and women everywhere. Autistic female college students now face having to live with others not in their comfort zone, being more independent, understanding college culture, and traveling independently. The offices for students with disabilities on the campuses have begun to accommodate the needs of autistic students by offering special housing, special advisors, and modifying the curriculum to include courses which fit the preferences of autistic students. Offering dorm rooms for individual students and not requiring roommates may help to reduce the anguish of having to adapt to a stranger's living habits.

It is a challenge for autistic adults to apply for work. The job interviews may be disasters if typical interviewing skills are needed; autistic students and young adults may need job coaches, rote learning of job etiquette, and advocates who introduce them to a potential employer. This is equally challenging for males as well as the females.

Women on the autism spectrum may marry and have children; their adjustment to the changes of marriage, pregnancy, and mothering may place another large stress on them. It may be difficult for them to empathize with their husbands and children, and it may be extremely hard to understand the changing needs of growing children. Meltdowns and emotional outbursts are inevitable when the demands of family and jobs tax the limited social skills of the autistic woman. The subtleties of intimacy and a continuum of sexual arousal may be difficult for the autistic woman to understand and may lead to awkward and unrewarding interaction with sexual partners (Attwood, Hénault, & Dubin, 2014).

Anxiety and Depression May Accompany Autism

It is sometimes difficult to come to the diagnosis of autism in girls and women until their personalities are followed for awhile. The deep and special interests so often seen in their male counterparts may not be as atypical. They may camouflage their special interests to appear less odd, according to Tony Attwood, a prolific writer about autism. Some women and girls may choose technology as their "friend" rather than human companionship and may avoid sexual difficulties by remaining celibate. Anxiety and depression, as well as attention disorders, frequently co-exist with the autism and need to be assessed and treated, if impairing.

Females and males on the autism spectrum often suffer from other co-morbid disorders. ADHD is probably the most common co-existing condition, followed by social anxiety disorder. These diagnoses occur in about 30% of autistic women as well as the males (Simonoff et al., 2008).

Obsessive behaviors may undermine relationships if an autistic woman becomes obsessive about another person. Facial expressions are difficult for some women and girls, leading to

negative interpretation by their peers and their partners. Emily Bazelon in an article in *The New York Times* (Nov. 2007), reviews recent data and studies that indicate high functioning autistic men are more likely to marry than their female counterparts.

It is important to discuss being on the autism spectrum with girls and women when they are cognitively able to process the information. Discussing this may help these patients understand the stress they experience in typical social environments. Physicians and therapists may recommend joining online chat rooms for people with autism, and since technology may be more attractive than live therapy groups, patients may feel more comfortable connecting over the Internet. Accommodating sensory difficulties and compulsive behaviors may allow autistic patients to function quite well in work and school. Advocating for autistic patients may help broker introductions leading to rewarding careers.

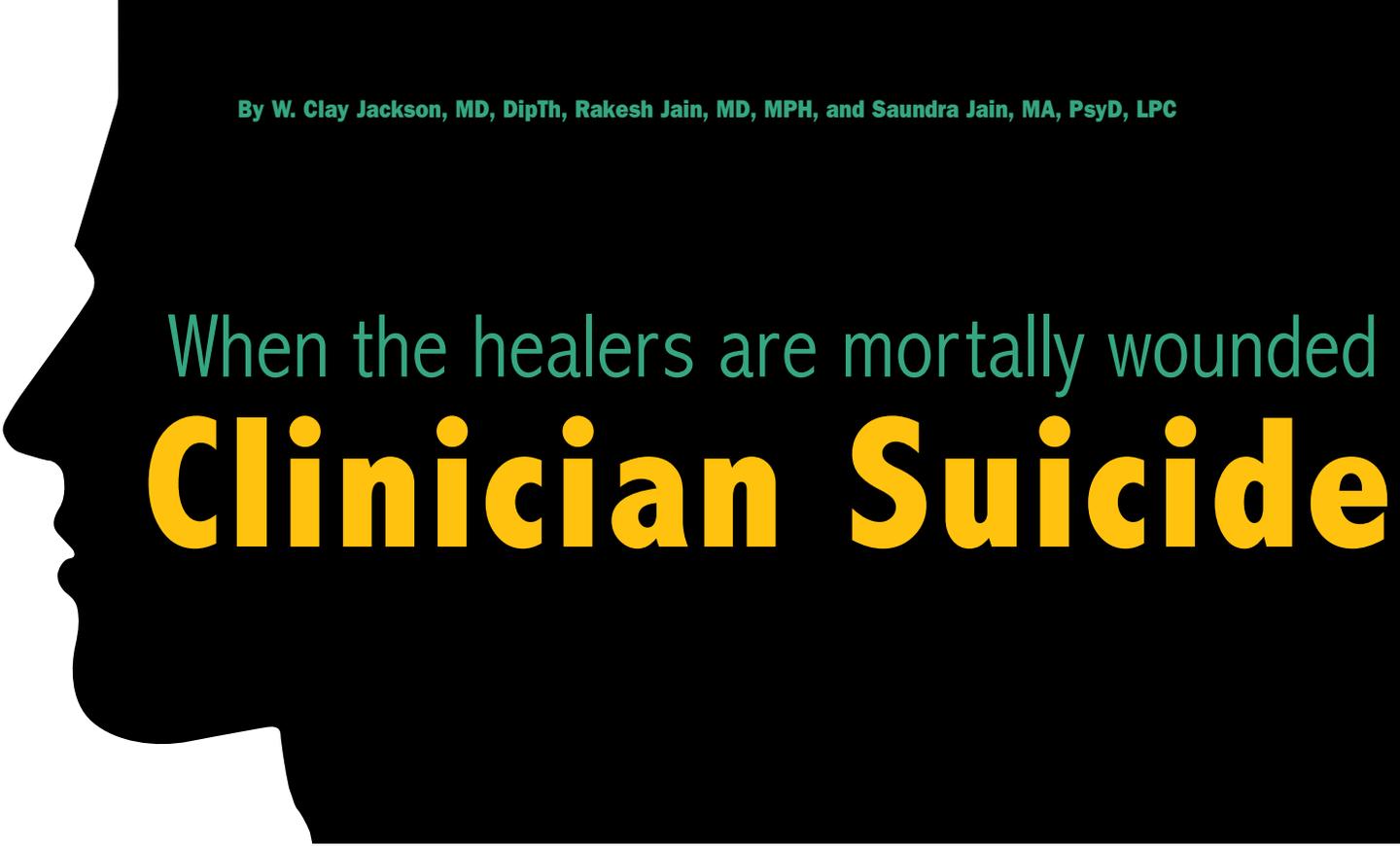
In summary, autistic women and girls are harder to detect than men with autism, make up about a quarter of all autistic people, and they may stay hidden due to their more subtle presentation. Autistic women and girls face a myriad of life events that are challenging since change is very distressing to them. Professionals who deal with this interesting group of people need to be aware of the requirements of different developmental stages and how they affect the girls and women in their care, keeping the women and girls safe and reducing their trauma. If we look carefully, we have met these women in our lives, and now we may understand them better and appreciate the many contributions they have made to our world.

