The Trauma Trap

PLUS:

Compulsive Buying Disorder

Ethical and Legal Issues in Geriatric Psychiatry

When Time Doesn't Heal All Wounds

Because She Matters

DEAN STEINER, LPC

Dean Steiner is the Executive Director of Behavioral Health Services at UnityPoint Health–Methodist | Proctor, which includes addictions treatment offered at the Illinois Institute for Addiction Recovery, and inpatient and outpatient behavioral health services offered at Methodist and Proctor campuses.

Dean received his master's degree in clinical psychology from Bradley University and is a licensed clinical professional counselor. He conducted research on coping mechanisms people employ when driving under the influence of alcohol while at the University.

He began his career at Methodist as a family therapist on the inpatient psychiatric unit at Methodist, working primarily with families of children and adolescents. He has been the manager of outpatient behavioral health services and the behavioral health unit within the Emergency Department at Methodist. In 2003, Dean became director of behavioral health at Methodist.

Dean is proud to be part of the team at the Illinois Institute for Addiction Recovery and their 35-year history of serving people with addictions. Since Proctor's affiliation with UnityPoint–Methodist, he has been impressed with the scope of services the Institute offers.

"Not only do we offer treatment for alcohol and other substances, we treat people struggling with process addictions such as gambling, sex and Internet," says Dean. "The staff is experienced and knowledgeable and absolutely committed to helping people; it's impressive. Individuals often contact us after treatment. They share with us how their lives have changed, how they've grown and how they have benefited from the treatment they received. It's amazing and rewarding."

Dean is excited about the synergy created by the affiliation of Methodist and Proctor. "The individual strength that both hospitals bring together—35 years of addiction treatment at Proctor and 60 years of mental health treatment at the Methodist—creates new opportunities to develop, grow, and strengthen all behavioral health services. We are all excited about the future."

PARADIGM

THE TRAUMA TRAP **6**

Ethical and Legal Issues in Geriatric Psychiatry **12**

Because She Matters .... Leaving the Life **14**

FEATURES

DEPARTMENTS

HIGH RISK BEHAVIORS
Among Sexually Exploited Youth

By M. Alexis Kennedy, PhD and Magann Jordan, MA

Trading sex for cash or drugs is occurring across all age groups, genders, and ethnicities in every corner of the United States. Youth surviving through selling sex illegally (prostitution, stripping or pornography, for example) were first labeled victims of human trafficking in 2005 when a domestic minor sex trafficking category was added to the Trafficking Victims Protection Act. Despite this federal victim description, these youth—Commercial Sexually Exploited Children (CSEC)—are still being prosecuted and criminalized as juvenile offenders in most states. The constant threat of arrest leads youth in this group, which has a high rate of alcohol and drug use, to avoid interactions with professionals (law enforcement, child protective services, health providers, etc.) and to hide their high-risk sexual behaviors to avoid identification. Chances to detect and intervene with these victims are increasing as those working with addicted youth, homeless youth, foster children and children involved with the juvenile justice system are educated about the warning signs for involvement in commercial sexual activity.

Many of the behaviors that we criticize youth for—involvement in the criminal justice system, drug use, alcohol use, and risky sexual behaviors—are actually red flags for underlying trauma. These acting out behaviors may be coping strategies for a history of sexual trauma and victimization. This interconnection is particularly apparent in youth exploited through commercial sexual activity. Victims internalize their sexual objectification and show similar negative symptomology (e.g., depression, shame, low self-esteem, PTSD, suicidal thoughts, etc.) across histories of childhood sexual abuse, incest and commercial sexual exploitation (Farley, 2013). Predators (consumers and pimps or traffickers) take advantage of the destruction of children's personal boundaries following a history of traumatic sexualization.

Abusers are emboldened by media's admiring portrayal of pimps and increasing sexual objectification of youth.

CSEC victims report significantly higher rates of sexual abuse and sexual assault than their peers in the delinquency system. A needs assessment of 161 girls detained in the juvenile delinquency system found that the third of the population (52 girls) involved in prostitution had significantly higher rates of sexual violence victimization: 73% for CSEC involved girls compared to 52% among non-CSEC involved girls (Kennedy, Ashby, Swanson & Pucci, 2009). The average age for starting sexual activity was younger for CSEC girls (12.5 years old) compared to their peers (14 years old). National rates for females being sexually active before age 13 are 4%; rates for these populations were higher, at 30% for non-CSEC girls and 46.5% for CSEC victims. Another concerning sexual behavior was the high rate of anal sexual activity among CSEC (36%) compared to the non-CSEC girls (8%). Condom use at last sexual encounter did not differ significantly (62% for CSEC, 54% for non-CSEC) nor did history of pregnancy (56% for CSEC, 42% for non-CSEC) but both comparisons highlight risky sexual behavior and its consequences.

Homelessness and a history of running away have been identified as risk factors for commercial sexual exploitation. CSEC victims reported a robust history of running away: 88% compared to 69% for their delinquent peers. (Kennedy et al., 2009). What is more telling is that 53% of the CSEC victims reported first running away at age 13 or younger. The housing and job options for children on their own at this age are very limited and trading their bodies for a place to stay, for drugs or for cash is one of the only economic options available for children on the run.

Children involved in the adult and underground world of commercial sexual exploitation report high levels of alcohol and drug use. All of the CSEC involved youth used alcohol, compared to 81% of their delinquent peers (Kennedy et al., 2009). Both groups reported high levels of marijuana use (87-96%). CSEC involved girls reported significantly higher rates of drug use than non-CSEC involved delinquent girls: cocaine (54% compared to 37%), crack (24% to 10%), crystal meth (56% to 38%), and heroin (20% to 7%). In addition to being a health hazard on their own, elevated rates of drug use exacerbate other high-risk behaviors such as engaging in unprotected sex (Solorio et al., 2008).

Warning Signs Overlap

Some of the warning signs for drug use overlap with warning signs of involvement in commercial sexual activity. Sudden changes in personality and behavior beyond the typical ups and downs of teen years are seen among exploited youth. Mood swings, decreased self-esteem, shame, PTSD symptomology and other emotional upheavals are seen among CSEC victims in a way similar to that of other traumatic situations (e.g., dating violence, child abuse, drug use etc.).

CSEC indicating behaviors may include changes in appearance to look more grown up, dressing more provocatively or getting tattoos. Pimps use tattoos to brand their victims. Youth who are unwilling to explain the meaning of their tattoos may be hiding their exploitation so adults should look for tattoos with references to the sex industry (e.g., Daddy, Wifey, Bitch, ATM and other references to money, etc.). Children being sexually exploited will also show physical symptoms similar to other abuse situations such as fatigue, bruises and frequent headaches. Persistent or repeat sexually transmitted infections and pregnancies are also indicators.

Social relationships can also raise red flags. Youth who change friends and their preferred activities may exhibit an increase in talking about sexual activity and casual sexual interactions. Another indicator is using terms related to prostitution (e.g., tricks, Johns, quota, strolls, tracks, "the Game," "the Life," etc.). Yet another warning sign may be teenagers who exhibit attachment or traumatic bonds with intimate partners who are older than the traditional peer group.

Access to money may also indicate involvement. One warning sign is a child who suddenly has cash without an identifiable source of income. Another indicator may be a child with new clothes, or hair and nail treatments that were not paid for by their caregivers. Possessing more than one cell phone is also a warning sign.

Familiarity with Rules May Help Identify Victims

Service providers will be more efficient at identifying involvement if they learn about the rules of the "game" or the illegal world of prostitution. CSEC victims are often in dependent living situations with adult pimps who frequently beat and sexually assault them. Children under the control of a pimp rarely refer to this adult as such but refer to the person as a boyfriend or "daddy." Their traumatic bond leads them to downplay the control exercised in terms of how they dress, who they can contact, how much they work and the quota of money that they must earn. Abusers reinforce their control by socially isolating victims from their families and friends, changing victims'

> **Some of the warning signs for drug use overlap with warning signs of involvement in commercial sexual activity.**

names to street names, reshaping their identity, moving them repeatedly, and taking control of the money. In addition to using violence against the victims, traffickers threaten violence against their families should victims attempt to leave. Direct service providers experienced in working with CSEC victims (e.g., www.yapinc.org, www.theembracingproject.org) train their providers to look critically at the "boyfriends" or "roommates" of the victims, as these individuals may be a source of violence against the victims and service providers, necessitating creation of a safety plan to accompany intervention and treatment.

Providing services to CSEC victims takes patience and understanding. These victims, with their histories of abuse, family dysfunction, running away and substance abuse, usually have multiple issues that need to be addressed simultaneously. Survivors say the most important skill in a provider is a non-judgmental attitude. Victims will often tell graphic stories of violence and sexual activity, sometimes looking to elicit a reaction of disgust from the provider. Having been told by their traffickers that they are worthless, they look for confirmation of this in the adults offering to help. They have a difficult time establishing trust due to prior disappointments with parents, child protective services, police interactions, and other adults who did not rescue them from earlier abusive situations. Service providers need to set clear boundaries with these victims and not over-promise protection and help as disappointments only reinforce this distrust. Providers must not take rejection from these victims personally; skepticism and doubt is a protective strategy for these children. They expect to be disappointed and when they push a service provider away through their bad behavior, they are proving that their doubts were correct. It is important to remember that providers will not get the whole story right away. On top of trust issues, admitting a boyfriend is really a pimp shatters the self-defense mechanisms that allow victims to survive in a violent illegal world.▼

Dr. M. Alexis Kennedy *is an Associate Professor in the Department of Criminal Justice at the University of Nevada, Las Vegas. She is a forensic psychologist and expert on child abuse. Dr. Kennedy may be contacted at alexis.kennedy@unlv.edu.*

Magann Jordan *is with the Victim Witness Assistance Program at the Clark County (NV) District Attorney's Office. She formerly provided direct services to CSEC victims through Youth Advocate Program (www.yapinc.org), a national diversion program that provides wrap around services for high-risk youth. Magann may be contacted at Magann.Jordan@gmail.com.*

References:

Kennedy, M.A., Ashby, D.T., Swenson, T. & Pucci, N. (2009). *Final Research Report: Department of Juvenile Justice Services, JDAI GIRLS Initiative.* Las Vegas, NV: NICRP.

Farley, M. (2013). Prostitution. In, E.L. Zurbriggen & T. Roberts (Eds.), *The Sexualization of Girls and Girlhood* (pp. 166-194). New York, NY: Oxford University Press.

Solorio, M.R., Rosenthal, D., Milburn, N.G., Weiss, R.E., Batterham, P.J., Gandara, M., & Rotheram-Borus, M.J. (2008). Predictors of sexual risk behaviors among newly homeless youth: A longitudinal study. *Journal of Adolescent Health*, 42, 401-9.

THE TRAUMA TRAP

AN EMERGENT THEME IN GROUP TREATMENT

By Izaak L. Williams, CSAC

The impressionistic and figurative language of metaphors that circulate within group treatment is revealing of the psychic attachment patients describe having with their drugs of choice. For example, a patient who let go of his or her drug of choice may figuratively narrate the love object (i.e., drug) as the loss of a best friend. Additionally, there are others who describe a "security blanket" attachment to their experiences with their drugs of choice as "my mistress in times of need." Some patients share feelings that psychologically imprint the emotional investment in their drugs of choice as a "marriage." Other patients reflect on the primary love/hate qualities of their relationship with their drugs of choice. Of these, all are metaphorical expressions in treatment that shed light on the depth of attachment and powerful belief system assigned to their perceived connection with their respective drugs of choice (Flores, 2001, 2004). (It should be noted that research scientist Carlton K. Erickson, who has been studying the effects of alcohol on the brain for over 30 years, contends that "choice" is a misnomer given that the addictive relationship has crossed the threshold of choice to necessity.)

