Illinois Institute for Addiction Recovery
at Proctor Hospital

Illinois Institute for Addiction Recovery

IIAR Opens Facility
In Springfield Illinois

PLUS:
Obsessed with Lolita
Too Much Empathy
Should I Write a Prescription?
The Illinois Institute for Addiction Recovery announces the opening of their newest facility located in Springfield, Illinois.

Proctor Hospital opened a new addiction treatment facility in Springfield, Illinois. The new facility provides several levels of care including: partial hospitalization, intensive outpatient, aftercare, family and individual therapy.

The Illinois Institute for Addiction Recovery at Springfield treats the following addictions:
- Chemical
- Gambling
- Spending
- Food
- Sex
- Internet
- Chronic Pain with Addiction

For additional information on the Illinois Institute for Addiction Recovery at Springfield and its treatment programs, call 1 (800) 522-3784 or visit the Web site www.addictionreco.org.

IIAR Wins Prestigious West Award

The Illinois Institute for Addiction Recovery at Proctor Hospital received the 2003 James W. West, M.D., Quality Improvement Award presented by the National Association of Addiction Treatment Providers at the 2003 annual conference in Indian Wells, California. Among the many distinguished guests were former President Gerald R. Ford and Mrs. Betty Ford who together received the 2003 Nelson J. Bradley Life Time Achievement Award. In addition, the IIAR was featured in the April 2003 Healthcare Tomorrow magazine for its award-winning quality improvement efforts.

SpotLight

New Facility Opens in Springfield, Illinois

Profile

The Children’s Art Project at The University of Texas M.D. Anderson Cancer Center began with one volunteer’s creative idea 30 years ago. Since then, thanks to the dedication of thousands of inspired volunteers, customers and community and corporate supporters, the Project has supported more than $17 million in patient-focused programs at M. D. Anderson. Today, the Project is one of the country’s largest and most well-known charitable card projects.

For a free catalogue of the Children’s Art Project holiday cards and gift items, featuring young cancer patients’ art, or to volunteer, call 1-800-231-1580 or visit the Web site www.childrensart.org.

Art Courtesy of NARSAD

Cover Titled “Thanksgiving Harvest” by Ashlie Moore, M.S., C.A.D.C., MISA II

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Art courtesy of NARSAD

Page 10 Titled “Little Mommy” by Larry Walker

NARSAD Award products showcase the art of talented artists who happen to suffer from brain disorders called mental illnesses. All sale proceeds go up to fund mental illness research. For information or a free color brochure call 1-800-607-2399. You may also visit the Web site www.narsadawards.org.

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The Christopher D. Smithers Foundation, Inc.

Shortly after his father’s passing, Brink himself marked an important date—his sobriety. It was almost fifty years ago that Yvelin Gardner, Deputy Director of the National Council on Alcoholism, met with Brink and told him, “Brink, you have a disease and there is treatment for it.” These words changed the direction of Brink’s life and the shape of the mission of the Foundation. It signaled Brink’s recovery from alcoholism, his life’s dedication to the establishment of a major hospital, providing detoxification, rehabilitation and professional training. This was the largest grant ever made by any individual or organization (including the federal government) to the fight against alcoholism. He wanted the rehabilitation program run in a separate facility and personally selected a grand $1 million mansion to house it.

In 1994 Brink passed away. Only a year after his death, St. Luke’s Roosevelt Hospital Center decided to sell off the mansion and move the center to a hospital ward. Brink’s widow, Adele Smithers-Fornaci, is suing St. Luke’s for the sale and for its administration of a $10 million endowment left by Brink. She had discovered that the hospital had used some of the endowment, which was restricted to financing alcoholism treatment, for other expenses. “If money is given for a certain cause or to be spent in a certain way, then I think it should be used for that cause or spent in that way,” she said.

Currently, the case is pending in the New York State Supreme Court. A trial date has not been scheduled.

Adele C. Smithers-Fornaci continues the mission of the Foundation on October 21, 1952 in memory of his late father. The Smithers Foundation is neither “wet” nor “dry” and solely concerned with alcoholism and drug dependence. The Smithers Foundation, under the leadership of the late R. Brinkley Smithers and Adele Smithers-Fornaci, worked tirelessly to remove the stigma attached to alcoholism, to encourage others to join in the fight against it, and were instrumental in helping in every area of this monumental task.

For example, in 1952:

- There were practically no treatment facilities for alcoholics. Today, alcoholics and their families may receive help and referral in just about every community in the country. Brink’s $10 million gift to the Roosevelt Hospital in New York City in 1951 established the Smithers Alcoholism Treatment and Training Center. This was the first facility for alcoholism to be included as an integral part of a leading hospital’s program and became the model for similar units throughout the country and the world.
- The federal government had little concern with the disease of alcoholism. In 1970 Congress passed legislation recognizing alcohol abuse and alcoholism as major public health problems, and created the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Today NIAAA has excellent programs, mostly in research.
- Companies and unions regarded alcoholics as “drunks” and fired them. Today, most large corporations have Employee Assistance Programs where such employees are referred to treatment and restored to productive lives.
- Few physicians would treat alcoholism. Today, the American Society of Addiction Medicine boasts thousands of members—all involved in treating alcoholics.
- Colleges and universities ignored alcoholism. Today, few campuses are without a program to conduct alcoholism research and educate students to facts that they can have fun in an alcohol-free environment.
- The stigma attached to alcoholism was so strong that public figures with alcoholism had never identified themselves. Today, celebrities speak about their alcoholism recoveries openly and thus encourage active alcoholics to seek help.
- Extensive coverage of alcoholism was scarce or “sensational” in nature. Today, all forms of the mass media give thoughtful coverage to the subject. Medical journals carry technical articles about it to keep professionals abreast of developments in the field.