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When the healers are mortally wounded

Clinician Suicide

On the face of it, suicide seems the ultimate personal and intimate tragedy. As any survivor of a suicide victim can attest, however, this very personal tragedy casts a shadow on the family, friends, and acquaintances who are left to grieve the loss, and grapple with questions of if and how such devastation could have been prevented.

When the suicide victim is a member of the healing professions, however, the pain of survivors can be particularly acute, as we typically idealize physicians and other clinicians in the role of helper. Patients can be left feeling abandoned, having lost a trusted partner in their healthcare. Evidence now shows that over 400 physicians commit suicide in the US annually, leaving approximately one million patients without their doctor (Wible, 2014).

The Case of 'Dr. Roberts'*

Dr. Roberts was a Caucasian male in his late 40's who had built a successful psychiatry practice in a major midwestern city. He was happily married and professionally successful, but had become distressed in the past three years over an investigation by the state Medicaid program for 'upcharging' (billing in excess of the time expected for the treatment of a given condition). He disputed the allegations vigorously, and felt that he was being unfairly singled out for inquiry. He felt persecuted and wronged. After receiving an unfavorable judgment which required repayment of monies received as well as civil penalties, he called his secretary from his office, told her that he planned to kill himself, and hung up the phone. She called the police and raced home to find him in his study, where he had ended his life with a handgun.

* selected demographic details changed for the purpose of protecting anonymity

Despite the tendency of laypersons to idealize the clinician occupying the healing role, there exist several demographic trends, professional expectations, and personal characteristics that may place physicians at particular risk of suicide. Historically, older males have been the cohort at highest risk of suicide across social groups. Over the past two decades, however, suicide rates have fallen precipitously in this and other groups. However, the cohort of males from age 30-49 has not fallen, and has actually begun to rise (“A Worrying Trend,” 2015). Although great strides have been made in increasing the diversity of the physician population, this demographic (young- to middle-aged males) is still heavily overrepresented in the physician pool (Xierali, Castillo-Page, Conrad, & Nivet, 2014; Kaiser Family Foundation, 2014), lending credence that the demographic trend of suicide places many physicians at increased risk.

‘Condemnation of life is madness
that leads to suicide.

Leo Tolstoy, *For Every Day*

In addition to the demographic data, other factors may influence the high rate of physician suicide, including social isolation, access to controlled substances, barriers to attaining quality treatment, and stress or burnout in the workplace. Women may also face greater role conflict and/or sexual harassment in their professional setting, compounding other factors that negatively affect perception of personal satisfaction (Shrira, 2009).

A study by Shanafelt and colleagues showed that on a standard screening tool for burnout, 38% of physicians reported emotional exhaustion, and 29% reported depersonalization—episodes that one might describe as “not even being there” or “going through the motions” (Shanafelt et al., 2012). Another survey of physicians across 28 specialties revealed the nature of “burnout,” and how it is experienced by physicians (Peckham, 2015). Burnout is defined as loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment. The most highly rated cause of feeling burned out involved dealing with too many administrative tasks. Across specialties, about half of the physicians self-reported suffering burnout, ranging from 37% in dermatology to 53% in critical care. Certain characteristics seemed to provide a protective effect against experiencing burnout, however, including living with a partner and volunteering within the community.

The cumulative effect of such intense external stressors and genetic predisposition to depression may lead to significant numbers of physicians expressing depressive symptoms. In a survey of over 3,000 Canadian physicians, one quarter of them reported a two-week period of depressed mood (Compton & Frank, 2011). In a study of US interns during the first three months of their training (Sen et al., 2010), their rates of depression rose dramatically—from 4% to 26%. Alarming, suicidal thoughts rose fourfold during the same timeframe.

A study of Scandinavian anesthesiologists showed that workplace stressors, including conflict with coworkers and a lack of control

over working conditions, played an unusually large role in predicting which clinicians were at risk of suicide (Lindfors, Meretoja, Luukkonen, Elovainio, & Leino, 2009). These findings were confirmed in a large survey of Swedish and Italian hospital physicians, where the 12-month incidence of suicidal thoughts was found to be 12-14% (Fridner et al., 2011; Fridner, Belkić, Marini, Minucci, Pavan, & Schenck-Gustafsson, 2009). Another study found that patient complaints were a significant risk factor for increasing anxiety, depression, and suicidal thoughts, and that the intensity of the effects rose with the severity of the patient’s complaints (Bourne et al., 2015).