Within the fold of such belief systems alternative treatment approaches can be molded to be more responsive in their applications to patients. For example, in the administration of trauma-informed care, a subgroup of patients might face challenges in orientating toward the contents of that treatment modality. In turn, a variety of themes can emerge that, in one way or the other, manifest as an impasse and create a trauma trap wherein patients encounter difficulties applying the treatment modality to aspects of their addiction and recovery.

Emergent Themes in Group Treatment

For all intents and purposes, the treatment of trauma on account of some trauma-informed modalities generally aims to get patients to crystallize the content of some past experience(s) as achieving trauma-potential, and then to process that information in the context of the current problem. This process starts off with a conceptual overview of trauma that lays out singular events qualifying as being potentially traumatic (e.g., witnessed or subjected to life-threatening violence or a car accident). This then sets the frame for the discussion of post-traumatic stress disorder (PTSD). Within this matrix, the content of treatment revolves around the X-axis of trauma and the Y-axis of PTSD. In response, a subgroup of patients can lose sight of the trauma treatment process and the relationship it has with their substance use disorder.

While some patients may conform psychologically, behaviorally, socially, and emotionally with PTSD, the fact that the trauma is located in such a far-off time and isolated place may put it too far outside of reach to form any mental connection between past trauma and current problems they are facing. Additionally, when a proportion of group patients voice trauma narratives, those patients who seem unable to retrieve the actual traumatic event from their memory may create a psychological grab-bag of overgeneralized, non-traumatic events, such as "getting lost in the woods while hunting" or "being left alone in a shopping mall as a child" and other seemingly stressful but non-traumatizing events.

Alternatively, group dynamics and preconceived notions of being branded and labeled may force patients who are self aware of being symptomatic of PTSD to malinger as if the treatment of trauma is irrelevant to their recovery. A case in point is the phenomenon of patients who openly endorse a traumatic qualifier but whose experiences and full-blown symptoms are normalized and not seen as traumatic despite clear linkages between PTSD symptomatology and the emotional, psychological, physiological, and behavioral symptoms they display.

Patients may also show symptoms in line with a physiological withdrawal state from the cessation of drug use; however, symptoms of PTSD are confused with withdrawal. In this way a blind spot is created from really seeing the withdrawal symptoms because said symptoms are viewed with trauma blinders on. Overdoing emphasis on trauma in group treatment could also possibly bring some patients to assume trauma experiences and the group norm expectations of what such trauma means psychologically, behaviorally, socially, and emotionally. Accordingly, the patient may attribute classic PTSD symptoms to himself or actually take on a psychosomatic reaction to it (McCann & Pearlmann, 1990; Perkonigg, Kessler, Storz, & Wittchen, 2000).

In Search of Constructive Alternatives

The feeling of emotional attachment expressed in the language of metaphors (i.e., wife, husband, best friend, mistress, etc.) indicates that patients might form different attachment patterns (secure, insecure anxious, ambivalent, insecure avoidant and disorganized) to their drugs of choice. In this context, the cessation of drug use could be thought of as relationship detachment. Once that takes place, the degree of current psychosocial function and capacity to cope with the ups and downs in recovery may have parallels to the attachment pattern exhibited to drugs of choice.

That conclusion leads to the example of a patient introduced to methamphetamine (meth) by her boyfriend. She maintained that she used the drug to identify herself with him and his addiction. This relational context was the basis of her drug use. This attachment pattern to meth suggests a disorganized style type. On the other hand, a patient who established a fixed pattern of drug use (likened to a marriage) and lacks emotional self-regulation, and, is psychologically maladapted, might be more reflective of a secure attachment to the drug of choice.

George Kelly's (1963) idea of constructive alternativism is instructive insofar as potentially helping some patients better understand, identify with and relate to the contents of the trauma treatment modality. Kelly put forth the idea to mean that personal experiences can be (re)constructed when information is presented in different directions, permitting it to be grappled with from other possible angles, thereby generating new personal meanings of that experience, i.e., trauma.

Flowing from this outline in parallel with constructive alternativsm are a few suggested alternatives to mold treatment approaches to be more accessible to different clinical populations in group treatment and in such a way as to shrink the dimensions of the trauma trap. One possible method is introducing patients to Maslow's (1943) Hierarchy of Needs. This is a nice schematic illustration for patients. Offering patients this visual aid and expounding upon it can highlight for some patients the idea that their drugs of choice virtually *are* the pyramid; at the very least they were or still are overlapping levels of needs. Knitted together with Ainsworth's (1985, 1989) developmental theory of relational patterns of attachment styles can illuminate patients' visualized aspects of their drugs of choice and the roles they played within Maslow's pyramid scheme and the current status of patients' recovery.

Deepening and widening patients' understanding of the particular types of attachment formed to their drugs of choice might be partially explained as a process of detaching from their drugs of choice and, in turn, forming new, healthy relationships and (re) attachments that promote and support high-quality recovery.

Then, to give patients a better perspective on the content of trauma-informed treatment, it might help to contrast the cessation of drug use as a potentially traumatic event or detachment from the drug of choice as a (complex) trauma in comparison with the *Diagnostic and statistical manual of mental disorders criteria* (American Psychiatric Association, 2013) illustrated in Table 1 on page 8.

Adopting such an approach strives for a solution to better ensure that the message about trauma can be accessed, normalized, and meaningfully integrated as a recovery construct that can be understood in addiction treatment. Another possible solution process, as a matter of focused perspective on symptoms of detachment from their drugs of choice, is to help patients incorporate the Five Stages of Grief outlined by Kubler-Ross

Table 1. DSM-5 Criteria for PTSD and Comparison Between Drug-Loss Induced PTSD-Like Symptoms

Criterion A: Stressor	Criterion B: Intrusive Symptoms	Criterion C: Avoidance	Criterion D: Negative Alterations in Cognitions and Mood	Criterion E: Alterations in Arousal and Reactivity
Trauma (traumatic loss of a loved one or close friend)	1. Nightmares 2. Intrusive memories 3. Dissociative reactions (e.g., flashbacks) 4. Distress after exposure to traumatic reminders 5. Marked physiologic reactivity after exposure to trauma-related stimuli	People, places, conversations, objects, situations, and things associated with trauma	1. Inability to recall key features of traumatic event 2. Persistent and (often distorted) negative beliefs and expectations about oneself or the world 3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences 4. Persistent negative trauma-related emotions (fear, horror, anger, guilt or shame) 5. Markedly diminished interest in (pre-traumatic) significant events 6. Feeling alienated from others (e.g., detachment or estrangement) 7. Constricted affect: persistent inability to experience positive emotions	1. Irritable or aggressive behavior 2. Self-destructive or reckless behavior 3. Hyper vigilance 4. Exaggerated startle response 5. Problems in concentration 6. Sleep disturbance
Giving Up Drug Use (perceived loss of "best friend," "security blanket," "marriage," or "love/hate relationship")	1. Nightmares 2. Intrusive memories (e.g. cravings and urges) 3. Intense and vivid reliving of drug experiences (e.g. flashbacks) 4. Auditory or visual drug cues trigger recollections of aspects of drug use 5. Autonomic physical reactivity (e.g. sweating, watery mouth / distinct taste in mouth, tingly feeling in jaw, increased heartbeat, upset stomach, physical pain)	People, places, conversations, objects, situations, and things associated with drug use	1. Romanticizing and glamorizing (eustress) features of drug; euphoric recall-remembering "good" (stress) while forgetting pain and hurt (distress) caused by drug 2. "I'll never be happy without my drug," "I'll never be my normal self without the drug" 3. "The legal system has it out for me because my drug use is not like those other addicts," "I am in treatment because I have bad luck," "The problem is not my drug use but everyone else around me" 4. Persistent negative drug loss-related emotions (fear, horror, anger, guilt or shame) 5. Pervasive sense of boredom, loss of interest and pleasure in natural motivators 6. Feeling alienated from others (e.g., detachment or estrangement) 7. Constricted affect: persistent inability to experience positive emotions (non-drug induced), emotionally numb feelings, depersonalization	1. Irritable, angry or aggressive behavior 2. Self-destructive or reckless behavior 3. Feel on edge, aroused 4. Exaggerated or startled response 5. Short attention span, difficulty remembering and thinking clearly 6. Restless or lack of sleep

(2005) as a perceptual framework for patients to meander their way through the trauma trap, which might also seem a bit less pathologizing.

Conclusion

Emergent themes discussed in this article may impede the development of effective group treatment and become real blockages to whatever interventions are orchestrated to address trauma and treat PTSD. Patient descriptions of metaphoric loss poignantly illustrate the potency of the emotional attachments patients have to their drugs of choice. Metaphorical language distilled by patients about the meanings ascribed to their drugs of choice and what it means to give them up sheds light on the potential trauma of that psychological experience. Along these lines, this can be instructive insofar as informing how close patients are psychologically to the fault line of trauma.

Capitalizing on the powerful expressions of metaphors entails providing different reference points for patients to frame such language through which to view (trauma/PTSD) clinical symptoms and the already-existent domain of problems. Patients might find a way around the entanglement of the trauma trap or maneuver out of it as the treatment modality is found to be more accessible and responsive to their transition from addiction to recovery.▼

Izaak L. Williams, *a Hawaii state-certified substance abuse counselor, conducts research in the field of addiction and facilitates group counseling at Ho'omau Ke Ola on the island of Oahu. He was selected in the 2014 cohort of emerging leaders by the Center for Substance Abuse Treatment's Behavioral Health Leadership Development Program. Izaak may be contacted at izaakw@hawaii.edu.*

References:

Ainsworth, M.D.S. (1985). Attachment across the life span. *Bulletin of the New York Academy of Medicine, 61*(9): 792-812.

Ainsworth, M.D.S. (1989). Attachment beyond infancy. *American Psychologist, 44*(4): 709-716.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, 5th edition: DSM-5*. Washington, DC: American Psychiatric Association.

Flores, P.J. (2001). Addiction as an attachment disorder: Implications for group therapy. *International Journal of Group Psychotherapy, 51*(1), 63-81.

Flores, P.J. (2004). *Addiction as an attachment disorder*. Lanham, MD: Jason Aronson.

Kelly, G. (1963). *Theory of personality: the psychology of personal constructs*. New York: W.W. Norton & Company.

Kubler-Ross, E. (2005). *On grief and grieving: finding the meaning of grief through the five stages of loss*. New York: Scribner.

Maslow, A.H. (1943). A theory of human motivation. *Psychological Review, 50*(4): 370-396.

McCann, I.L., & Pearlman, L.A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. New York: Brunner/Mazel.

Perkonigg, A., Kessler, R.C., Storz, S., & Wittchen, H.U. (2000). Traumatic events and post-traumatic stress disorder in the community: Prevalence, risk factors and comorbidity. *Acta Psychiatrica Scandinavica, 101*, 46-59.

Williams, I.L. (2014). Considering discontinuation of drug use as a potentially traumatizing event. *Mental Health and Substance Use. 7*(1): 1-4. doi: 10.1080/17523281.2013.872695.

By April Lane Benson, PhD

COMPULSIVE BUYING
DISORDER

Let's Stop Smiling at the Smiled-Upon Addiction

Whoever said that money can't buy happiness didn't know where to shop.

Shopping makes for easy jokes. This post-it version hints at shopping as panacea, a magical elixir that promises more than it could ever deliver. Retailers seize any opportunity to prey on this fantasy. One of the most fashionable stores in New York City unabashedly mailed postcards to its customers, inviting them to a "psychotherapy sale," urging them to bring in their emotional baggage to fill with mood-enhancing bargains. "Get in touch with your inner shopper," the store beckoned.