Introduction

The clinician should know that chronic pain is a pathologic condition that has its own characteristics. Acute pain is an adaptive beneficial response necessary for the preservation of tissue integrity. There is no positive physiological reason for the existence of chronic pain, and therefore it should be treated appropriately with medicine approved by the Food and Drug Administration consistent with state and federal regulations for prescribing a scheduled controlled substance. When a clinician is evaluating a patient for treatment of moderate to severe pain with opioids, it is very important to be able to differentiate between a patient who is seeking pain relief and a patient who is drug seeking. If a patient is drug seeking, the patient will declare him or herself by not following the agreed-upon medical regimen.

This article will discuss what a clinician should consider when deciding whether to prescribe opioids to a pain patient with a history of addiction.

The prevalence of addiction in the general population is approximately 10 percent. At the present time, there are no good prospective studies determining what the relapse rate is in this patient population treated with opioids. Therefore, patients in recovery are often discriminated against in regard to the treatment of their pain. It just makes sense that, if someone with moderate to severe pain who is in recovery is not treated with appropriate medications, his or her chance of relapse will increase, and the patient should do before the first prescription is written:

1. Agree to start or continue recovery programs such as AA, NA, and NA are compatible with the treatment of all medical and mental disorders. (American Society of Addiction Medicine review courses)

It is imperative that clinicians understand the difference between addiction, physical dependence, and tolerance when considering opioid analgesics for patients with a history of substance abuse (Table 1). A recovering alcoholic or drug addict may become physically dependent during a therapeutic trial of opioids, but this normal physiological response to the drug must not be confused with addiction, in which patients seek substances despite deleterious effects on quality of life. For example, a patient who becomes physically dependent on corticosteroids to treat asthma or physically dependent on insulin to treat diabetes, but certainly in the latter instance, we do not call it insulin-addictive diabetes.

Assessment

Proper pain assessment and comfort of the clinician treating the patient remains the cornerstone of pain management regardless of substance-abuse history. It must be emphasized that there is no legal or regulatory obligation to prescribe opioids on demand or at the first visit. The treatment plan is discussed and agreed upon based on mutual trust and honesty. Consent to random urine drug tests, which should be part of the treatment plan, will be obtained by the clinician. Agreement to do before the first prescription is written:

1. Agree to start or continue recovery programs such as AA, NA, and NA are compatible with the treatment of all medical and mental disorders. (American Society of Addiction Medicine review courses)

The clinician should:

• Take a complete history and physical examination, including review of pertinent past medical records and treatment, successes, and failures, including patient disclosure of substance abuse history and medications currently prescribed
• Perform an assessment to determine any underlying psychiatric diagnoses such as anxiety, depression, bipolar disorder, or eating disorders. N- and antidepressant, sex and sexual, social, economic, or environmental factors that affect the patient’s holistic well being must be also part of the evaluation
• Provide informed consent on all opioid risk including a statement that risk of relapse may be greater in patients with a history of substance abuse
• Know the pharmacology of the drugs used
• Know how to taper the patient off any prescribed medications
• Plan to document all of his or her thoughts in the chart
• Explain that he or she will work with the patient’s significant others

The patient should:

• Sign a waiver of privacy so that the clinician can contact appropriate sources to obtain or provide information about the patient’s care or actions or obtain additional consultations deemed necessary
• Agree in writing upon a treatment plan based on mutual trust and honesty. Consent to random urine drug tests or pill counts at the clinician’s request
• Agree to stop or discontinue recovery programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) if there is a history of substance abuse
• Agree to the need for complete, honest self-report of pain relief, side effects and function at each medical visit

The clinician and patient should:

• Agree that the prescribing of opioids is a therapeutic trial to decrease pain and increase function with continuation of opioids based on a positive clinical response
• Agree on regular medical visits for evaluation of the agreed-upon treatment plan and medication refill; the patient should bring the original bottles of prescribed medication to each visit
• Agree on prescription renewal only during regular office hours
• Agree that one physician and one pharmacy will be responsible for opioid prescribing/dispensing
• Agree that any evidence of drug hoarding and/or use of any illegal drug may cause termination of the physician-patient relationship. Use the word “may” instead of “will” in the agreement so clinical judgment can be used in each situation
• Agree that if the patient violates the agreement, patient and physician should talk and decide if opioids are still appropriate, adjusting the boundaries of the treatment plan accordingly

Treatment

Certainly not all patients with chronic or acute pain should be treated with opioids. However, if it is determined that opioids are needed, it is very important to choose the correct agent to treat pain in a patient with the disease of addiction. The clinician should choose a controlled-release (IR) opioid, such as oxycodone and oxycodone or fentanyl, is delivered via a controlled-release delivery system. While all opioids may cause physical dependence and tolerance, evidence suggests that long-acting or CR opioids are less likely to induce tolerance and abuse than IR opioids. This clearly would favor use of IR formulations for moderate to severe pain in patients with an addiction history.

Morphine should not be the opioid of choice for patients with a history of heroin addiction, since heroin is metabolized to morphine. Results of random urine drug tests, which should be part of the treatment plan, may be positive for morphine. The clinician will not know if the positive result was because of the prescribed morphine or a relapse with the use of heroin. Therefore, in this particular clinical situation, one should choose an opioid such as methadone, which has also shown to have a lower abuse potential than morphine.