Physicians Reluctant to Seek Support

Despite the high rates of depression and even suicidal ideations among practicing physicians and physicians-in-training, significant barriers to receiving adequate social support and mental healthcare persist. Very early in medical training, students and residents acquire a strong subcultural message: physicians are not to complain of mental health symptoms, because “real doctors” or “those who can take it” should be able to overcome any symptoms of mental illness on their own. In addition, many doctors may (accurately) fear discrimination with respect to attaining hospital admitting privileges or admission to insurance panels if they list mental illness on their professional inquiry forms (Schwenk, Davis, & Wimsatt, 2010; Schwenk, Gorenflo, & Leja, 2008; Hassan, Ahmed, White, & Galbraith, 2009). In an effort to avoid the stigma of mental illness, many clinicians may employ suboptimal treatment strategies for their symptoms, including avoiding treatment altogether, self-treatment via sample medication, utilization of poorly evidenced complementary-alternative treatments, receiving “off-the-record” treatment from a colleague, or seeking treatment far from their home community (Adams, Lee, Pritchard, & White, 2010; Shanafelt et al., 2011).

Of those physicians who are unable or unwilling to receive adequate help, and unfortunately are at the greatest risk of suicide, the strongest predictor of suicide completion appears to be problems related to the workplace, or that threaten one’s professional role. It appears that physicians identify so closely with the role of professional caregiver that circumstances which threaten this role viability strike at the *raison d’etre* of personhood itself. However, a number of factors that can predict suicide in the general population are not as helpful in predicting suicide in clinicians. These include conflict with a current or former intimate partner, other relational conflict, physical health problem, financial or legal trouble, a recent crisis, death of a family member, or suicide of a family member within the past five years (Gold, Sen, & Schwenk, 2013).

“The problem for doctors is that they receive information
but not a true education.”

Bernie Siegel, MD

Given the evidence for the lack of adequate mental health treatment for physicians, and in the face of growing evidence of high rates of mental illness symptoms and completed suicides,

a planning group of the American Foundation for Suicide Prevention published a consensus statement in the *Journal of the American Medical Association* (Center et al., 2003) that recommended “transforming professional attitudes and changing institutional policies to encourage physicians to seek help.” A decade later, however, that call to action remains far from full implementation.

There does appear to be a path forward: by openly discussing the hidden reality of clinician suicide, the professional community can draw attention to the broad scope of the challenges to mental health faced by physicians, who may be socially isolated and frustrated by workplace as well as personal difficulties. Actively seeking to change the “don’t ask, don’t tell” culture regarding emotional and mental symptoms of caregivers will take time, but is well worth the effort. Regular, institutionally sanctioned debriefing (such as is practiced with Balint groups), as well as informal support networks, can make a profound difference. Not all healers are well, but not all wounds are mortal. Though it is sadly too late for Dr. Roberts and hundreds like him, for the sake of our colleagues—and ourselves—the time for action is now.

“Grinning and bearing it’ is not an acceptable coping strategy.”

Starla Fitch, MD

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RESISTANCE

By Alana Smith, LCSW, LCDC

Addressing *Resistance* and Denial in the Family System

Working with resistance and denial in the family system is not easy work for therapists as it can challenge the denial and resistance in us.

The addiction treatment field has made significant headway in researching, understanding, and conceptualizing the symptoms and behaviors of substance use disorder. There have been innumerable contributions to our present day understanding of addiction, with the American Medical Association proclaiming in 1956 that “alcoholism is an illness,” preceded by the founding of Alcoholics Anonymous (1935), and recently the documentary *The Anonymous People*, along with the associated movements and marches to end addiction stigma. The mental health field and society as a whole can agree more than ever that addiction is an illness that is chronic, progressive, and fatal. Substance use disorder is a physical, mental, emotional, and spiritual illness, and people can recover regardless of their life circumstances.

When clinicians are presented with resistance and denial in a client with substance use disorder, there is understanding that we are dealing with the rudiments of an illness, and we respond with appropriate clinical interventions. Long gone are the days when clinicians believed that frothy emotional appeal, teaching will-power, or simply motivating addicted clients would aid them to get sober. Educating clients that they have an illness and providing comprehensive understanding of recovery concepts is the foundation of effective addiction treatment.

The family recovery field has its origins in the advent of the Al-Anon Family Groups beginning in 1951 and the research of Dr. Joan Jackson in the early 1950's. Years later, throughout

the 1980's and 1990's, there were significant contributions from Claudia Black with the Adult Children of Alcoholics movement and the understanding of codependency. At the turn of the century the research of Stephanie Brown and the invaluable contributions of Jeff and Debra Jay have kept the flames fanned on the work with families. However, unlike the zealous momentum and more public evolution of the addiction recovery field, the energy and focus directed towards the family recovery field has seemingly taken a back seat in spite of these contributions. There is also difficulty within the addiction treatment field in conceptualizing and appropriately intervening on the family illness of addiction.

Family Illness Also Chronic, Progressive, Fatal

Family members struggling to understand what to do in the midst of the crisis of addiction are instructed to read a book on boundaries, take care of themselves, and just let go. Would we tell someone with addiction to read a book and develop better self-care? In some ways it seems as though many view the family illness much the way our society and mental health field viewed alcoholism some 50-60 years ago, i.e., that family members need to use will power and make better choices, and all will be well. The reality is that the family illness of addiction is not very different conceptually from what we know about addiction. The family illness, too, has definable symptoms and behaviors. It is chronic, progressive and fatal. Its symptoms and behaviors manifest physically, mentally, emotionally, and spiritually. Family members can recover despite the outcome of the addicted person's recovery.

In the mental health and addiction treatment field it is strongly encouraged that therapists take care of themselves just as they would have their clients do. Many addiction treatment counselors are in Twelve Step recovery themselves, and embrace their recovery as a meaningful foundation of what they have to offer in their professional work to clients. This wisdom speaks to the importance of clinicians doing continued work to avoid denial within themselves in order to effectively address the denial and resistance in their clients. This same truth applies to clinicians working with families. Clinicians from addicted or dysfunctional families who have not done their own family of origin work can find themselves caught in a web of countertransference, ineffectiveness, and burnout. It is well known that we cannot give away what we don't have, and by extension that we cannot take a client somewhere that we have not gone. Not having this level of insight and awareness promotes resistance and denial within the clinician. All of this to elucidate the important point that as clinicians addressing resistance and denial, it is important to ensure that we are cautious in counseling family members while stones in our own family of origin work have been left unturned.