Whether it's the overpromising post-it, a tongue-in-cheek postcard, or the bumper stickers that boast, "When the going gets tough, the tough go shopping" and "Shop 'til you drop!"— shopping stereotypes are quick fodder for a laugh. All this comedy underscores a strongly mixed cultural message: shopping, however important to our economy, is silly and superficial, as is anyone who passionately pursues it.

Though often referred to as the "smiled upon addiction"—after all, our economy is fueled by overconsumption—compulsive buying disorder is no laughing matter. It can and often does have serious, long-lasting aftershocks. In addition to the obvious financial consequences, emotional, interpersonal, and occupational problems abound; in extreme cases, incarceration and suicide have occurred. Despite the fact that compulsive buying disorder has been inching its way farther and farther out of the closet, research interest in this widespread, often addictive, disorder is still in its infancy. Compared to its psychological siblings—eating disorders, substance abuse, and gambling disorder—research interest in effective treatment for compulsive buying has been extremely limited and relatively few therapists and clinics screen for this problem.

What is Compulsive Buying Disorder?

Compulsive buying disorder is broadly and formally defined as a maladaptive preoccupation with buying or shopping, characterized by irresistible, intrusive, and/or senseless impulses and behaviors, or results in frequent buying of more than can be afforded, frequent buying of items that are not needed, or shopping for longer periods of time than intended, even in the face of adverse personal, social, and financial consequences (McElroy, Keck, Pope, Smith, & Strakowski, 1994). In short, the compulsive buyer is a person who allows shopping to destructively deflect resources—whether of time, energy, or money—from the fabrication of everyday life.

A large-scale telephone survey of over 2,000 randomly selected U.S. households suggested that 5.8%—approximately 17 million Americans—may demonstrate symptoms of compulsive buying disorder (Koran, Faber, Aboujaoude, Large & Serpe, 2006). Particularly noteworthy about this study was the fact that the 5.8% whose responses were suggestive of compulsive buying disorder were almost evenly divided between the two genders. A later study examined the prevalence of compulsive buying disorder in three narrowly defined subgroups and concluded that the prevalence of compulsive buying disorder may be even higher (Ridgway, Kukar-Kinney & Monroe, 2008). Despite the variations in percentages and sample populations, such studies unequivocally demonstrate that compulsive buying is extremely prevalent in the United States.

Evidence that compulsive buying is a grave and worsening problem is mounting. In the only longitudinal study to date, Neuner, Raab and Reisch (2005) reported that the frequency of compulsive
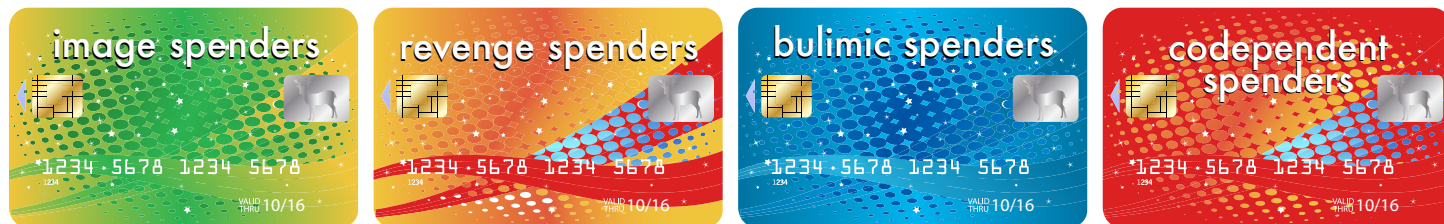
buying in Germany increased significantly between 1991 and 2001, following the fall of the Berlin Wall, attributing this rapid rise, in part, to the acculturation process brought by reunification. While compulsive buying is considered a culture-bound syndrome that occurs mostly in cultures that offer "mushrooming credit facilities and boundless buying opportunities," globalization and the Internet have greatly extended its reach. Either scholarly or popular articles have been written about compulsive buying on every continent but Antarctica.

An accurate profile of the typical compulsive buyer remains elusive. Like other addictions, shopping addiction is complex and multi-determined, and the spectrum of compulsive buyers is wide, reflecting a set of people who differ from one another in age and gender, in socioeconomic status, in the intensity of their compulsion, and in underlying motivation. Compulsive buyers also differ in their patterns of buying. Some are compulsive daily shoppers, some go on occasional but consequential shopping binges, and some collect compulsively. There are image spenders, revenge spenders, bulimic spenders (who need to rid themselves of their money), and codependent spenders (who enable the spending of others). Some buy multiples of each item, some compulsively hunt for bargains, others are compulsive hoarders, and still others engage in ceaseless buy-return cycles. This diversity suggests that efforts to capture the essence of the archetypal overshopper are likely to be fruitless.

Why Overshop?

American culture is one of "competitive consumption," in which the acquisition of consumer goods and services is associated with the attainment of happiness. Women are taught that a flattering outfit or the perfect hair care product will make them irresistible to men, while men come to believe that purchasing a sports car attests to their masculinity and success. The false belief that goods are transformative agents becomes toxic when combined with the over-availability of credit cards.

Many shopaholics seek and achieve emotional relief and momentary euphoria through compulsive buying. Some overshop in response to loss or a major life trauma, to avoid confronting something important, or to feel more in control. Others overshop to express anger or exact revenge, or use buying for others as a way to hold onto love. Still others overshop to belong to an appearance-obsessed society or to put forth an image of wealth and power. Underlying many of these motivations is an attempt, albeit ultimately unsuccessful, to gain social status or move closer to what they believe is a better or ideal self. It's an attempt to bridge the gap between how they see themselves, how they wish to be, and how they wish to be seen (Dittmar, Long & Bond, 2007). Compulsive buyers experience a higher than normal rate of associated disorders—depression, anxiety, substance abuse, eating disorders, and impulse-control disorders—and may be using their overshopping to self-medicate.

Challenges for the Therapist

Even as our marketing-intensive culture has elevated retail seduction to a high art, shopping is simultaneously discouraged and devalued. We therapists are hardly immune from this institutionalized ambivalence about shopping and spending. While I've studied, researched, and treated compulsive buyers for nearly 20 years, it's been extremely difficult to attract enough therapists to develop a specialty in working with compulsive buyers to adequately serve this under-recognized population. Why?

Until I developed a specialty in the treatment of compulsive buying, my own clinical experience reflected that of my colleagues, i.e., it is unusual for someone to refer himself or herself for treatment for a compulsive buying problem. Typically the compulsive buyer is referred by a financial counselor, lawyer, law enforcement officer, family member, or spouse. It's normally not until overshoppers incur large amounts of debt, experience repeated conflicts with family members about spending, encounter legal or criminal problems related to their buying, or begin to see their behavior being repeated by their children that they look for help. Much more frequently, a compulsive buying problem reveals itself in the course of ongoing psychotherapy, either directly, in the context of financial independence and responsibility issues, relationship or parenting problems, or difficulties at work. Compulsive buying may also present itself indirectly in therapy: a patient may wear something new or different to every session, arrive with shopping bags week after week, repeatedly give gifts to the therapist, or fall behind in paying the bill. Often, a patient will enact several of these behaviors simultaneously.

Unless a therapist thinks to ask relevant questions, he or she is very likely to miss the problem altogether. Inquiring about finances, debt, and about the acquisition and disposal of possessions will invite these issues into the room, although many therapists are afraid that if they ask such specific and targeted questions their clients will flee. We might also under-inquire because we haven't examined our own money scripts, those unconscious and unexamined beliefs about money that lead to our own self-limiting money behaviors and keep us blind to those of our clients (Klontz, Kahler & Klontz, 2008).

For example, an overspending therapist may join with the client and unconsciously reinforce his or her justifications for overspending. Alternatively, because of early money messages that revered scarcity, a therapist may be too harsh once a client's overspending has been brought to light. We may feel hostility toward a client who treats us as an "object" or just another "hired hand," rather than a collaborator. As members of a humanitarian profession, we may not feel entitled to be paid adequately for our services and feel conflicted about acquiring status and expensive possessions. More often, though, we want success,

approval, wealth, and comfort as much as most Americans and contend with the same acquisitive pressures as our overshopping clients. Feelings of envy, jealousy, competitiveness or idealization may be inevitable when a client is wealthy or more comfortable around money than we are. We might silently belittle and judge a client as shallow and superficial, all the while denying our distaste for the parts of ourselves that wish we had the client's financial resources. We need to remember that we don't always adhere to the more enlightened values that we would like to help our clients move towards. The opportunity to discover our own feelings and motivations contributes to making this work so rich and so fascinating.

The Stopping Overshopping Program

Following the publication of *I Shop, Therefore I Am: Compulsive Buying and the Search for Self* (Benson, 2000), I began to hear from compulsive buyers, their loved ones, their therapists, and sometimes even their lawyers, and began to be known as someone who specialized in working with compulsive buyers. Over the next five years, I developed a treatment program, using techniques that had proven effective when I had worked with people with eating disorders and incorporated other tools and strategies that had proven efficacy in helping people with other addictions.

I've used the program "Stopping Overshopping," (published as *To Buy or Not to Buy: Why We Overshop and How to Stop* in 2008), with individuals and groups for the last nine years. It is a 12-week experience that integrates aspects of cognitive and dialectical behavior therapy, psychodynamic psychotherapy, psycho-education, motivational interviewing, acceptance and commitment therapy, and mindfulness. The program teaches specific skills, tools, and strategies that help compulsive buyers break the cycle that leads to compulsive buying and develop the capacity to lead a richer life in the process. A detailed description of the model can be found in Benson & Eisenach (2013).

As I came to see changes, sometimes small, often enormous, in my own clients and the clients of the therapists that I trained, I decided that it was time to test the model empirically and see if my subjective experience of its efficacy would be confirmed by objective measures. In 2010, we embarked on a pilot randomized controlled trial that compared the efficacy of this model with a waiting list control group. Results showed significant improvement on all compulsive buying measures. In fact, scores improved from levels solidly in the compulsive buying range to scores that were solidly in the normal buying range. The amount of money and time spent, and the number of compulsive shopping episodes, were also significantly reduced. All these improvements were well-maintained at six-month follow-up. (Benson, Eisenach, Abrams & van stolk-Cooke, 2014).

Group Therapy Most Consistently Positive

While a number of other forms of treatment with compulsive buyers have been reported since the late 1980's, the only randomized controlled treatment studies for compulsive buying have been of drug therapy and group therapy. Among drug treatments, the results have been equivocal. Two identically designed studies, done at the same medical school, showed contradictory results and much of the rest of drug treatment reported is based on only one or two cases (Black, 2007).

Group therapy provides the most consistently positive evidence of successful treatment. The results of three randomized controlled trials (Mitchell, Burgard, Faber, Crosby, & de Zwaan, 2006; Mueller, Mueller, Silbermann, Reinecker, Bleich, Mitchell, & de Zwaan, 2008; and Mueller, Arikian, de Zwaan, & Mitchell, 2012), using the same cognitive behavior therapy 12-week group treatment for compulsive buying, suggested that the treatment was effective in significantly reducing compulsive buying behavior and that these gains held at six months.