Conclusion

Moderate to severe pain is undertreated across the world, especially in the population of patients with the disease of addiction. For this reason, we have moderate to severe pain and the treatment regimen can include opioids. When deciding whether to prescribe opioids to this population, the clinician should BET on his or her patient; i.e., believe, evaluate, and treat as indicated with a mutually agreed upon treatment plan, keeping in mind that

The boundary setting must be part of any opioid treatment plan with all patients, with or without an addictive disorder. Through education of clinicians and patient and honest and open communication, pain management in patients with or without addiction being present can improve. This is consistent with the ethic of care: “I will prescribe a regimen for the good of my patient according to my ability and my judgment and never do harm to anyone.”

Table 1

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<tr>
<td><strong>Addiction</strong></td>
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<td><strong>Physical Dependence:</strong> A state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt discontinuation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.</td>
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<tr>
<td><strong>Tolerance:</strong> A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug’s effects over time.</td>
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Dr. Howard A. Heit, is best certified in internal medicine and gastroenterology. He is also certified in addiction medicine by the American Society of Addiction Medicine (ASAM). Dr. Heit was an author, section coordinator and an editor on the section “Pain Management and Addiction Medicine” for ASAM’s textbook Principles of Addiction Medicine. Dr. Heit is an assistant professor of medicine at George Mason University School of Medicine in Fairfax, Virginia.

References

Why Use Intervention?

It was once believed that an individual struggling with addiction or resisting to change unhealthy behaviors had to sincerely want help in order to get help. The individual had to “hit bottom” before being motivated to change. This, of course, is not always true.

No person can easily survive without support from someone close to him/her. Interventions are based on this fact. A person will continue to live his/her life of active addiction or unhealthy behavior when friends and family offer inappropriate support. This type of support typically allows the addiction or behavior to continue. In most cases, family and friends feel they are protecting the individual, but in fact, are creating an unhealthy support system for the person.

The intervention process addresses the unhealthy support system that allows the addiction to progress. Addiction breeds secrecy and isolation for both the individual and those who care about him/her. The intervention process brings together family, friends, and other concerned persons and creates a support network for each member. The support network in turn engages and empowers the individual to grow and change in a positive way.

How do you Conduct an Intervention?

In the ARISE method (A Relational Intervention Sequence for Engagement), a three stage approach is utilized to match the level of effort used by the intervention network to the resistance of the individual in order to motivate a start in treatment. A network of support is formed which will be used to advocate for the person to change his/her behavior. A trained professional works closely with members of the network and facilitates each stage of the intervention.

What Occurs in an Intervention?

Each stage of the intervention has its own goals.

Stage I uses motivational techniques designed specifically for telephone coaching. Professionals help you establish a basis of hope, identify whom to invite to the intervention meeting, design a strategy to mobilize the group and teach techniques to successfully invite the individual to the first meeting.

Stage II follows if starting treatment does not occur from the initial efforts. Typically, between two to five face-to-face sessions are held, with or without the individual present, to mobilize the intervention network in developing motivational strategies to reach the individual with the goal of treatment engagement.

In Stage III, family and friends set limits and consequences for the individual in a loving and supportive way. By the time the intervention network gets to this point, the individual has been given and has refused many opportunities to enter treatment. Because the individual has been invited to each of these meetings, this final limit setting approach is a natural consequence and does not come as a surprise.

The ARISE process is designed to protect and enhance the long-term nature of the family relationships, while at the same time removing the addiction or behavior from controlling the family.

When Can an Intervention Occur?

A call placed to the Illinois Institute for Addiction Recovery by a concerned person starts the intervention process. A professional and the concerned person will plan the date and time of the first meeting.

Who Can Be Involved in an Intervention?

The support network for an intervention is comprised of family, friends and others with a caring, significant relationship to the individual. All members of the support network must agree to empower the individual to make change, not shame or humiliate him/her because of past behavior.

For more information about Intervention or other services offered through the Illinois Institute for Addiction Recovery or to speak with the Business Manager about program cost, please call 1 (800) 522-DRUG (3784) or visit the Web site www.addictionrecov.org.

The Illinois Institute for Addiction Recovery has centers at the following three locations:

Proctor Hospital
5409 N. Knoxville Avenue
Peoria, IL 61614

BroMenn Regional Medical Center
Virginia at Franklin
Normal, IL 61761

Illinois Institute for Addiction Recovery
3050 Montvale Drive
Springfield, IL 62704

All members of the support network must agree to empower the individual to make change, not shame or humiliate him/her because of past behavior.
A little boy quietly came to answer the door.

Outside stood a salesman, “Is your mother here?”

“Yes,” whispered back the little boy.

“M ay I talk to her?” inquired the man.

Still in a whisper, the boy answered, “She’s busy.”

“How about your father, is he here?”

“Hey, he’s busy too.”

“Well, is there anyone else here?”

“Yes, a fireman and a policeman.”

Frustrated the salesman asked, “What are they all doing?”

Quietly the boy answered back, “They are all looking for me.”

How many times do we go looking for something we want — only to look in the wrong places — when all along it was right under our noses?

In 1979 as a young high school teacher, I had hopes of inspiring young people to look for success in their lives. I soon discovered many of our youth walking into the dead end trap of violence, drug and alcohol abuse — destroying their dreams. Reaching out to help them, I began wondering what factors would lead some people to use and abuse others not. Why were these young people searching for happiness in physical beauty, money, fame, power or drugs?

In America the number of books on happiness has quadrupled in recent years. The therapy industry has tripled, and anti-depressant prescriptions have increased five fold. Cosmetic surgeries are rocketing each year. Half of all Americans dream of becoming rich. Baby boomers (born between 1946-64) assume they should be happy and are four times more likely to say they are not satisfied with their lives than their parental generation. Incidence of psychological depression is ten times what it was pre World War II. Following in their parent’s footsteps, a recent survey in our community revealed that over 42 percent of our high school students felt sad or depressed most of the time.