After having done our own personal work, and with a solid understanding of the disease concepts of addiction and the family illness of addiction, we are then best equipped to appropriately address and intervene beyond a behavioral level. We are dealing with the pain, confusion, hurt, self/other blame, and numbness of family members who believe that the *only* problem to be addressed is their loved one's chemical use. When family members show up in our offices and treatment centers they are often still grappling with the denial of problematic chemical use

in the family. To take family members further in understanding that they have their own healing separate from that of the person with substance use disorder can invite resistance and denial.

When we speak of resistance of family members, what exactly are we talking about? It is the non-engagement in the treatment process, strategically holding back from volunteering information about the addiction issue, and in the dictation of what the addicted person needs to do differently while having little insight into what changes are needed in the family to support sobriety. Resistance and denial takes many forms. It is important to stress that resistance and denial are merely the defense mechanisms and protective system surrounding the impact of addiction. The defenses are in themselves the structure of the denial system. This is no different than resistance and denial in a client who is getting sober. It is about the avoidance of pain, truth, change, and grief. Most commonly, resistance is more deeply about fear, anger, avoidance, and protection.

Fear of Being Blamed

Family members tend to struggle with the concept of powerlessness in a similar way that their addicted family member struggle. The notion that the addiction is no one's fault appears to be a 'cop-out', and family members are certain that involvement in the recovery process will be an excavation project to assess why the addiction started, and whose fault it was. Family members struggle with a deep-seated fear that their involvement in the treatment process will reveal that they are responsible for the chemical use. We know from Al-Anon the "Three C's:" that we didn't cause, we can't control, and we can't cure another's alcoholism. It is important to address with families on phone calls, in sessions, and at the beginning of a family program that this is not a fault-finding mission. It is very relevant to stress that no one person was powerful enough to create an addiction in another person, and that the family recovery process is about understanding, healing, and letting go of responsibility for another person's illness. It is imperative to emphasize that responsibility lies in our responsibility to participate in the recovery process and in our own healing. Families need to hear that they have a role to play, that their role is in their contribution by engaging in recovery.

Anger and Resentment Common Sentiments

How many times have we heard, "Why do I have to come for sessions, go to meetings, or attend a family program? I'm not the one with a problem!" The resentment that family members carry because of addiction is often palpable. The anger is multifaceted in its origin. It often stems from not understanding addiction and believing that the addicted person keeps choosing to drink or use. It can come from a belief that "if they really loved me and our family, they would quit," as well as from a feeling of martyrdom in thinking "after all that I've done for them, now I'm expected to do more work and participate in treatment." The anger is absolutely about the unfelt and oftentimes unknown hurt, betrayal, and grief towards addiction. Being on the receiving end of anger, a clinician might feel intimidated and thus take a hands-off approach to give space to disgruntled family members who feel victimized. This is especially true when the family members are footing the bill and are sometimes seen as the customer looking only for updates and guidance on how to navigate coping with their addicted loved one. Rolling with the

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To take family members further in understanding that they have their own healing separate from that of the person with substance use disorder can invite resistance and denial.

resistance of anger, and validating the confusion and betrayal of the consequences of addiction is an important beginning. While problem identification is necessary for healing, skilled clinicians are able to strategically track and help attune the family member to their unfelt emotions. True healing is in helping families to emotionally understand the hurt, confusion, trauma, loss, and insecurity that come from being impacted by addiction. Diana Fosha's work in developing Accelerated Experiential Dynamic Psychotherapy (AEDP) offers a powerful template for clinical interventions with the family system in addiction.

An Enabling Family is Avoiding Pain

Clients with substance use disorder can early on admit that they are avoiders of pain and want a quick fix to avoid discomfort. Family members impacted by addiction are slow to admit that they too go through this same avoidance process. Family members will tell themselves and others that they are helping in order to provide comfort for their addicted love one, but as it turns out the permissiveness and enabling are really about the family member avoiding their own pain. Entering into recovery is what family members might state that they want, but they can be truly terrified of the overwhelming felt sense of emotions that this brings. There can be grief of dashed dreams, lost years, lost sense of self, and fear of the unknown. Family members come to our offices with generations of unconscious adaptations and beliefs regarding emotions, e.g., "too busy to feel", "there is no point to feeling if you can't do anything to change the situation," "feelings equal weakness," etc. More recently with the outpouring of self-help books, clients will quip about "being positive" or "looking at the glass half-full," and all the while neatly avoiding the pain that a personal creed, book, or quote cannot heal. Families understanding the impact of their beliefs, getting psycho-education on feelings, and receiving experiential assignments and writing exercises can have a good beginning in thawing the frozen feelings of pain. The efficacy and genuineness of the therapist, and ability to engage families in group process (Al-Anon and family program), is key in providing a safe space for the family members to uncover and discover their feelings.

Protecting the Secret of Addiction is a Conscious Choice

While many of the thoughts and feelings of family members remain unconscious in the maladjustment to addiction, the protection of family secrets is a relatively conscious decision. Ask a family member, "How many people close to you know that your loved one is in treatment or struggling with addiction?" Often the answer we get from unrecovered family members is "It is not my business to share that," or "When they feel comfortable to share, then they can talk about it." The reality is that this is not just the story or business of the person with substance use disorder. This is the story of everyone who is involved. Educating on the difference between gossip versus the healthy undoing of isolation in protection of secrets is the primary task of the clinician with the family. Supporting families as they come to understand that they can have more than one feeling at a time towards a situation or person is incredibly impactful, e.g., "I can love my dad unconditionally, but I hate his behaviors and his drinking." The adage that "our secrets keep us sick" is revealing itself as evidence-based truth. Dr. Fosha in *The Transforming*

Power of Affect reveals that trauma is the end result of bearing unbearable feeling in isolation or in the absence of sufficient emotional support (Fosha, 2000). In other words, that the protection of secrets in the family is a form of trauma in its inherent isolationism.