Considered the *smiled upon* addiction because consumption fuels our economy, compulsive buying is too often under-recognized, under-diagnosed, and under-treated. As the growing body of research suggests, the severity and frequency of compulsive buying symptoms can be addressed clinically to great effect and scores of overshoppers have told me, over the years, what a relief it has been to find specialized, effective treatment for this problem. It's been a hard sell to the mental health community, though. Isn't it time that we, as counselors and therapists who work with people with addictions, start offering shopping addicts effective help that they can usefully buy into?▼

Dr. April Lane Benson *is a nationally known psychologist specializing in the study and treatment of compulsive buying disorder. Dr. Benson is the editor of* I Shop, Therefore I Am: Compulsive Buying and the Search for Self *(2000), the first book, in English, for mental health professionals about compulsive buying disorder, and author of* To Buy or Not to Buy: Why We Overshop and How to Stop *(2008). Her findings on the efficacy of the Stopping Overshopping model of treatment were recently published in the* Journal of Groups in Addiction & Recovery. *Maintaining a private practice in New York City and a comprehensive website www.shopaholicnomore.com, Dr. Benson also trains therapists and frequently appears in the media. She can be reached at (212) 799-3793 and at aprilbensonphd@gmail.com.*

References:

Benson, A.L., & Eisenach, D.A. (2013). Stopping Overshopping: An approach to the treatment of compulsive buying disorder. *Journal of Groups in Addiction & Recovery, 8*(1), 3-24.

Benson, A.L., Eisenach, D.A., Abrams, L.A., & van Stolk-Cooke, K. (2014). Stopping Overshopping; A preliminary randomized controlled trial of group therapy for Compulsive Buying Disorder. *Journal of Groups in Addiction and Recovery, 9*(1).

Benson, A.L. (2008). *To buy or not to buy: Why we overshop and how to stop.* Boston, MA: Trumpeter.

Benson, A.L. (2000). *I shop therefore I am: Compulsive buying and the search for self.* New York, NY: Aronson.

Black, D.W. (2007). A review of compulsive buying disorder. *World Psychiatry, 6*: 14-18.

Dittmar, H., Long, K., & Bond, R. (2007). When a better self is only a button click away: Associations between materialistic values, emotional and identity-related buying motives, and compulsive buying tendency online. *Journal of Social and Clinical Psychology, 26*(3), 334-361.

Klontz, B., Kahler, R., & Klontz, T. (2008). *Facilitating financial health: Tools for financial planners, coaches and therapists.* Erlanger, KY: National Underwriter Company.

Koran, L.M., Faber, R.J., Aboujaoude, E., Large, M.D., & Serpe, R.T. (2006). Estimated prevalence of compulsive buying behavior in the United States. *American Journal of Psychiatry, 163*(10), 1806-1812.

McElroy, S.L, Keck, P.E, Pope, H., Smith, J., & Strakowski, S. (1994). Compulsive buying: a report of 20 cases. *The Journal of Clinical Psychiatry, 55*(6), 242-248.

Mitchell, J.E., Burgard, M., Faber R., Crosby R.D., & de Zwaan, M. (2006). Cognitive behavioral therapy for compulsive buying disorder. *Behavior Research & Therapy, 44*(12), 1859-65.

Mueller, A., Arikian, A., de Zwaan, M., & Mitchell, J.E. (2012). Cognitive behavioural group therapy versus guided self-help for compulsive buying disorder: A preliminary study. *Clinical Psychology and Psychotherapy. doi: 10.1002/cpp.773.*

Mueller, A., Mueller, U., Silbermann, A., Reinecker, H., Bleich, S., Mitchell, J.E., & de Zwaan, M. (2008). A randomized, controlled trial of group cognitive-behavioral therapy for compulsive buying disorder: Post-treatment and 6-month follow-up results. *Journal of Clinical Psychiatry, 69*(7), 1131-1138.

Neuner, M., Raab, G., & Reisch, L. (2005). Compulsive buying in maturing consumer societies: an empirical re-inquiry. *Journal of Economic Psychology, 26*: 509-522.

Ridgway, N.M., Kukar-Kinney, M., & Monroe, K. (2008). An expanded conceptualization and a new measure of compulsive buying. *Journal of Consumer Research, 35*(4), 622-639.

Ethical and Legal Issues in Geriatric Psychiatry

By Rajesh R. Tampi, MD, MS, FAPA and Deena J. Tampi, MSN, MBA-HCA, RN
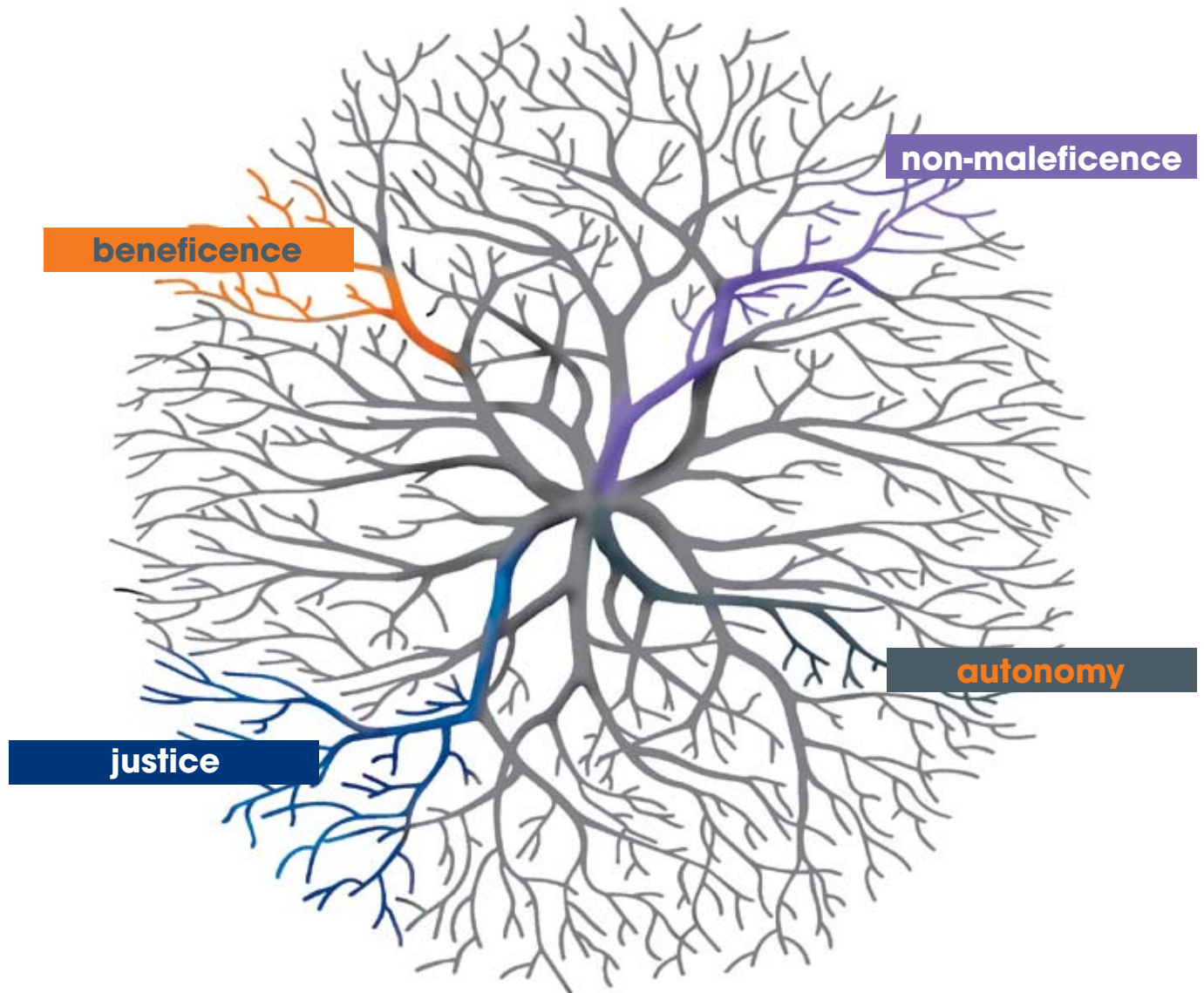
Introduction

The population of the United States is aging (Aging Statistics – Administration on Aging). Current data indicates that individuals aged ≥ 65 years constitute 12.9% of the population. By 2030, the number of those ≥ 65 years will increase to about 19% of the population or 72.1 million. Many of these older adults lose their independence and autonomy due to the presence of medical and psychiatric conditions rendering them vulnerable to exploitation and abuse.

There are many ethical and legal issues that the aging population faces. These issues include the struggle to maintain autonomy while preserving the individual's safety. Family dynamics, financial constraints and end of life issues add to the concerns for the older adults. In this review, we highlight the assessment of capacity in older adults and the process of dealing with individuals who lack capacity to care for themselves.

The four ethical principles that are important in healthcare are autonomy, beneficence, non-maleficence and justice (The Belmont Report|HHS.gov). In healthcare, autonomy defines an individual's ability to make informed healthcare decisions (Walaszek, 2009). The ability to provide informed consent depends upon the availability of relevant information, the

individual's capability to make a decision and the ability to make a free choice (Roberts, 2002). Age and gender do not appear to play a role in an individual's decisional capacity but ethnicity, culture and spirituality do influence one's decisional capacity (Walaszek, 2009; Moye & Marson, 2007). Older adults with mild cognitive impairment and dementias have impaired decisional capacity (Okonkwo et al., 2008; Huthwaite et al., 2006). Older adults with psychiatric disorders such as depression, psychotic disorders and substance use disorders may have impaired decisional capacity (Ganzini, Lee, Heintz, Bloom, & Fenn, 1994; Palmer, Dunn, Appelbaum, & Jeste, 2004).

Voluntarism describes an individual's ability to make free choices without coercion or manipulation from others (Roberts, 2002). Voluntarism is influenced by developmental factors, illness-related considerations, psychological issues, cultural and religious values and external pressures. Older adults who are subject to external pressures from families and caregivers are at risk of exploitation and abuse (Walaszek, 2009).

Older individuals with cognitive impairment, psychiatric and neurological disorders may not have the capacity to make specific healthcare or financial decisions; however, the presence of one or more of a particular type of disorder does not necessarily signify the lack of decisional capacity in an individual (Moye, Karel, Azar & Gurrera, 2004).

Capacity Evaluation vs. Competence Assessment
A capacity evaluation is distinct from the evaluation of an individual's overall competence to manage one's life. The competence assessment involves a formal judicial process (Walaszek, 2009). The capacity assessment is done via a clinical evaluation and it takes into account all other relevant information to determine the individual's capacity to make healthcare or financial decisions (Karlawish, 2008). Unfortunately, there is significant variability in the clinical practice of capacity assessments (Marson, McInturff, Hawkins, Bartolucci & Harrell, 1997). There is often a low level of agreement among the assessors of capacity. The level of agreement among the assessors can be improved by providing specific legal standards regarding the evidence needed to demonstrate the process of making a reasonable treatment choice, appreciating the consequences of the treatment choice made and providing rationale for a treatment choice (Marson, Earnst, Jamil, Bartolucci, & Harrell, 2000). Standardized cognitive assessment scales like the Folstein Mini Mental State Examination (MMSE) aid in the assessment of decisional capacity but using cut-off scores on these scales to determine decisional capacity is unhelpful (Kim, Karlawish & Caine, 2002; Kim & Caine, 2002).

Standardized tools developed for the assessment of capacity include the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), the Hopemont Capacity Assessment Interview (HCAI) and the Competency to Consent to Treatment Interview (CCTI) (Walaszek, 2009). The MacCAT-T is based on the individual's understanding of the actual clinical situation and the reasons for treatment choices. The HCAI and CCTI use hypothetical vignettes to assess an individual's decisional capacity. A study evaluating these three instruments in older adults indicated that there is fair agreement for overall capacity,

very good agreement for understanding, and very poor agreement for choice, but these instruments are rated no better than chance for reasoning and appreciation (Gurrera, Karel, Azar & Moye, 2007).