Why is the were the wealthiest, healthiest, most educated generation in our nation’s history?

I am Here to Say That Happiness is Over Rated!

We have become a generation rearing another generation with expectations that were not even dreamed—let alone achievable—by our parents. Many people are waiting to “arrive at happiness” before they can enjoy life. The essence of happiness is pausing to savor the gift of the present moment. We find it not in the big things, but really in the small events along the way. For example, we can find happiness while at lunch with a close friend, reading a bedtime story with your child, on an evening walk with your spouse, or curling up by the fire with a good book. The old adage, “Take time to smell the roses” is still viable. President Abraham Lincoln stated, “People are about as happy as they make up their minds to be.”

The hunt for heroes has taken a similar voyage with the help of Hollywood. In John Wayne’s day one needed friends to help get the job done and be a hero. Then along came Rambo and the Terminator showing us that we only need ourselves, a dose of anger and revenge to be a hero. Action figures like the Power Rangers do not even have a mouth to speak with; yet they were heroes through acts of power. More recently many people looked to movies and rock stars as their heroes since they had the ultimate goals of fame, fortune, and power at their fingertips.

On September 11, 2001, our country had a paradigm shift in thinking regarding what a true hero was. For the first time in decades, people saw the common person — firemen, policemen and common citizens — doing their job well, putting others before themselves and showing the power the “will” has over their thoughts and emotions. These true heroes were serving and saving others. These people were elevated back to being the true heroes through their actions of being unselfish, caring, and giving. Even at all Halloween, many children were excited about fireman and policeman costumes.

We can look in our own lives for the everyday heroes who are caring, giving, unselfish and are serving as mentors to us. A mentor is like a hero — only better. You can do what you can do to admire a hero from a distance. On the other hand, a mentor is part of your life offering new ideas, changing the way we look at the world and ourselves, and helping us discover latent abilities and talents. Take time to thank the mentors in your life and strive to become a mentor yourself.

If we, in the helping profession, can use the national experience of 9/11 to help people understand the power of the mental shift in thinking that took place, we can help them to see the power the “will” has over our thoughts and emotions when stuck in a destructive thought process. The “will” can overcome with the power of our thoughts we have. A simple example of the “power of the will” is experienced each morning when the alarm goes off and we think we are still too tired and do not feel like getting up. Nevertheless, the will takes over and we get up! This same “power of the will” can be used in choosing to see our self and the world through positive glasses. The “will” can be used to change the mental talk in our brain, thereby changing the feelings. (Even though we did not feel like getting up, once the “will” changes and we get up, the feeling changes with the action.) Life is a series of problems that can be seen as obstacles or opportunities. We can use the glasses to see the world as it is or as it was.

H umans have three levels of being — physical, mental and spiritual. Americans have put too much emphasis on the development of the physical and mental over the years. Spirituality and good character have been sadly missed leaving a void in our lives. This void within has led many people to try filling it with drugs and alcohol in pursuit of happiness and happiness. The new 9/11 heroes have also brought back to mind the importance of good character and spirituality. When we take time to develop our relationship with God and value good character traits within ourselves and others, we see the world and our expectations in a totally new light that is not based on physical looks, money, fame and power. Our expectations of what we think we deserve become —what can we do to serve others? We become unselfish, caring and giving which are ingredients for becoming a mentor and a true hero. When all three levels of being (physical, mental and spiritual) are in balance, there can be peace, joy and happiness. Over 2000 years ago King Solomon said, “As a man thinketh so is he.” Proverbs 23:7.
Sara dreaded hearing the telephone ring in the morning, as it was most likely one of her family members wanting her to do something for them. No matter how hard she tried to ignore the ringing, she was unable to. Almost every time she answered the phone, it was an aunt, uncle, mother, grandmother, brother, or another family member asking her to do a favor for them. She never refused the request, even though she felt that they were taking advantage of her.

Jed wondered if his wife would be very upset if he stopped at Bill’s house on the way home as he had done for the past two weeks. Nancy, his wife, had begun to make comments about all the time he spent over there. Jed hoped that she would understand that his friend needed him as he was going through the breakup of his relationship, and Jed felt his pain and loneliness. He really felt that his friend needed him, but that Nancy did not appreciate his caring for his friend.

If asked why they were so responsive in spite of their feelings, or the inconvenience, Sara and Jed would likely reply that they had too much empathy. They felt strongly that others needed them, they could feel what others were feeling, and had to do something to make them feel better. You too may be like Sara and Jed and think that you have too much empathy, and find that you are overly responsive to others’ feelings and concerns. If you feel that you have too much empathy, think again. It is really a case of “catching other people’s feelings,” but it is not empathy. If you have ever felt paralyzed, overwhelmed, or caught up in other people’s feelings, and either felt like running away, or that you were expected to do something about their feelings, then you understand what it is like to “catch” other people’s feelings. You, and others, may think that you care too much for other people, and/or that you are too empathic, when actually you do not have sufficient boundary strength to prevent catching other’s emotions, nor are you able to keep from identifying with those emotions, and acting to reduce them. Typically the outcome is that you carry the emotions for the person, which allows that person to “feel better.” They did not resolve what produced the emotion; instead, they gave it away and you accepted it. This scenario is a major premise for: “Whose life is it anyway?” When you stop taking care of their feelings and start taking care of your own (Brown, 2002).

Family Enmeshment

Lack of sufficient boundary strength and susceptibility to “catching” other people’s feelings begin with family enmeshment. The family is where you learn to take care of other people’s feelings, and to give their feelings and needs priority over your feelings and needs. This is a trap that allows you to be manipulated or intimated to do things you do not want to do, and/or are not in your best interest just because you were conditioned to feel responsible for the psychological and emotional well-being of other people.