The metaphorical picture of a family in a wrecked automobile provides a clear picture of what needs to happen to the entire family involved in addiction. In this real life scenario, everyone in the car recognizes that not just one of them needs to get out of the car to safety. It is obvious to everyone in the car that they must all find a way to get out, get to safety, and get help for their injuries. However, with addiction, family members fall into the trap of believing that if only one person gets out of the wrecked car (gets "fixed" by going to treatment and getting sober), then the rest of the family will be healed. There is a tremendous difference between the relief we feel that one person has healed versus the recovery and healing that takes place when everyone in the family has sought a way out of the wreckage and damage of addiction. Educating family members that their dependence on the addicted family member to get recovery in order for them to feel relief places an unhealthy burden on their loved one. Furthermore, the disparity of one person getting well mentally, emotionally, and spiritually, while the other family members do not seek help, fosters strained relationships and difficulty with healthy closeness. Stephanie Brown elucidates this in evidencing that family members are invited to enter into the change of culture and facilitation of closer relationships by entering into their own recovery program such as Al-Anon and their own counseling (Brown & Lewis, 1999).

Working with resistance and denial in the family system is not easy work for therapists as it can challenge the denial and resistance in us. Doing our own personal recovery work as clinicians, having a solid understanding of the facts of addiction and the family illness of addiction while staying connected with other family addiction/recovery practitioners in the evolution of our field, is the surest way that we will continue to do powerful and effective work.

Alana Smith is a licensed clinical social worker and a licensed chemical dependency counselor. She has worked in inpatient, outpatient and private practice settings since 2003 and has developed chemical dependency treatment programming, family treatment programs, and provides education and staff development on addiction treatment and family recovery. She received her bachelor's degree in psychology and her master's degree in social work in 2004 from the University of Houston under the professorship and tenure of Dr. Brené Brown. Alana has a passion for educating families and empowering them to heal from the illness of addiction. She is the clinical director at Vista Taos Renewal Center in Taos, NM. Vista Taos is a Twelve Step, abstinence-based treatment center. Alana is also the vice chair of the International Association of Family Addiction Professionals (IAFAP) that seeks to unite family addiction recovery professionals in sharing best practices in family recovery. Alana may be reached at (800) 245-8267 or at Asmith@vistataos.com.

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Kissing & Driving



By Alan Cohen, MA

I saw a romantic greeting card which showed a couple kissing in the front seat of a car. The message said, “If you can kiss while driving safely, you are not giving the kiss the attention it deserves.”

Anything that is worth doing is worth doing with a whole heart. And mind. And body.

We get into trouble not because we do things that are wrong, but because we approach our activities with divided intentions. Our body is doing one thing while our heart is elsewhere. We go to jobs we’d rather not be at, we sleep with people we don’t love, we go to parties we secretly find boring or repulsive. At the same time we love people we don’t express our love for, we deny ourselves food we would really enjoy, we have creative impulses we do not follow, and we know truths we do not act on.

I have a very simple definition of integrity: You are in integrity when what you are doing on the outside matches who you are on the inside. I respect people who live unapologetically. I know people who do things I don’t agree with, or wouldn’t do myself, but I respect them for being 100% who they are. They are in integrity.

In *Emmanuel’s Book II: The Choice for Love*, Emmanuel suggests, “When you move into your physical loving, as you remove your clothing, take off your mind as well. It simply is not equipped to hear the music.”

In the movie *City Slickers*, a veteran cowboy named Curly teaches some angst-ridden dudes some country wisdom. When things get tough, Curly raises his index finger and nods. Eventually the city slickers figure out what he meant: “Do one thing at a time. If you can really focus on what is right before you, everything falls into place.”

I read a fascinating article in *USA Today* about multi-tasking, the process of doing several things at once. Years ago this was called “spinning plates.” Now it’s multi-tasking. Whatever. The writer stated that we invented time—and labor-saving devices to give us more time to enjoy life. But instead of enjoying life with our extra time, we find more things to do. Ultimately our life is not richer because of our voicemails, emails, cell phones, faxes, pagers, and microwaves; it is just busier. If we did more of the things we really want to do with our free time, these inventions would be worthwhile. Instead, we find more things we have to do.

In the late 1950’s a survey asked a large group of people if they considered themselves happy. Nearly 60% of the group answered yes. A few years ago a similar study was conducted, and 57% of

the group answered yes. So all of our slick technology has not improved the quality of our life. Quantity of activities, for sure; quality, no.

What is it, then, that makes our lives qualitatively better? Presence. Being 100% with what you are doing. Approaching work, relationships, *everything* with a whole heart.

I would like to tell you about the most prosperous man I know. Iani sits on a local beach and sings love songs. He strums handsome exotic Indian instruments which he meticulously crafts at home, then comes to the beach around sunset, and chants. He sings love songs to God, to the sea, to the sky, to the sand, to the wind, and, if you pass by, Iani will sing a love song to you. During many memorable sunsets I have sat with Iani and sung with him. I take an empty plastic water bottle and do percussion. Iani lives very modestly and has few possessions. He is the most prosperous man I know because his heart is full of love and he is fully present. When I am singing with Iani I don’t miss my cell phone. Email is non-existent. Money has no value. I am content.

“But Alan,” you say, “Not all of us have the luxury of sitting and chanting on a Maui beach. Some of us have jobs and families to support, and responsibilities.”

Fine. It doesn’t matter. Just be fully present with whatever you are doing. When you are at work, that’s all that exists. When you are making love, make total love. When you are with your kids, really be with your kids. One.