Assessment tools like the Kohlman Evaluation of Living Skills (KELS) provides clinicians with an objective measure of an individual's capacity to live safely and independently while identifying those individuals at risk for self-neglect (Pickens, Naik, Burnett, Kelly, Gleason & Dyer, 2007; Burnett, Dyer & Naik, 2009). The Assessment of Capacity for Everyday Decision-Making (ACED) is a reliable and valid measure to assess everyday decision-making capacity (Lai, Gill, Cooney, Bradley, Hawkins & Karlawish, 2008). The Financial Capacity Instrument (FCI) measures domain-level financial activities and task-specific financial abilities in older adults (Marson et al., 2000).

The Karlawish model for the capacity evaluation includes a series of questions to assess the older individual's ability to understand and appreciate the situation, make a choice and the reason for the choice (Karlawish, 2008). These answers are then rated as either being adequate or inadequate. These questions can be supplemented by standardized cognitive scales and capacity assessment tools. Based on the assessment of each decisional-ability with supporting data from the cognitive scales and the assessment tools, it is determined as to whether the individual has the capacity to consent to or to refuse a particular intervention. If the intervention that is being proposed or that is being refused has higher risk then the standard required to consent to or refuse treatment is also higher (Drane, 1984; Sprung & Winick, 1989).

When it is determined that an individual lacks decisional capacity, the next step is to identify potential etiologies for this incapacity (Walaszek, 2009). Those etiologies that are reversible must be managed appropriately. Strategies that have been shown to improve the individual's ability to provide informed consent include the use of verbal re-explanation, enhanced written consent procedures, slideshow presentations and the use of multimedia educational aids (Mittal et al., 2007; Jeste, Dunn, Folsom & Zisook, 2008).

Circumstances May Indicate Healthcare Proxy Needed
When the decisional capacity of an individual cannot be restored, a surrogate decision-maker (healthcare proxy) must be appointed (Walaszek, 2009). If there is a documented healthcare power-of-attorney, then these individuals will oversee the healthcare decision-making. If there is no appointed surrogate decision maker, then for emergency decision making, the spouse or adult children are considered as the surrogate decision-makers, until a legal representative is appointed (High, 1994). If there is no family involvement, then clinicians assume the responsibility of surrogate decision makers until a legal representative is appointed.

The surrogate decision makers operate on two standards; the best interest and the substituted judgment standard (Moore, Sparr, Sherman & Avery, 2003). In the best interest standard, the surrogate decision maker arrives at a decision based on what

> **Many of these older adults lose their independence and autonomy due to the presence of medical and psychiatric conditions rendering them vulnerable to exploitation and abuse.**

they perceive to be in the best interest of the individual. In the substituted judgment standard, the surrogate decision maker selects the decision based on what the individual would have made, if he or she had the capacity to make the decision. Despite best efforts, individual-designated and the next-of-kin surrogates correctly predict the individual's treatment preferences in only about two– thirds of the cases (Shalowitz, Garrett-Mayer & Wendler, 2006).

When an individual lacks the capacity to make health and other important life care decisions and there is no designated surrogate decision maker, then a guardian has to be appointed by the legal system (Moye & Naik, 2011). Limitation of guardianships includes the loss of privacy and autonomy for the individual, legal costs and the risk of early institutionalization.

Conclusion

Aging brings with it multiple ethical and legal issues that complicate the care of older adults especially those with significant medical and psychiatric illness. Pertinent issues like autonomy, decisional capacity and voluntarism are often complex in older individuals with multiple competing interests. When evaluating such issues, the clinician must keep in mind the competing interests and the acuity of the situation. Safety of the older individual should be the first priority. This is then followed by a careful assessment of the individual's needs and the needs of the family and caregivers. When appropriate, available legal mechanisms should be enlisted to provide safe and appropriate care for these individuals and to resolve ethical dilemmas, family conflicts and systems issues.▼

Dr. Rajesh R. Tampi *is an Associate Professor of Psychiatry at the University of Texas, San Antonio and an Associate Clinical Professor of Psychiatry at Yale University School of Medicine, New Haven, CT. He trained in psychiatry at the University of Leeds in England and the University of Vermont in Burlington. During residency training in England, he also attained a diploma in clinical psychiatry from the University in Leeds. He completed his Geriatric Psychiatry Fellowship at Yale University. Dr. Tampi was a recipient of the American Association for Geriatric Psychiatry, 2013-Clinician of the Year Award. He is also a recipient of the Geriatric Academic Career Award (GACA) instituted by the Department of Health and Human Services. Dr. Tampi also received three "Outstanding Teaching Attending Award" and the "Chairman's Award" for outstanding teaching, research, and clinical work from the Department of Psychiatry at Yale. Dr. Tampi is a chief editor for three books in psychiatry and serves on the editorial board of various peer reviewed national and international journals in psychiatry. He may be contacted at rajesh.tampi@yale.edu.*

Mrs. Deena J. Tampi *earned her nursing degree from the College of Mount Saint Vincent, Bronx, NY and a MBA at the University of Phoenix. She is currently the Executive Director of Behavioral Health Services at Saint Francis Hospital and Medical Center, Hartford, CT. Mrs. Tampi has multiple publications in the area of geriatric behavioral health. She has also presented on educational evidenced based topics ranging from behavioral health crisis prevention and management, falls prevention and nursing leadership. Mrs. Tampi is the winner of the 2013 Community Service Award instituted by the University of Phoenix and the 2010 Nightingale Award for Excellence in Nursing Leadership. She is the former chair for the Connecticut Hospital Associations Mental Health Chapter. She may be contacted at dtampi@stfranciscare.org.*

References:

Aging Statistics – Administration on Aging. (2014). Retrieved May 14, 2014, from http://www.aoa.gov/Aging_Statistics/

The Belmont Report | HHS.gov. (1979). Retrieved May 14, 2014, from http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html.

Burnett, J., Dyer, C.B., & Naik, A.D. (2009). Convergent validation of the Kohlman Evaluation of Living Skills as a screening tool of older adults' ability to live safely and independently in the community. *Archives of Physical Medicine and Rehabilitation, 90*(11), 1948-1952.

Drane, J.F. (1984). Competency to give an informed consent. A model for making clinical assessments. *The Journal of American Medical Association, 252*(7), 925-927.

Ganzini, L., Lee, M.A., Heintz, R.T., Bloom, J.D., & Fenn, D.S. (1994). The effect of depression treatment on elderly patients' preferences for life-sustaining medical therapy. *The American Journal of Psychiatry, 151*(11), 1631-1636.

Gurrera, R.J., Karel, M.J., Azar, A.R., & Moye, J. (2007). Agreement between instruments for rating treatment decisional capacity. *The American Journal of Geriatric Psychiatry, 15*(2), 168-173.

High, D.M. (1994). Surrogate decision making. Who will make decisions for me when I can't? *Clinics in Geriatric Medicine, 10*(3), 445-462.

Huthwaite, J.S., Martin R.C., Griffith, H.R., Anderson, B., Harrell, L.E., & Marson, D.C. (2006). Declining medical decision-making capacity in mild AD: a two-year longitudinal study. *Behavioral Sciences and the Law, 24*(4), 453-463.

Jeste, D.V., Dunn, L.B., Folsom, D.P., Zisook, D. (2008). Multimedia educational aids for improving consumer knowledge about illness management and treatment decisions: a review of randomized controlled trials. *Journal of Psychiatric Research, 42*(1), 1-21.

Karlawish, J. (2008). Measuring decision-making capacity in cognitively impaired individuals. *Neurosignals, 16*(1), 91-98.

Kim, S.Y., Karlawish, J.H., & Caine, E.D. (2002). Current state of research on decision-making competence of cognitively impaired elderly persons. *The American Journal of Geriatric Psychiatry, 10*(2), 151-165.

Kim, S.Y., & Caine, E.D. (2002). Utility and limits of the mini mental state examination in evaluating consent capacity in Alzheimer's disease. *Psychiatric Services, 53*(10), 1322-1324.

Lai, J.M., Gill, T.M., Cooney, L.M., Bradley, E.H., Hawkins, K.A., & Karlawish, J.H. (2008). Everyday decision-making ability in older persons with cognitive impairment. *The American Journal of Geriatric Psychiatry, 16*(8), 693-696.

Marson, D.C., McInturff, B., Hawkins, L., Bartolucci, A., Harrell, L.E. (1997). Consistency of physician judgments of capacity to consent in mild Alzheimer's disease. *Journal of the American Geriatrics Society, 45*(4), 453-457.

Marson, D.C., Sawrie, S.M., Snyder, S., McInturff, B., Stalvey, T., Boothe, A., ... & Harrell, L.E. (2000). Assessing financial capacity in patients with Alzheimer disease: A conceptual model and prototype instrument. *Archives of Neurology, 57*(6), 877-884.

Marson, D.C., Earnst, K.S., Jamil, F., Bartolucci, A., & Harrell, L.E. (2000). Consistency of physicians' legal standard and personal judgments of competency in patients with Alzheimer's disease. *Journal of the American Geriatrics Society, 48*(8) 911-918.

Mittal, D., Palmer, B.W., Dunn, L.B., Landes, R., Ghormley, C., Beck, C., ... & Jeste, D.V. (2007). Comparison of two enhanced consent procedures for patients with mild Alzheimer disease or mild cognitive impairment. *The American Journal of Geriatric Psychiatry, 15*(2), 163-167.

Moore, C.D., Sparr, J., Sherman, S., & Avery, L. (2003). Surrogate decision-making: judgment standard preferences of older adults. *Social Work in Health Care, 37*(2), 1-16.

Moye, J., Karel, M.J., Azar, A.R., & Gurrera, R.J. (2004). Capacity to consent to treatment: empirical comparison of three instruments in older adults with and without dementia. *Gerontologist, 44*(2), 166-175.

Moye, J., & Marson, D.C. (2007). Assessment of decision-making capacity in older adults: an emerging area of practice and research. *The Journals of Gerontology Series B Psychological Sciences and Social Sciences, 62*(1), 3-11.

Moye, J., & Naik, A.D. (2011). Preserving rights for individuals facing guardianship. *The Journal of American Medical Association, 305*(9), 936-937.

Okonkwo, O.C., Griffith, H.R., Copeland, J.N., Belue, K., Lanza, S., Zamrini, E.Y., ... & Marson, D.C. (2008). Medical decision-making capacity in mild cognitive impairment: a 3-year longitudinal study. *Neurology, 71*(19), 1474-1480.

Palmer, B.W., Dunn, L.B., Appelbaum, P.S., & Jeste, D.V. (2004). Correlates of treatment-related decision-making capacity among middle-aged and older patients with schizophrenia. *Archives of General Psychiatry, 61*(3), 230-236.

Pickens, S., Naik, A.D., Burnett, J., Kelly, P.A., Gleason, M., & Dyer, C.B. (2007). The utility of the Kohlman Evaluation of Living Skills test is associated with substantiated cases of elder self-neglect. *Journal of the American Academy of Nurse Practitioners, 19*(3), 137-142.

Roberts, L.W. (2002). Informed consent and the capacity for voluntarism. *American Journal of Psychiatry, 159*(5), 705-712.

Shalowitz, D.I., Garrett-Mayer, E., & Wendler, D. (2006). The accuracy of surrogate decision makers: a systematic review. *Archives of Internal Medicine, 166*(5), 493-497.

Sprung, C.L., & Winick, B.J. (1989). Informed consent in theory and practice: legal and medical perspectives on the informed consent doctrine and a proposed reconceptualization. *Critical Care Medicine, 17*(12), 1346-1354.

Walaszek, A. (2009). Clinical ethics issues in geriatric psychiatry. *Psychiatric Clinics of North America, 32*(2), 343-359.