You may even have been a parentified child where you took care of a parent’s psychological and emotional needs instead of the parent taking care of yours. This experience caused your not being able to develop sufficient boundary strength to repel external and internal assaults on yourself, and you become overwhelmed. However, once empathy is defined, one can better understand why catching other people’s feelings are not empathy. True empathy occurs when you open yourself to experience what the other person is feeling without losing your sense of yourself as separate and distinct from that person. It is the last part that many people who catch emotions lack; they do not have the ability to stay connected to oneself, and to deeply know and understand that the other person is not an extension of oneself.

The concept, extensions of self, is abstract and complex and cannot be fully explained here. There is a broader discussion for this in Children of the self-absorbed (Brown, 2003), and in “The destructive narcissistic pattern” (Brown, 1998). This article offers you some idea of what is meant by that concept. Examples of an inability to see others as separate and distinct from your self include any of the following.

• Feeling closed in.
• Lack of power and control over your life.
• Few meaningful and satisfying relationships.
• Feel that your life lacks meaning and purpose.
• Chronic physical health problems such as hypertension.

You do not have too much empathy, what really happens is that you end up with other people’s unwanted feelings because your emotional shielding is not sufficient to repel external and internal assaults on yourself, and you become overwhelmed.

Continued on next page
Raising Confident, Courageous Daughters

Part I: Brain Science and Strudel Theory

The ‘girl thing’ has been overdone,” a national media commentator told me one day explaining why she was not interested in doing any more shows on girl topics for the foreseeable future. It was true; there had been a wave of stories, more accurately a tidal wave of media attention on the subject of relational aggression among girls. A couple of highly publicized books on the subject had just come out, and the media had, indeed, been awash in stories about girl meanness.

I agree, “the girl thing” has been overdone, but overdone out of a willingness to address the developmental caricature of girls as a subset of the species that is catty, gossipy and socially evil. Do girls struggle with the complexities of development? Of course — what child doesn’t? However, I have worked with girls, parents, and teachers of girls for more than twenty years, and there is more — much more — than that distinguishes girl life.

The grain of truth is this: it really addresses is girls’ capacity as critical thinkers and relational architects, their willingness to take the world as-is and act on it.

However, the real ‘girl thing’ that is rarely addressed is girls’ capacity as critical thinkers and relational architects, their willingness to take the world as-is and act on it. Girls today live on the pioneering edge of social transformation that is unprecedented in history. Theirs is a future in which girls and boys, men and women, will seek partnership and intimacy in new relationship styles, and in a future in which the very qualities of social intelligence, energy and wisdom will have currency like never before. She can transform life around the globe in ways never possible before.

For a high school senior described it to me this way: “It’s pretty hard being a girl nowadays. You can’t be too smart, too dumb, too pretty, too ugly, too coy, too aggressive, too defenseless, too individual, or too programmed. If you’re too much of anything then others envy you, or despise you because you intimidate them or make them jealous. It’s like you have to be everything and nothing at all, without knowing which you need more of.”

How could we not be talking about that, about how girls grow and what they need from us and from their environment to grow into healthy, resilient, self-expressed women? How can we nourish and prepare girls for the extraordinary demands of our time?

In my work with girls and the adults who live and work with them, I find that parents, teachers and girls themselves are hungry for two kinds of information. They want the “hard science” — specifically new information about the neurological growth of girls. Also, they want a companionable way of understanding the information because it helps them understand themselves. It helps explain the internal and interpersonal dynamics, which they see every day as a part of their relational dimension that is so compelling and vivid for them. I have found that the “hard science” is a lot easier for them to digest and put to use if they can develop a child development in language they enjoy and understand.

Strudel Theory: Building a Life with Layers of Experience

When we see a little boy turn to the box of blocks and a little girl turn to the coloring corner, we see the backdrop for the “nature versus nurture” debate: gender preferences the result of genetic “hard-wiring” or of socializing influences in the environment? The answer stimulates heated debates in some circles, but only in terms of how much. We accept that individuals are shaped by nature and nurture, it is the interplay of effect of nature, nurture and life experience that shapes a child, and it does so in some special ways from the very beginning when that child is a girl.

Basic Strudel Theory says that each of us is born with the main ingredient (our nature) but it is the layering of that main ingredient with other ingredients (nurturing) and the interaction of all together over time (life experience) that creates the finished product.

Think about a girl you know well — maybe a student, maybe your own daughter — and how she of herself and label it either sweet cherries or tart apples. Starting with that main ingredient, imagine adding a cup of sugar and the amygdala, the emotional center of the brain. This tells us that there is no “true” or “false” or “good” amygdala. The amygdala has a powerful influence on all thoughts and behaviors, especially in the female. Females seem to have a very sensitive and active amygdala. The thought processes of the female are influenced by the chemistry that occurs in the mixing and baking.

In human terms, Strudel Theory says that whatever qualities and experiences are mixed, the layering of experiences and actions over time, on an hourly, daily, weekly, monthly and yearly basis, leaves a lasting impression on a girl and strongly shapes her image of herself and her relationships with others.

Research offers insights into the nature of girls and the distinctly female development of the core nervous system, which includes thinking, perceiving, feeling and movement — in other words, the nature of a girl's experiences. A few simple points about brain development help set the stage for understanding the female experience of life and learning from the earliest days of life, when the learning begins.