I noticed that when I did book signings, I felt rushed so I could accommodate everyone in line. I was not fully present with some people because I was aware of the people behind them in line. Then I realized that I was cheating them and myself. So I decided to be fully present with each person, and stay with them until I really connected with them. Suddenly book signings became a delight. Now I love talking to people, touching them, looking into their eyes. I learned that it does not take a lot of time to make contact; just a few moments of full presence can be completely fulfilling.

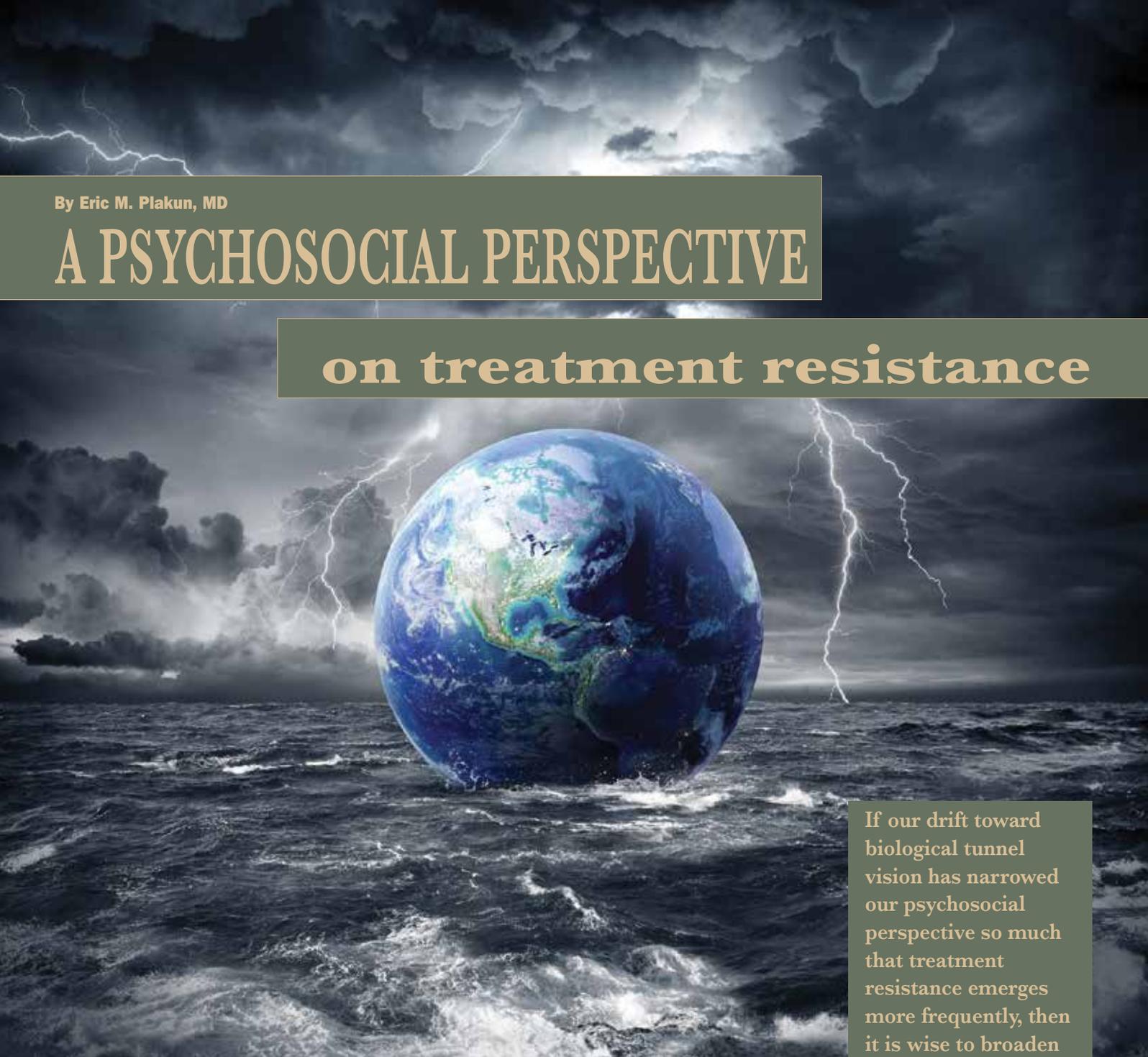
Everything is like kissing and driving. If you’re driving, really drive. If you’re kissing, really kiss.

Alan Cohen is the author of the new bestseller *A Course in Miracles Made Easy: Mastering the Journey from Fear to Love. Become a certified professional life coach through Alan’s transformational Life Coach Training beginning September 1. For more information about this program, his free daily inspirational quotes, online courses, and weekly radio show, visit www.alancohen.com.*

By Eric M. Plakun, MD

A PSYCHOSOCIAL PERSPECTIVE

on treatment resistance



If our drift toward biological tunnel vision has narrowed our psychosocial perspective so much that treatment resistance emerges more frequently, then it is wise to broaden our psychosocial approach to patients.

Despite advances in research methodology and efforts in the mental health and addictions fields to move toward evidence based treatment, large numbers of patients fail to respond to our best evidence based treatments. This has led to growing recognition of the phenomenon of treatment resistance. For example, during recent 20-year period overall Medline citations in psychiatry increased 25%, while citations on treatment resistance increased 800% (Mintz & Belnap, 2011).

Although there is no universal definition of treatment resistance, as used here and in much of the field it refers to failure to respond adequately to at least two evidence based treatments to which a

patient has adhered. The problem of treatment resistance is related to the complexity of mental health and substance use disorders, but also to the drift toward a biologically reductionistic stance that takes a narrow, unimodal view of mental disorders. For example, most algorithms for treatment of depression offer a rational sequence of steps for choosing medications, with little or no attention to psychosocial factors and how they may be part of the causation and treatment of this mood disorder. It is my contention that the drift toward biological tunnel vision is based in large part on widespread and sometimes unwitting belief in three false assumptions about mental disorders that emerging science suggests are untrue (Plakun, 2015).