Because She Matters

By Nancy Todd, MA

•••• Leaving the Life

Many recovering addicts supported their drug habits with sex work. Whether they traded sex for drugs, stripped, acted in the porn industry or worked the streets, the resulting damage is often the same—posttraumatic stress disorder (PTSD) and lifelong emotional distress. There is a life after leaving the sex industry, however. With help in exiting and reframing their experiences, many former sex workers lead productive, joyful lives.

The Slide Into Sex Work

Not every sex worker comes from a classically broken family. How does a young person go from an apparently happy home to life as a sex worker? Many sex workers come from a seemingly normal family—still-married parents, brothers, and sisters, even an upper-middle class upbringing. Heidi Fleiss is an example. Although her parents divorced, her father, a pediatrician, remained a strong, codependent force in her life. No one becomes a sex worker in a vacuum.

Even without physical abuse, many former sex workers describe a childhood of profound emotional neglect, abandonment and emotional abuse. Study after study finds that most sex workers were molested as children. These emotional and sexual abuses set the stage for a search for bonding often met after a runaway meets a pimp at a bus station or finds a father figure in an older man. They ultimately use that young girl's neediness to exploit her.

Sex work does not always begin with an act of prostitution. Entry into sex work may begin as a psychological game called "grooming." Here a pimp systematically brainwashes a young girl into surrendering her power to him.

In the event you believe we can blame pimps for everything bad that happens to women in the sex industry, a fascinating study by De Paul College of Law in Chicago highlights the brutal truth of the 25 pimps surveyed. Fully 88% of the respondent pimps suffered physical abuse as children and 76% suffered childhood sexual assault. Victims frequently become victimizers. It takes hard work to escape the pattern of abuse from one generation to the next.

Drugs—A Gateway or a Savior

Women may begin prostituting or stripping to pay for their drug habits or start using drugs after they enter the sex industry to numb the feelings associated with the dehumanizing status of the prostitute. No matter the reason for the drug abuse, the sex worker must address her substance abuse if she is to leave the industry successfully.

More than one recovering sex worker believes that drugs may have saved her life. What she means is that her life as a sex worker was so painful, if she had not had drugs to medicate the feelings, she may have chosen suicide.

The therapist must address the drug or alcohol component before most sex workers will seriously consider leaving the industry.

So I'm Clean—Now What?

We know that discontinuing drug use and quitting prostitution may not occur simultaneously. While many men and women come into a Twelve Step program and immediately stop their lives of crime, it may not be so straightforward with sex work.

A talented stripper or escort can make more than $1,000 a night. To ask a sex worker with few job skills and perhaps a criminal record to work for minimum wage may be unrealistic. Many women stop using drugs yet continue to turn tricks or strip. They may attend meetings and believe that everything is fine in their double lives. Eventually, though, their secret becomes toxic and they must reach out for help. This is where we can help. How can we best support women trying to exit the sex industry?

Just like some addicts who relapse repeatedly before they finally surrender their addiction, sex workers often keep "regulars" or strip part-time as they go to college or learn new job skills. Our role as counselors and sponsors is to listen and remain nonjudgmental. What these men and women who are grappling with their livelihood need is very often simply a listening ear.

Over time, as sex workers stay clean and begin to experience a new spiritual paradigm, they work hard to build a new career. They must consider, however, how their new life will look and this is where we can help.

The Sex Work Exit Cycle

Stopping the use of drugs may occur quite suddenly. The addict may overdose. An arrest and referral to treatment may take place. Perhaps the family intervenes successfully. With sex workers, stopping their profession is not always so simple. We know that exiting the industry often occurs like this model.

SUCCESS

EXIT ATTEMPT

RELAPSE INTO OLD BEHAVIOR

EXIT ATTEMPT

RELAPSE INTO OLD BEHAVIOR

EXIT ATTEMPT

In her seminal work on exit roles, Helen Rose Fuchs Ebaugh describes a clear exit cycle (Ebaugh, 1988). This exit cycle includes this pattern:

- The sex worker experiences periods of extreme doubt about her role as a sex worker.
- She begins to seek alternatives to life as a sex worker.
- A turning point—the proverbial straw that breaks the camel's back. This may be an event like an arrest, beating, rape or perhaps the birth of a child.
- Finally, the sex worker creates a new identity after she finds a clear exit path.

The pattern, according to Ebaugh, looks much like this model.
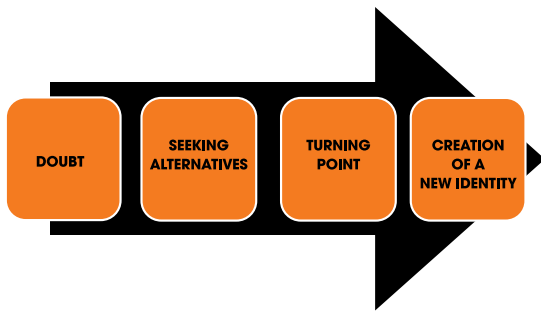
Other researchers in substance abuse exit using Ebaugh's model found that any negative influences at any stage of this exit cycle might delay this exit by as much as six years. We know that with the violence surrounding sex work, these women may not have six years. Positive reinforcement is critical for this cohort. Our best method of approach is to make use of those crises—those turning points—to provide a clear message that there is a life beyond the sex industry.

How Can We Best Support Former Sex Workers?

First, we can be that non-judging friend or therapist who listens, refraining from offering advice. This means we must work our own codependency program to be truly effective. As we listen to the sex worker recount the insanity associated with her life in the industry—the violence, the drug use and the chaos *(which may be important catalysts driving her further toward recovery)*—it may be hard for us to refrain from offering suggestions. However, if the sex worker is even considering leaving the industry, she is working through the issues and usually only seeking emotional support as she considers her choices. *Processing her feelings in a safe and supportive atmosphere is imperative for the sex worker who is trying to exit the industry and to reframe and make sense of her experiences.*

Next, several Twelve Step programs can help. Once the woman interrupts her addiction to drugs or alcohol, referral to an Adult Child of Alcoholic/Dysfunctional Parents meeting may help the recovering sex worker deal more effectively with the pain of his or her childhood. There is tremendous shame in our society associated with sex work. Former sex workers carry that burden of shame and secrecy. Pointing the sex worker to the childhood origins of her pain can help her understand that she was a victim, not a terrible person.

Finally, former sex workers usually need ongoing counseling or emotional support. Most sex workers suffer from severe posttraumatic stress disorder. Melissa Farley, PhD, (1998)

director of the Prostitution Research and Education in San Francisco, performed the first study in 1998 of PTSD in prostitutes. Her study revealed that ongoing physical and sexual assault in this cohort created a high level of PTSD. Sixty-seven percent of the sex workers she interviewed met the criteria for a PTSD diagnosis. The level of PTSD in her sample was actually higher than for a sample of Vietnam veterans.

The first time someone acknowledges the level of fear and horror the sex worker often experiences during her time in the sex industry may be a turning point in her recovery.

Career Planning an Important Part of the Recovery Process

Many sex workers despair of finding a career. That they will always work at menial jobs is the believable lie. Help with building job skills or with obtaining an education helps sex workers build self-confidence. The skills these women used to survive in the industry and on the streets are beneficial in today's business world. Many former sex workers go on to become highly successful investigators, counselors, healers, writers and even an architect, to list but a few professions where we have watched them excel.

Early in the career planning process, the sex worker should explore if she wants to work in a profession where she must deny her past. If she chooses to work in traditional industries like banking, retail or manufacturing, she may feel she lives a double life because she cannot reveal her history. If she decides to work in a helping profession, she may sacrifice income for the freedom to speak her truth. Making this choice early in her career planning can make the difference between finding her true path and merely existing in a corporate environment where she may always live in fear of exposure.

A Life After Sex Work

Several support groups can help sex workers reframe and reintegrate their experiences. Talking with other survivors is vital for women exiting the life. Others who have been down the sex work road will acknowledge the residual feelings from sex work—the trauma, the shame—and give the former sex worker a safe place to discuss current fears and difficulties of reintegrating to a life without sex work.

Sex Workers Anonymous (formerly Prostitutes Anonymous) helps support women in their exit. A support group, *Because She Matters*, helps sex workers reframe and make sense of their experiences. Family members of sex workers are also welcome to discuss the impact their loved ones' choices have on their lives.

It is critical that former sex workers find other successful survivors of the sex industry to begin the healing and to provide ongoing support. With support, life improves.▼

Nancy Todd *is the founder of Because She Matters, a support group that offers hope to sex workers and their families. Reach Nancy via her blog at http://www. becauseshematters.blogspot.com or at becauseshematters@gmail.com.*

References:

Ebaugh, H. (1988). *Becoming an ex: The process of role exit.* Chicago: University of Chicago.

Barkan, H; Farley, M. (1998). *Prostitution, violence and posttraumatic stress disorder.* Retrieved 4/16/14 from Prostitution, Research and Education website: http://prostitutionresearch.com/1998/03/17/prostitution-violence-and-post-traumatic-stress-disorder/

UTILIZING MI in a Cocaine Group in a Methadone Clinic

A Brief Analysis of Practical Cocaine Group-Based Interventions

By Thomas E. Broffman, PhD, LICSW, LCDP, LCDS and Brian P. Crockett, MA, LADC1

Introduction

This article describes an adaption of the evidenced-based practice of motivational interviewing (MI) to group format by integrating MI and core group therapy concepts into coherent MI groups to assist opiate addicts deal with co-occurring cocaine addiction. Motivational interviewing has been developed as a client-centered, goal-oriented, individual therapeutic approach and focuses on client perspectives rather than framing issues from only a professional viewpoint. Practitioners avoid directing clients toward specific solutions. Instead they evoke clients' own interests in change and steer the conversation toward commitment to specific actions that lead toward clients' change goals, using the spirit of motivational interviewing—autonomy, collaboration and evocation.

What is Motivational Interviewing?

Motivational interviewing is an evidence-based psychotherapeutic method that is relatively brief, specifiable, and applicable across a wide variety of problem areas, complementary to other active treatment methods, and learnable by a broad range of helping professionals (Miller & Rose, 2009). MI is a collaborative, client-centered counseling style aimed at eliciting and strengthening clients' intrinsic motivation to change. There is strong evidence supporting the efficacy of MI, notably in its application among people with alcohol and drug use disorders (Forsberg, Forsberg, Lindqvist & Helgason, 2010).

Rollnick and Miller (Miller & Rose, 2009) emphasized that MI is not a set of specific techniques but a skilled style of counseling that requires careful training. Conceptually, MI works through therapists' efforts to interact with clients in a style that is collaborative, supportive of client autonomy and self-efficacy, and that elicits client "change talk," namely statements that indicate a client's movement toward behavior change. These components embody the "spirit" of MI delivery. Therapists use what Miller and Rollnick referred to as "micro-skills" (open-ended questions, affirmations and reflections delivered with MI spirit), and advanced skills (methods for evoking change talk and handling client resistance), and they avoid strategies such as unsolicited advice or direct confrontation, in order to increase client motivation for change during the session (Martino, 2008). Clients' outcomes after substance abuse treatment vary widely, depending on the therapist to whom they were assigned (Carroll et al, 2006).

Cocaine Addiction Among Opiate Addicts

Addictive diseases, including addiction to heroin, prescription opioids, or cocaine, pose massive personal and public health costs. Heroin and prescription opioids, such as oxycodone or hydrocodone (e.g., OxyContin and Vicodin, respectively) act primarily as agonists with relatively short duration of action, whereas cocaine (and other stimulants, e.g., methamphetamine) act primarily to increase synaptic dopamine by inhibition of dopamine reuptake or an increase in release. Cocaine has become a major drug of abuse among the general population and among opiate addicts. Cocaine abuse is reported at about 17% of opiate addicts seeking treatment and by seven to 11% of ex-addicts on methadone maintenance. Concurrent cocaine dependence (CD) among poly-substance abusers has been associated with negative consequences, although it may not necessarily lead to poor treatment outcomes. One of the most efficacious treatments for cocaine abuse is MI, but little

research has explored the impact of CD on abstinence outcomes, particularly among patients in methadone maintenance. Based on these associations, we offer several guidelines for treating cocaine abuse in opiate addicts.