Girls Brain: The Accent on Caring and Complex Thought

We each are born with an ebbing pattern and number of neurons, or nerve cells, that conduct impulses weighing throughout the body and to and from the brain. However, with each experience and with layered experiences using the same set of neurons, two things happen. First, the unused cell body, becomes thicker with added coats of the myelin, a fatty covering on a nerve that conducts an impulse faster. It is like a tree that grows thicker. The entire neuron grows thicker through this process of myelination. Basically, as a neuron or set of neurons is used, it gets bigger and more conductive. Branch Strudel deciduous development in language they enjoy and understand.

Part II: Brain Science and Strudel Theory

Raising Confident, Courageous Daughters

by JoAnn Deak, Ph.D.

Paradigm • Fall 2003

Continued on page 18
Seize the moment when you encounter: a stranger, an acquaintance or a friend. You can decide how it will go. Whether it is a brief smile, an elevator exchange, or the beginning of a beautiful day you can set the tone, tune in to the sunshine. This article suggests that seizing a moment of connection may build a wave, which washes clean certain misperceptions.

The barriers to seizing a moment of connection are self-preservation and shame. First, never overlook the uh-oh feeling. John Bradshaw’s book, Healing the Shame that Binds You opens up by saying, “Because of its preverbal origins, shame is difficult to define.” The healthy type is an acknowledgment of limitations. The toxic variety has been programmed distortions for possibilities which enhance. It is a missed opportunity for both of us. Our power, as John Bradshaw says, comes from admitting “the shame that binds us.”

First, it is necessary to acknowledge, in the secret place where you hate someone for dying, that you can recognize in yourself the effects of shame. I am describing patient recovery or the fairly normal stuff. The acknowledgment of my own shame unlocked the paralysis of waiting for someone to tell me how to be. Let me start with a moment of connection.

The Insight
On a bitter Chicago morning, I sat near the door listening to the Sunday speaker. M. icha, a longtime acquaintance, was cutting out early. I glanced up at the feeling of being watched. Our eyes met. Instead of smiling broadly because I like him, I waited for M. icha’s cue. This was a shame-based response. The greater loss unfolded during the week. I broke the following Sunday morning with an understanding. When I had perceived M. icha’s attention, I could have looked up, smiled, and shared the moment. Instead, I waited for his signal. The moment was stillborn, a missed opportunity for both of us. Our power, as John Bradshaw says, comes from admitting “the shame that binds us.”

I realized I could decide in the moment how I want to think and feel on that Sunday morning. I became aware that it is my own thoughts that need fixing instead of waiting. If I am culturally conditioned to do, I can originate the feelings, I want to experience, the outcome I desire. An exponential change! However, absent any conscious decision and re framing, my subliminal mapping willingly supplies shame-filled preordained choices. In its quest for security, the culture shames spontaneity. Yet, spontaneity is the power of the moment. It is the moment that God’s grace lingers. Now that I recognize this enormous and transitory power, how can I implement such revolutionary choices?

First, I contacted M. icha to share this revelation. Although acknowledging him probably noticed on his way out, M. icha did not recall the details — others to whom I related the experience immediately.

The Keys
There are three keys: awareness, altering expectations, and transforming automatic shame-based behavior into the willingness to be something positive. This may appear to require more courage than you think you have. Initially it may feel awkward, artificial, and disingenuous. Harder perhaps for women, for it might mean rejection and ridicule at first. It was difficult for me at first. Status quo is a powerful inhibitor. On a subsequent Sunday I walked in late. M. icha, someone I have known for several years and whom I respect and admire, caught my eye. I looked away instead of smiling to acknowledge someone else I like and learn from. Yet, the awareness was instant. Afterward, M. icha and I talked about my looking away and the change I was making. There is no question, being open with the people in your life is hard.

Awareness
Awareness is not only being in the absolute moment, it is a conscious decision to recognize the self-empowerment that hides in the moment. Taking advantage of chance encounters gains the power of the moment. Such power imprints and energizes. It is suspecting that even an enemy might smile because you are both wearing the same color. Scriptwriter clichés and ancient expectations dilute and distort this power by reducing it to repetition of the same old same old. To be aware of others requires focusing on their wants and needs. Perhaps pivotal to awareness of others is prayer. In my daily affairs, I come in contact with many people in need of my prayers. Therefore, my encounter may well be a person for whom I have already sought God’s goodness and generosity.

Expectation
The second key is expecting that the other person might also enjoy a human connection — not sex, coffee, and forever — just a brief exchange. It is attributing good motives to the stranger. The stranger in in desperate need of a smile. Perhaps the woman across the table is not after your job; she just wants your friendship and your expertise.

Perhaps the other person is waiting for you to smile or to speak. When you insist that the other person speak first, not only do you hand over the moment’s power as surely as cash at the checkout stand with nothing to show for it. You are not gaining respect and control; you are robbing both of you. Isn’t the sunshine of another’s smile what you deserve? By delaying your response, are you tricking them into believing you are valuable? The odds are excellent that the other person simply sees the sunshine of your smile. If not, maybe you have softened the ice rather than adding another layer.

Expectation is a powerful shaper of the future. It kicks in the week. I awoke the following Sunday morning with an instant impression. Over time we learn to trust them. Ultimately, the goal is to thrive with others, instead of just trying to impress or control them.

Grace J. O’Leary began her writing career in the Pentagon as an editorial assistant creating position books for the Joint Chiefs of Staff. She has written articles, newspaper features, and authored a series of group-work exercises for DoD clients. Further, M. O’Leary has authored a novel, Dragged Out of the Future, which explores addiction: “what it was like, what happened, what it’s like now.” Currently, she is writing a sequel, and creating marketing and networking strategies for J. French, Attorney at Law in Chicago, IL. You may contact Ms. O’Leary by email at pensivefriends.com.