Three False Assumptions

These include that (a) genes = disease; (b) patients present with single disorders that respond to evidence based treatments; and (c) the best treatments are pills. Let's look at these one at a time.

Genes = Disease: With the decoding of the human genome in 2003, there was hope that the genetic underpinnings of mental disorders would be unearthed. However, genetic research has not identified genes underlying mental disorders like schizophrenia, depression, or bipolar, anxiety or substance use disorders. Using sample sizes large enough to find relevant single nucleotide polymorphisms (SNPs) for diabetes, inflammatory bowel disease and some cancers, searches for SNPs associated with mental disorders have led either to no clear genetic loci, as in depression, or to so many candidate SNPs, as in schizophrenia, that it is clear inheritance is not a matter of straightforward Mendelian genetics. Although it is clear mental disorders are heritable, the mechanism of inheritance is much more complex than suspected.

Caspi and colleagues' seminal study (2003) of short and long alleles of the serotonin transporter promoter gene, the most cited paper of the first decade of this century, opened the eyes of mental health clinicians to gene-by-environment interactions, or epigenetics. In Caspi's now replicated study homozygous short alleles of this gene were associated with greater risk of adolescent or adult depression in those children who were exposed to early adverse experiences like abuse than those with homozygous long alleles. This finding helped shift thinking toward a notion of genes conferring vulnerability to environmental factors, like early adversity. Of note, though, this "genes = vulnerability" model also falls short of fitting the data.

As it turns out, those with homozygous short alleles also have the least likelihood of depression in the absence of early adversity—a lower risk than those with homozygous long alleles. This important finding is often overlooked in ways that reflect our bias toward a stress-diathesis "vulnerability" model of disease (Plakun, 2016). The actual data are less consistent with a model of epigenetic vulnerability and more consistent with a model of epigenetic "plasticity," where genes respond to beneficial and adverse environments with differential susceptibility (Belsky, 2009). If we can open our minds to follow the data and think this way, we may learn much about what leads to disease and to resilience.

The shift from a genes = disease model to a gene-by-environment or epigenetic model follows recognition that environmental factors are far more important in how genes work than we suspected.

Concurrently, the so far unsuccessful search for biomarkers of mental disorders has been likened to a quest for the Holy Grail, while early adverse experiences have emerged as powerful predictors of later psychiatric, substance use and medical disorders. In the absence of biomarkers, early adversity appears to be an "enviro-marker" (Molnar, Buka, & Kessler, 2001).

Further demonstrating the power of environmental versus genetic factors in mental disorders, depressed mothers tend to have adolescent children with depression whether the children are biologically related or adopted (Tully et al., 2008), while a study of mothers who were twins suggests that anxious mothers transmit anxiety to their children principally in non-genetic ways (Eley et al., 2015).

Patients present with single disorders that respond to evidence based treatments: Studies of major depression show that 15 to 50% of patients fail treatment (Thase et al., 2007), with comparably high failure rates for other disorders. The large, multi-site STAR*D study of depression teaches us not only about the frequency of treatment failure in depression, but also about what kind of depressed patients present for treatment. Surveying the STAR*D sample, Wisniewski et al. (2009) report that fully 78% of the sample presented with the kind of comorbidity or suicidal ideation that would exclude them from most randomized controlled trials of medications or other treatments. This comorbid majority had lower response and remission rates to medications. This validates the experience of many clinicians that their depressed patients seem sicker than those who respond to drugs developed and tested in carefully screened non-comorbid samples.

Hence, comorbidity, along with early adversity, emerges as a significant contributor to treatment resistance. More specifically, the Collaborative Longitudinal Personality Disorder or CLPS study demonstrates that comorbid personality disorders, especially comorbid borderline personality disorder (BPD), "robustly predicts the persistence of major depression" (Skodol, 2011). Skodol and colleagues propose that diagnosis and treatment of personality disorders is essential in treating major depression. According to the practice guideline for treatment of personality disorders, psychotherapy, not medication, is the mainstay of treatment. However, using DSM-IV, the mostly frequently diagnosed Axis II disorder was "Deferred," suggesting that clinicians often fail to attend to personality disorders and to their robust contribution to treatment resistance.

Our learning from depression teaches us that most depressed patients present with comorbid disorders—including undiagnosed personality disorders—and that these comorbid patients are harder to treat, while we often fail to diagnose and treat personality disorders as part of the treatment of depression.

The best treatments are pills: We are learning that we have overestimated the efficacy of medications by as much as a third when unpublished studies that did not show advantage to an antidepressant drug over placebo are included in data analyses (Turner et al., 2008), and that as much as 75% of antidepressant efficacy is due to the placebo effect (Kirsch et al., 2008). This high placebo response rate likely relates to the concerned and caring relationships that are part of the placebo arm of a randomized trial. Meanwhile, thousands of studies have demonstrated the efficacy of cognitive behavioral therapy (CBT) and hundreds have demonstrated

the efficacy of psychodynamic therapy. We tend to be blind to the power of psychosocial factors in treatment, but the data should open our eyes.

What Works With These Patients?

Nemeroff and colleagues (2003) compared nefazodone and a form of CBT called Cognitive Behavioral Analysis System of Psychotherapy (CBASP) in treatment of 681 patients with chronic major depression, many of whom had early abuse histories. They report that in patients with abuse histories, chronic depression responded better to psychotherapy alone than to medication alone, while the combination was only slightly better than psychotherapy alone. They conclude that, in patients with depression and histories of abuse, psychotherapy may be an essential component of treatment.

Recent studies report the efficacy of CBT (Wiles et al., 2016) and long-term psychodynamic therapy (Fonagy, 2015) in patients with previously treatment resistant depression. The response of treatment resistant disorders to psychotherapy is not surprising since early adversity and comorbidity, especially personality disorder comorbidity, make substantial contributions to treatment resistance. Given the evidence, we are wise to look beyond biology in treating patients with treatment resistant depression and other comorbid disorders.