Cocaine Use at a Methadone Clinic
People aren't at a methadone clinic for cocaine treatment; they are there for opiate treatment! This may be true, but there is no denying that many patients have not been terribly selective with which substance they have chosen to use. A patient's substance use may have ultimately led to heroin but often the patient used cocaine first. The heroin use may have stopped and the cocaine use has resumed, or continued in some cases.

CARE Groups
Cocaine intervention groups are called CARE groups, (Cocaine Awareness and Relapse Education) and in the context of this group there was a significant level of immediate change made on the patients' part. Patients suffer the withdrawal symptoms and aftereffects of their cocaine use in a way that is often impossible concerning opiates because of the medicating and blocking nature of methadone. When patients experience these withdrawal symptoms, and are not shielded from the potential consequences, they often perceive the need to change. There is, quite frankly, little room to hide.

A CARE group functioning for 16-18 months in Taunton, MA, demonstrated a success rate of approximately 58%. A success rate of just over half may not seem like much but without any intervention, the success rate of patients quitting on their own may very well be zero. More than one out of two patients who were referred to this group were able to refrain from cocaine use, create boundaries to prevent future use, and continue methadone treatment without jeopardizing it by continued cocaine use.

What this article endeavors to share are some observations about practices that may have contributed to the success rate of this group. First, motivational interviewing has been effective in prompting patients to quit their cocaine use, combined with a Cognitive-Behavioral approach concerning analysis of any relapses that occur. This approach seeks to maximize engagement in the recovery process, empower patients to make healthy changes, and resolve patterns of substance abuse. While this experience occurred in the setting of an outpatient methadone clinic, the principles contained herein would be effective in any modality.

Group Fundamentals: (CARE)
CARE group focuses on providing a group-based, clinical intervention to help patients reduce and ultimately end their cocaine use. Given these fundamentals, every discussion and activity done in the group setting should be geared towards promoting and encouraging the following three values:

Autonomy
Ultimately, patients become fully autonomous without needing to rely on anything to get them through the day. It is the clinician's job to help patients build a sense of self-efficacy and the surest way to do that is to never enable. Enabling patients does not create autonomy; it creates dependency on service providers. For example, if a patient misses a group and does not provide the required documentation and 24 hours notice they are marked with a no-show group in their case history. Building autonomy in patients means allowing the chips, in the patient's life, to fall as the patient allows them to fall. Building autonomy also means helping patients to pick up the pieces afterward to learn the positive and negative consequences from their choices.

Respect
The desire to prompt autonomy begins by respecting the patients as people and wanting to see them change and grow for the better. Respect is conveyed by allowing patients to be autonomous and is displayed whenever we affirm a patient's right to decide or ask if we may offer feedback before actually doing so. Respect also means that clinicians recognize that their goals and a patient's goals might not be the same and forces us to be accepting of that. If clinicians seek patients' autonomy then it becomes much easier to be respectful towards them.

Empower
When clinicians refrain from enabling patients, display respect for their decisions and affirm their self-efficacy, they begin to empower patients to choose for themselves and break a sense of dependency upon others and, more importantly, any substance. When clinicians empower patients they are helping patients discover a new level of personal freedom to choose without nagging or coercing the desired behavior. Patients are allowed to choose positive behavior for themselves and enjoy the related benefits.

An Invitation—Engagement
Group is impacted by many different factors. At its most basic level, group is affected by the people that comprise the group. Rather than waiting for patients to be mandated into a cocaine group for reasons of treatment compliance, offer it as an intervention to those patients who are using cocaine but who have not yet been required to attend. In so doing the patient is offered a useful intervention that prompts self-efficacy through respecting the patient's decision regardless of what that decision is.

A person who accepts the offer to make use of a cocaine intervention group will bring his or her motivation into the group setting where it can act upon other group members to potentially help motivate them as well. Group members can draw a tremendous amount of strength, motivation and confidence from one another's successes, struggles and even failures.

If the person declines, clinicians can simply respect their decision by affirming their autonomy and other commitments that may make such group attendance seem impossible or a hardship to the patient at this time. In so doing the clinician builds and maintains rapport while at the same time allowing them to experience the consequence of their actions. If, for example, someone who declines the invitation is later required to go, it is incumbent upon the clinician not to take the "I told you so" road with that patient. The patient was allowed to choose (not to attend group), that decision has had an impact upon behavior (continued cocaine use which has mandated a cocaine group),

There is strong evidence supporting the efficacy of MI, notably in its application among people with alcohol and drug use disorders.

and now the patient must work through those consequences (by coming to terms with inability to stop cocaine use). Such a response respects the patient's autonomy and provides good clinical services without enabling the patient.

The fact that this service was offered, which was initially declined, and the patient's inability to change the habit of cocaine use, which now requires this intervention, is also informative to the patient. It prompts the patient to learn from the choice made to ignore an offer of assistance before assistance became required and may allow the patient to begin to connect early intervention with treatment effectiveness and better overall recovery.

Once the patient is in a cocaine cessation group, it is important to review the criteria for completing group. In this setting the criteria was for a patient to refrain from cocaine use for 60 days as attested to by drug tests, at which point the patient was released from the obligation to attend. If a relapse occurs, the 60 days begins again. Once the 60 days are over patients are allowed to choose to remain in the group for an additional 60 days for continued support in cocaine prevention after which they may no longer attend. However, the additional 60 days is treated as a requirement once the patient has agreed to it. In a group that promotes autonomy, respect and empowerment, more people will volunteer to stay for the additional 60 days than one might otherwise think. If a patient declines, allow the choice but also allow re-entry upon request. In so doing the clinician is rewarding a patient who is attempting to prevent use before it begins and that is a picture of a powerful and mindful recovery.

Other criteria to mention and review for new and established group members is how the group functions. Clinicians inform group members that the group will discuss how long patients have been able to abstain from cocaine, discuss relapses that occur to help patients overcome these circumstances, encourage patients who have remained cocaine free and identify what has helped to sustain the abstinence. Being frank and honest with patients sets a tone that encourages patients to act in a similar fashion. Clinicians need to model the behavior they want group members to follow.

The Session
It is important to help people feel at ease in a group treatment setting, as it is quite likely to trigger various struggles with anxiety, social phobias, and unlearned social cues. Encourage the patients to introduce themselves to a newcomer and invite the newcomer to do so as well. Thank the patients for attending even if they are mandated to attend. This extends understanding that it can be frustrating to be told what to do and helps to build rapport. Furthermore, thanking the patient acknowledges that patients still made a choice to be present which is proven simply by the fact that some who are required to attend will still not attend, and they have clearly made a choice also.

It can be helpful to review with patients that this approach to the group has seen an approximate 58% rate of successful completion. This helps empower patients with a sense of hope that making change is, indeed, possible. If there are several newer group members the clinician also reviews with them what they already know about how cocaine impacts the brain, body, and methadone dose along with other medications.

If group ended last week with an unfinished conversation, summarize it and continue the discussion. If not the clinician has two other options: ask a newer group member to share with the group his or her relationship with cocaine or ask a more established group member how long it has been since he or she last used cocaine.

The first question, open-ended as it is, allows the patient to fill in the gaps and begin to reflect upon a cocaine habit. Many patients will begin to identify triggers when asked this question even during the first session. If someone struggles with answering the question feel free to clarify. Some examples might be: "Tell me what you have noticed about your cocaine use," or "What do you get out of cocaine?"

It is worth noting that to some clinicians and even to many patients the answer to what someone "gets" out of using cocaine is painfully straightforward: "the rush" or "to get high." Due to cocaine being a stimulant, and the patient enjoying the rush, the patient has just shared something very important with us: that he often feels down to the extent that he perceives a strong need for a powerful and immediate high. Clinicians can reflect this to patients: "Sounds like you struggle with being down quite a bit if you feel the need for that intense, immediate change. What's going on that leads you to feel so down so frequently?"

Other patients may very well chime in at this point, being able to identify with similar feelings or struggles themselves, and possibly having some success in overcoming them. Encourage this type of sharing through thanking sharing members, reflective listening and affirmation of the courage it takes to share in a group setting. Very often the patients know more about the reality of drug use than the clinicians do and that is liberating. In a sense it is not the clinician's job to be the expert on every person in the room, the expert on drugs, or the expert on anything. Rather it is the clinician's job to prompt patients to learn about those behaviors that bring about cocaine use in order to empower patients to change these behaviors.

Being free from the expert role also takes a tremendous amount of stress from the clinician who can then focus on the good but often difficult work of provoking change. This requires clinicians to actually listen to the patients and not presume to know what they are thinking or feeling. Even if the clinician does know, if the patient does not understand, then leading them by the nose

and dictating or prescribing changes is not helpful in the long-term. Even if the patient is compliant, the clinician has begun to make the patient dependent upon the service provider.

When discussing the amount of abstinence a patient has acquired, it is vitally important to affirm whatever is said regardless of the answer. If a patient shares that she used earlier that same day, it is important to affirm and appreciate that person's honesty and courage to share that information with a room full of virtual strangers. If a patient has managed to remain cocaine abstinent for 10 days it is just as important to affirm the changes she has begun to make.

The person who is struggling needs affirmation to feel comfortable in the group setting and help to resolve the sense of guilt and shame that inevitably accompanies substance abuse. Helping to free a patient from crippling shame is important because it's a powerful trigger for many people. Similarly, having affirmed this patient, it is important to ask what brought about the cocaine use in order to help the patient begin to understand what preceded the relapse, what could have been done differently, and what the patient has learned from the experience. It is just as important to help the patient identify what can be done differently or what changes the patient can begin to make today to prevent future cocaine use.

The other patient, the one who is putting together significant amounts of sobriety time, also requires just as much affirmation in having victory over something that may very well feel unbeatable. Very often clinicians work with struggling people who are bereft of any encouragement or self-esteem. Anything that can be done to help them receive and internalize positive thoughts for being sober is vitally important. Ask these patients what changes they have made, how they made them, what is difficult about sustaining them, and what it is like to be having victory over cocaine use. Such a line of discussion promotes patient insight but newer group members, or relapsed members, will also be served well.

Another activity that has proven to be helpful is to rehearse drug refusal skills. In practice, the clinician should first get consent from group members. The activity revolves around a patient asking the patient to the left (or right) if they want to use as one would typically ask outside the treatment center. The patient being asked then practices saying "no" and turning down the offer by using various reasons, excuses, etc. The usefulness in this exercise is to give patients the opportunity to actually refuse a substance offered, an experience that many patients have never had since they began using.

The potential danger is that the exercise will trigger someone, which is why the clinician should procure permission first. It is incumbent upon the clinician to be very mindful of patients' affect and body language to indicate if someone is being triggered, along with asking patients if this is the case. In the event that a patient is triggered, thought-changing exercises help to alter the course of thinking and safely navigate the craving. Using thoughts of things important to the patient seem to prove most useful; for example asking a patient about a favorite memory with a child or other loved family member or friend, or about a favorite relaxation spot, vacation spot, hobby or activity, etc. to help the patient get beyond the craving. In

so doing, the clinician also demonstrates how one successfully navigates cravings outside the treatment center. Practicing such an exercise during the first session is not recommended, as patients are still becoming comfortable with one another and the clinician.