Shame was finally identified for me in such a visceral way I recognized its presence as intimately as drops of my own blood. Bonnie DerDovan, speaking about attachment disorders as they are expressed in work and money addictions, finally lanced the vein that even I could see. Presented by The M edows of Wickenburg, AZ, her workshop was attended by those charged with the emotional well-being of others. I finally had the courage to acknowledge that the shame was mine, not my patients’, not my mother’s, not my children’s, not my friend’s and not recovery’s. It was mine. Once I named it and admitted to it, I had the power to understand it. From that came greater acceptance of myself and others, and the freedom to risk creating something I want rather than once again setting for what I get. I had to accept that I am okay just as I am.

Caveats
If this sounds scary or impossible, please one of us in your planner six months hence. You will be amazed at what happens during the incubation. If, like me, you did not receive much emotional nourishment in childhood and getting beyond the shriveling shame seems impossible, talk to someone you trust. Before I started recovery, I was invalidated on a regular basis, ineffective, and the person I am today was so deeply buried that no one would have predicted the success I have accomplished. Now I know I am making progress when I start to sing too early and that shriveling feeling is missing.

In the months since this revelation, I have had many opportunities to practice seizing the moment. The start was small and fleeting. I wished a CTA motorman a good day I smiled at people I passed. Not conditionally but recognizing them as deserving, too. Perhaps the other person is waiting for you to smile or to speak. When you insist that the other person speak first, not only do you hand over the moment’s power as surely as cash at the checkout with nothing to show for it. You are not gaining respect and control; you are robbing both of you. Isn’t the sunshine of another’s smile what you deserve? By delaying your response, are you tricking them into believing you are valuable? The odds are excellent that the other person simply sees the sunshine of your smile. If not, maybe you have softened the ice rather than adding another layer.

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"The secret of living without frustration and worry — is to avoid becoming personally involved in your own life." - Linda Hutchinsion

Using Humor to Reduce Stress

by Linda Hutchinsion

What is the greatest source of stress? In her wonderful book, The Search for Signs of Intelligent Life in the Universe, Jane Gooden answers, "Reality, the greatest source of stress amongst those in touch with it." Since she put reality on the back burner, her life has been jam-packed and fun-filled.

One way of reducing tension in our lives is to invent a little lie or tell a joke. What is your interpretation of reality? I grew up with the notion that life is hard work. When I put that notion on the back burner, my life is jam-packed and fun-filled.

In my "humor shops" we explore various ways to use humor to turn tense situations around and to reduce the impact of stress on our lives. One of my brain messages for preventing tension is D o not be offended, even if it is intended. Easier said than done. As humorous beings, we are great at turning molehills into mountains. Since I have applied the practice of not being offended, I am a lot happier and more serene.

On the other hand, do not allow people to degrade you. It is a paradox. D o not be offended and do not allow putdowns. If your cat, a parrot, or a child who is offended by your humor should offere the use of an offense as an opportunity to educate. One simple technique is to ask them to explain the joke or comment. Often, jokes and other forms of humor lose the "funny" when it has to be explained.

There are different ways to address tense situations. If you can, avoid tense situation. Do not entertain people who experience as offensive. Another way is to build your immune system — to be prepared. If humor does not have an advantage over your opponent by turning his strength and energy and sending it spinning in the opposite direction. He tells how actress Eva Arden used to work as a co-star, a prankster who arranged to have the telephone ringing when she was not supposed to on stage during a live performance. Arden calmly answers the phone, then she hands it over to the prankster saying, "Try for you.

Besides using humor as Aikido, joke-jitsu, and tongue-fu, and other forms of therapy what is it that you take too seriously? What would you like to lighten up about? H umor therapist, Arden calmly answers the phone, then she hands it over to the prankster saying, "Try for you.

There are many kinds of tense situations in which to use humor: ill health, terminal illness, death, natural disasters, and all forms of human conflict. Of course, there is one form of development more advanced than all of these: the wisdom of the cartoon character, Ziggy. Ziggy observes, "The secret of living without frustration and worry — is to avoid becoming personally involved in your own life."

Linda Hutchinsion is an adult educator, keynote speaker, consultant, and author with 30 years of professional experience designing and delivering programs for large and small organizations, national and professional associations. Owner of Hutchinsion Associates, Linda also teaches college courses on humor and spirituality. She is currently completing an examined articles on humor and social issues that will be released this fall. You may contact Linda at www.DEAKgroup.com.
Two years ago a South Florida TV news station did an investigative report that uncovered another new phenomenon driven by the Internet — child modeling Web sites. The investigation focused on a Fort Lauderdale company called Webe Web that runs dozens of child modeling Web sites. Sites like “Little Amber.” The site’s home page features a dozen pictures of Amber, a pretty blonde pre-teen, modeling clothes and bathing suits. However, few of these pictures look like the snapshots that you would take of your 9-year-old daughter. Although there is no nudity, young Amber poses like a woman who knows how to appear sexy. Patrons can pay a monthly fee of $19.95 for the privilege of seeing hundreds of more pictures updated regularly. Webe Web claims that Amber and her parents earn approximately $1,000 a month.

Not surprisingly the TV news investigation uncovered that the Webe Web Company also operates at least 14 pornographic Web sites. Sites like “Little Amber.” The site’s home page features a dozen pictures of Amber, a pretty blonde pre-teen, modeling clothes and bathing suits. However, few of these pictures look like the snapshots that you would take of your 9-year-old daughter. Although there is no nudity, young Amber poses like a woman who knows how to appear sexy. Patrons can pay a monthly fee of $19.95 for the privilege of seeing hundreds of more pictures updated regularly. Webe Web claims that Amber and her parents earn approximately $1,000 a month.