Where is the “Resistance” in Treatment Resistance?

Given the complexity of what it means to be human, there has been resistance to treatment as long as there has been treatment. Some patients resist treatment because they don't want it for reasons of their own, rational or otherwise. They don't see it as offering something they need or want. Other patients seem caught in the ambivalence that is part of being human and are resistant because they fail to adhere to medication or therapy regimens even when they have sought them. In these instances the resistance may be located in the patient. However, for patients who have lived lives of profound early adversity, in which they have experienced abuse, neglect, abandonment, deprivation or the like in early relationships with authorities like parents or others, failing in treatment may represent a less than trusting response to authority figures like doctors.

Further, in a treatment system that often leaves such people powerless and passive recipients of treatment doled out by authorities, failing treatment may be the best way for them to find their voice, empowerment and agency in a life of being controlled, defeated and rendered passive. In these instances, again, treatment resistance may be located in the patient. However, I would propose that much of the resistance in treatment resistance is located in our unimodal, biologically reductionistic treatment models and in our prejudices about treatment, and thus in ourselves and in our treatments, and not in our patients (Plakun, 2011).

Toward a Psychosocially Informed View of Treatment Resistance

If our drift toward biological tunnel vision has narrowed our psychosocial perspective so much that treatment resistance emerges more frequently, then it is wise to broaden our psychosocial approach to patients. In my experience, it is a psychodynamic perspective that allows the most useful integration of psychosocial approaches into our treatments.

One example of such an integration is “psychodynamic psychopharmacology” (Mintz & Belnap, 2011), which is an approach to prescribing that attends to the meaning effects of medications, not just to their biochemical effects, and to “how” to prescribe in addition to “what” to prescribe. Mintz and Belnap (2011) speak about treatment resistance “to” medications, “from” medications and about the “nocebo” effect.

The nocebo effect is a negative placebo effect in which, instead of an expectation of benefit from treatment, patients with histories of early adversity have an expectation of harm that detracts from the effectiveness of medications. Patients who are nocebo responders often report intolerable side effects even to miniscule doses of drugs.

Treatment resistance from medications may take the form of overprescribing when the psychiatrist's zealous wish to be helpful leads to over sedation. A good example of treatment resistance to medications that is based on meaning is a patient I recall. She was a psychotically depressed mother whose child had died, for whom neuroleptics and antidepressants did not reduce auditory hallucinations—until it was recognized that the hallucinated voice was that of her dead child. To respond to the medications would mean she had lost her daughter forever. This mother could respond to medications only after this was grasped and the work of grieving was undertaken in her psychotherapy.

There are other things we can do to be more responsive to the psychosocial needs of our patients. A psychodynamic focus that offers a nuanced, complex, but integrated systems perspective on work with treatment resistant patients offers much promise. Here are a few recommendations for improving our psychosocial focus, many of which are fundamentals of a psychodynamic approach:

- Consider personality disorder diagnosis in every patient.
- Get the patient's developmental and narrative history, looking for therapeutic stories about early adversity that are being repeated in the present that may help explain what underlies treatment resistance and how it may even make sense in a life of abuse, neglect and deprivation.
- Negotiate a therapeutic alliance that respects both the freedom and the responsibility of patients as active agents in their treatment. After all, we have learned that nothing has a more powerful treatment effect than a strong therapeutic alliance, and it cannot be strong or even an alliance unless a patient's freedom and responsibility are part of it.
- Focus less on symptom suppression than on helping people take charge of their lives. What would make their life more livable? What are their goals? What is in the way of achieving them?
- Use treatment relationships that continue over time, that attend to the meaning of symptoms and to the meaning of treatment resistance itself, and that respect the voice of the patient.



The problem of treatment resistance is related to the complexity of mental health and substance use disorders, but also to the drift toward a biologically reductionistic stance that takes a narrow, unimodal view of mental disorders.

- Learn to tolerate the despair and hatred that are often part of the experience of patients who have experienced early adversity. They have learned early that life is not fair, that those they depend on may fail, injure or abandon them. These experiences will tend to repeat in the course of treatment as we, as imperfect humans, fail them in ways large or small. In psychoanalysis this stance is known as being able to tolerate the negative transference, i.e., tolerating being hated or experienced as a corrupt authority at times as therapy goes through cycles of rupture and repair over time. We are wise to avoid “refusing” these transferences. Therapists are ultimately imperfect humans who are capable of unwittingly injuring patients. We must avoid retaliating for anger by counterattacking or by ending the work. Learning to negotiate a viable relationship that can weather storms of hate and anger may well be of use to patients—as they have come by their anger and sense of disappointment quite honestly.
- We are wise to understand that enactments are part of work with such patients (Kayatekin & Plakun, 2011). Enactments are enmeshed tangles we may get into with patients in which we and they get caught in mutual and complementary projective identification involving issues from the lives of both participants. If we can detect, then analyze and then utilize what we have learned in these enactments, we can deepen the work. However, doing this often requires an outside perspective, a “third” who can consult to us about what we have gotten caught in. Enactments are a slippery slope. However, as in skiing, the practice is meant to take place on a slippery slope. In skiing as in therapy, the trick is to find one’s edges while sliding down the slippery slope, staying in control and understanding the dynamics of the slide.
- Develop and use treatment teams that (a) integrate treatment by all providers; (b) include treatment for comorbid disorders; (c) use a psychodynamic formulation to guide the work; (d) detect, analyze and utilize learning from enactments; and (e) that view splits and disagreements on the team as opportunities to understand the splits and struggles of the patient’s inner world and perceived family experience.

With inclusion of psychosocial approaches like these we can better attend to aspects of patients’ life contexts that are relevant to helping them emerge from suffering and from treatment resistance.

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