Welcome to the worldwide obsession with Lolita. Not the 19th century creation of a sexually-weird young girl, innocent yet seductive, unintilitated yet bursting with latent sexuality, lives on as a powerful sexual icon pursued by thousands of men around the world. The Internet has thrown fuel on the embers of this old fire and one of the latest accelerants are child modeling Web sites.

Are these sites mere promotion or exploitation? Are they innocent or shrewd? Are they harmless or a powerful attraction for a new generation of men? The Internet is introducing millions of men — and some women — to images of child sexual exploitation. If child modeling Web sites don’t inflame Lolita obsession, then those not willing to participate in it.

The root causes of Lolita obsession, on which most psychologists, researchers and law enforcement officials agree, do not tend to include hard-core pornography, or child modeling sites. Those causes are child sexual abuse, unresolved childhood trauma or conflict that solaces itself in the seduction and control of children; emotional fixation at an immature stage compounded by a lack of social skills and finally, plain old lust, opportunism and the proximity of a vulnerable child.

What is more controversial is whether or not exposure to child modeling or web-cam sites and whether or not to allow children to be featured on child modeling Web sites or not.

In a more global sense the very idea of childhood as a protected state of development is under attack. Historians and anthropologists will point out that the idea that childhood is a modern Western creation that may be an artificial construct. Some go further and argue that childhood is a delve into the repressive construct and the time has come to grow out of it. Childhood may be relatively new but it is still a good and progressive idea. And a society that cannot grow out of it.

To participate in a renewed legislative effort to address child modeling Web sites or to help educate others about this problem, contact Don Checkley at (412) 281-4565 or technical@pittsburghcoalitions.com.

Mr. Dorn Checkley, Executive Director of the Pittsburgh Coalition Against Pornography (PCAP) since March of 1986, is a lifetime resident of Pittsburgh. He earned a Bachelors of Fine Arts degree in Filmmaking from Emerson College in Boston, Massachusetts. Following graduation, Checkley joined Covenant House of New York City to help runaway and homeless youth. Many of the young people whom he counseled were prostitutes or were sexually exploited by the pornography industry.
Psychological Boundaries
When you have a good understanding of where you end, and where other people begin, you are well on your way to developing sufficient psychological boundary strength. Discussed in Whose life is it anyway? are several psychological boundaries: strong and resilient, soft, spongy and rigid.

Strong and resilient boundaries are those that are flexible enough to let someone in, and inflexible enough to repel assaults. Soft boundaries occur when people lack psychic strength. These are the people who can easily become enmeshed or overwhelmed. Rigid or inflexible boundaries are held by people who are fearful of becoming enmeshed or overwhelmed and will not let anyone in. Spongy boundaries are a combination of soft and rigid where large parts of the self are closed to the person, and he/she is unaware of becoming enmeshed or overwhelmed. People with strong and resilient boundaries are able to decide:

- When to stop taking care of others’ feelings.
- When their feelings are most important, and self-care is appropriate.
- To use emotional shielding appropriately.
- To open self to being empathic, but do not “catch” others’ feelings.
- That they have control of their lives and their feelings to a sufficient degree.

Stop Catching Emotions
How can you protect yourself from catching others’ feelings? Have you caught your feelings from becoming triggered by contact with other’s emotions? The first situation is an external assault where the other person is sending or projecting their feelings of discomfort, and you are open to catching them. The second is an internal assault where your uncomfortable feelings are set off because of your unresolved issues, such as family of origin issues, unfinished business from past experiences, and old parental messages. The external assault can be easier to prevent or repent than can the internal assault as the latter calls for an awareness of, and working through these unresolved issues. However, even the more difficult prevention of the external assault where you do not catch others’ emotions; thereby, reducing the chances of your feelings will have gotten through, but many more can be repelled. Thinking can also remind you to use your emotional shielding, and quickly put it in place. Some simple nonverbal behaviors, such as the following can be very helpful to prevent you from catching others’ emotions.

- Turn your body slightly away from the other person.
- Do not maintain eye contact. Look at the person’s forehead, across their shoulders, or around the room.
- Put something between you and the person, for example a purse, pillow, table, chair, etc.
- Attend to something on your person, such as clothes, hair, fingernails, etc.

These are the opposite of showing interest, and that you are really listening to the other person.

Distraction behaviors can be very effective at protecting you. Change the topic, call someone over to join you, turn away pick up something from the floor, or take stuff out of your pocket or purse; the list is long. The behavior will distract you, and the other person.

There may be times when you are unaware of the snare and start to be captured by the other person’s emotions. Do not give up, or give in. Instead, start to think to keep from becoming ensnared by their feelings. Think of your emotional shielding, and quickly put it in place. Some feelings will have gotten through, but many more can be repelled. Thinking can also remind you to use your nonverbal withdrawal strategies.

These suggestions will work as the short-term barriers. However, you do not want them to become your habitual behavior as they will negatively affect your other relationships that you want to maintain. This means that you should consciously use the strategies, be aware of using them, and understand that these are short-term strategies. The long-term solution is to build your psychological boundaries to be strong and resilient.

Dr. Milna W. Brown is a professor and eminent scholar of counseling in the Educational Leadership and Counseling Department at Old Dominion University in Norfolk, Virginia. She received her doctorate from The College of William and Mary and additional training in group psychology from the American Group Psychotherapy Association. Dr. Brown is a licensed professional counselor, a nationally certified counselor and the author of 13 published books. Her latest books are Working with the Self-Abolished (New Harbinger) and The Un知ing Life: Counseling Across the Lifespan (with Parker; Greenwood Press). You may contact Dr. Brown by email at nbrown@odu.edu.

True empathy occurs when you open yourself to experience what the other person is feeling without losing your sense of yourself as separate and distinct from that person.
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