Finally, it is very helpful and healthy to allow brief breaks from the conversation at hand. Such moments allow patients to refresh themselves, as good counseling can be exhausting for both clinician and patient. Such tangential conversations also allow a look into a patient's thought processes and can be very helpful when observed and reflected to the patient, with respect. Furthermore, such tangents may also help illustrate associations in the patient's mind or allow the clinician to identify depressive, anxious or otherwise distorted thought processes and also relate back to how such thoughts impact cocaine use.

Conclusion
We believe a MI group has something to offer to each of these clients experiencing a therapeutic impasse. The MI combination of client-centered attitudes and goal-oriented processes can help establish momentum toward positive change, while avoiding some of the pitfalls of becoming overly directive or nondirective when leading a group. While MI can help these groups avoid or move past their therapeutic impasses, no approach can eliminate every challenge or obstacle. Some impasses and conflicts perhaps shouldn't be eliminated even if it were possible, because they can lead to transforming a set of individuals into a more meaningful, cohesive working group. During these transformative moments, many group members find their voices and increase ownership of their own lives and recovery.▼

Dr. Thomas E. Broffman *is an Assistant Professor in the BSW program at Eastern Connecticut State University. He has a BSW and a MSW from the University of Pittsburgh and a PhD from Boston College, Graduate School of Social Work, where he wrote the doctoral dissertation* Gender Differences in MH & SA Disorders as Predictors of Gambling Disorders. *Broffman is a Chemical Dependency Consultant for the Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals at Eleanor Slater Hospital in Cranston, RI, and a regionally known MI trainer and consultant. In 2006 Broffman was named Social Worker of the Year in Addictions by the Rhode Island Chapter of the National Association of Social Workers. He can be contacted at broffmant@easternct.edu.*

Brian P. Crockett *is the Clinical Supervisor for New England Aftercare Ministries' Bridge House Program located in Framingham, MA. His current work is focused on systemically adding elements of Motivational Interviewing into residential substance abuse treatment. Crockett has a BA from the University of Massachusetts at Amherst and a MA from Gordon-Conwell Theological Seminary. He attained his LADC1 from the Massachusetts Bureau of Substance Abuse Services in 2010 and has worked in residential, outpatient and medically managed substance abuse treatment facilities. He can be contacted at brianc@thebridgehouse.org.*

References:

Carroll, K.M., Ball, S.A., Nich, C., Frankforter, T.L, Farentinos, C., Kunkel, L.E., ... & Woody, G.E. for the National Institute on Drug Abuse Clinical Trials Network (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: a multisite effectiveness study. *Drug and Alcohol Dependence, 81*(3), 301-12.

Forsberg, L., Forsberg, L., Lindqvist, H., & Helgason, A. (2010). Clinician acquisition and retention of motivational interviewing skills: A two-and-a-half-year exploratory study. *Substance Abuse Treatment, Prevention and Policy, 5*(8), 1-14.

Martino, S. (2010). Strategies for training counselors in evidence-based treatments. *Addiction Science & Clinical Practice, 30*(12), 30-39.

Miller, W., & Rose, G. (2009). Toward a theory of motivational interviewing. *American Psychologist, 64*(6), 527-537.

By Michael G. Bricker, MS, CADC-2, LPC

WHEN TIME DOESN'T HEAL ALL WOUNDS

ADVERSE CHILDHOOD EXPERIENCES AND BEHAVIORAL HEALTH

An emerging issue in the healthcare field concerns the impact of "Adverse Childhood Experiences" (ACE) on chronic health problems and early mortality. Based on research from Kaiser Permanente and the Centers for Disease Control and Prevention (CDC), there appears to be a linear correlation between nine specific traumatic events and increased incidence of heart disease, diabetes, early onset drinking, high-risk sex, and other risk factors for early death.

The Adverse Childhood Experiences survey was conducted by Kaiser Permanente, and perused the childhood experiences of over 17,000 adult HMO patients seeking routine medical services (Felitti, 2004). These patients were over 50 years old, and not seeking behavioral health treatment, but were dealing with medical challenges such as diabetes, chronic obstructive pulmonary disease (COPD), and obesity. The impetus for the study was the observation that, when patients in the obesity program began successfully losing weight, a large proportion of them inexplicably dropped out of treatment. This phenomenon is familiar to any addiction counselor who has watched their client "snatch defeat from the jaws of victory."

Felitti and his colleagues came to the realization that obviously destructive adult medical conditions can be understood as maladaptive efforts to manage childhood trauma. Again, no surprise to any mental health clinician. What is unique—and promising—is the discovery of an almost linear progression between the childhood "trauma dose" and adult addictions to alcohol, nicotine and IV drugs as well as other chronic disease processes.

The ACEs Survey adapted by the author examines 10 categories of childhood experiences: emotional, physical and sexual abuse, emotional and physical neglect, substance abuse or mental illness in the home, parental violence, incarceration of a household member, and both biological parents not being present. Each category is scored "1" if present or "0" if absent before age 12. The working hypothesis for this age cut-off is that children lack both the cognitive and developmental coping skills to reframe and deal with traumatic experiences, leaving them more vulnerable to the trauma

response. The simple scoring method results in a "trauma load" of zero to ten. This version of the ACEs Survey also examines the client's assessment of the current impact of the trauma: lifetime hospitalizations, suicide attempts, treatment for mental health and substance use disorders.

Questionnaire Results as Conversation-Starter

So how does this inform our treatment? Clearly we can't go back and provide corrective childhood experiences for adult clients. Bruce Johnson, LCSW has been using the ACEs Survey with his clients at the Crisis Respite Center of the Yukon-Kuskokwim Health Corporation in Bethel, AK. A recent two-month sample of 13 intakes revealed an average ACEs score of 4.6. Five respondents had scores of 5 or above, and three clients endorsed 9 ACEs. Johnson is investigating the correlation between ACE score and re-admissions to emergency psychiatric care. "The main value of the questionnaire is to open a conversation with the client—helping them see there are reasons for the subconscious responses they make today based on what happened long ago," Johnson explains. It tends to normalize an abnormal experience when the client realizes that they aren't the only person these things have happened to—indeed, they are tragically common.

Mary Johnson, Coordinator of the Suicide Prevention Program for YKHC, has found similar results in a voluntary sample of community members attending an open workshop on Healthy Parenting. Of 45 respondents, 69% had an ACE score of at least 4, and 40% reported a 7 or higher. The most common ACEs: growing up with a substance abuser (76%), living with someone who was mentally ill or attempted suicide (67%), a family member who went to prison (64%), and emotional abuse (60%).

A more recent sample from MH Screenings of referrals to the Lutheran Community Services Drug Court Program reveals a similar profile. Most of the referrals to the program are for methamphetamine-related disorders; some of the clients are from third-generation meth impacted family system, i.e. both the client's parent(s) and grandparent(s) were involved with meth. The author is in the process of analyzing two years' worth of data; initial review indicates an average ACE trauma score of 5.1 for 62 respondents. There is a high incidence of emotional and physical neglect, domestic violence and sexual abuse in this sample.

> " CLINICIANS KNOW HOW INTRACTABLE THESE TRAUMA EFFECTS CAN BE—PERHAPS BECAUSE WE HAVE BEEN USING PSYCHOLOGICAL TOOLS TO FIX A PHYSIOLOGICAL PROBLEM. "

Selecting Appropriate Tools to Regulate Response

What treatment interventions might be helpful in dealing with ACEs? Current research is focused on the hypothesis that repeated trauma somehow resets the baseline of autonomic arousal in the developing central nervous system (ANS). The earlier—and more frequently—this happens, the more robust and long-lasting this ANS hyper-arousal becomes. It's like having your foot on the gas all the time, and working the clutch and brake with your other foot—a rough and bumpy ride that will prematurely wear out your engine, clutch and brake…and probably cause some accidents along the way!

Clinicians know how intractable these trauma effects can be—perhaps because we have been using *psychological* tools to fix a *physiological* problem. Insight alone can do little to mediate a hard-wired, unconscious hyper-arousal, which has been the "new normal" for many years. This suggests that interventions helping to down-regulate the sympathetic ANS (e.g. visualization, breath work, meditation, Tai Chi) may help to reset the client's baseline arousal, and give them tools to use to manage both emotional and physiological stress. Perhaps the use of medications to lower physiological arousal (e.g. propranolol) as an adjunct to psychotropics might be explored. Clinicians should be aware that clients may find this new and lower set-point to be paradoxically uncomfortable. We need to educate and support our clients as they forge a "new normal" for themselves.

Various forms of the ACEs Questionnaire are available on the Web. Clinicians are encouraged to explore this emerging awareness of ACEs with their clients, and help bring truth to the saying "It's never too late to have a happy (er) childhood."▼

Michael G. Bricker *is a Behavioral Health Clinician with the Drug Court Treatment Program of Lutheran Community Services in rural Klamath Falls, Oregon. He is also a consultant on recovery from substance use and addictive disorders through the STEMSS Institute, and specializes in blending research-based treatment with Native wisdom traditions. Michael and his colleagues have developed a version of the ACE Questionnaire more specific to behavioral health. For more information about that version, or for other related information, contact him at mbricker@LCSNW.org.*

Reference:

Felitti, V.J. (2004). *Origins of addiction: evidence from the Adverse Childhood Experiences study.* San Diego, CA: Kaiser Permanente Medical Care Program.

AUGUST 13TH–15TH

Family Meeting Approach Intervention Training
Phil Scherer, CAADC, NCGC-II, ICCS, CIP
Training held on the campus of IIAR at UnityPoint Health–Proctor
Workshop cost: $300.00 (*must attend all days–21 CEU's*)

Utilizing didactic lecture, video, case vignettes, role-plays, and interactive group discussion, *this workshop will*:

- Describe the underlying philosophy and principles of the Family Meeting Approach to Intervention and how to utilize this approach to assist families in addressing issues related to addiction and other problems impacting upon the family system
- Review the Johnson, Systemic and the ARISE Models of Family Interventions
- Increase familiarity for coaching "Concerned Other" through the process of developing a support system in order to facilitate the Intervention
- Provide practical information in order to implement Intervention techniques within a clinician's practice
- Educate participants on becoming certified as an Interventionist
- Address how to determine what Intervention approach or Model to use
- Learn how to assess for "Safety Issues"
- Provide Intervention techniques to address Process Addictions, such as gambling, food, sex, Internet, compulsive shopping/spending

About the speaker: Phil Scherer is the Director for the Illinois Institute for Addiction Recovery (IIAR). Mr. Scherer is certified through the Illinois Alcohol and Other Drug Abuse Professional Certification Association and is a certified Problem and Compulsive Gambling Counselor as well as a Mental Illness and Substance Abuse II professional. Mr. Scherer is also certified through the American Compulsive Gambling Counselor Certification Board and the National Council on Problem Gambling as a counselor of problem gamblers. Mr. Scherer is a trained Board-Registered interventionist and a member of the Association of Intervention Specialists.

Registration begins at 8:15am and training is from 8:30am–4:30pm unless otherwise noted. For lodging information, call 1(800) 522-3784. Refreshments will be provided, but lunch will be on your own for all workshops.

NEW EDUCATION SERIES

Please watch for our education series of Educate Cafe and Lunch and Learns. For information visit our website www.addictionrecov.org

Continuing Education Units

Illinois Institute for Addiction Recovery and *Paradigm* magazine Offer CEUs

The Illinois Institute for Addiction Recovery is now offering continuing education credits (CEUs) for the *Paradigm* magazine. 2 CEUs for $30.00 with completion of a post test. To obtain your continuing education credits visit http://www.addictionrecov.org/Paradigm/CEU/Summer2014CEU.pdf.

Recovery Walks! 2014

Save the Date

Saturday, September 27th
at the Campus of UnityPoint Health—Proctor

Proceeds benefit the Ameel Rashid Scholarship for Addiction Recovery
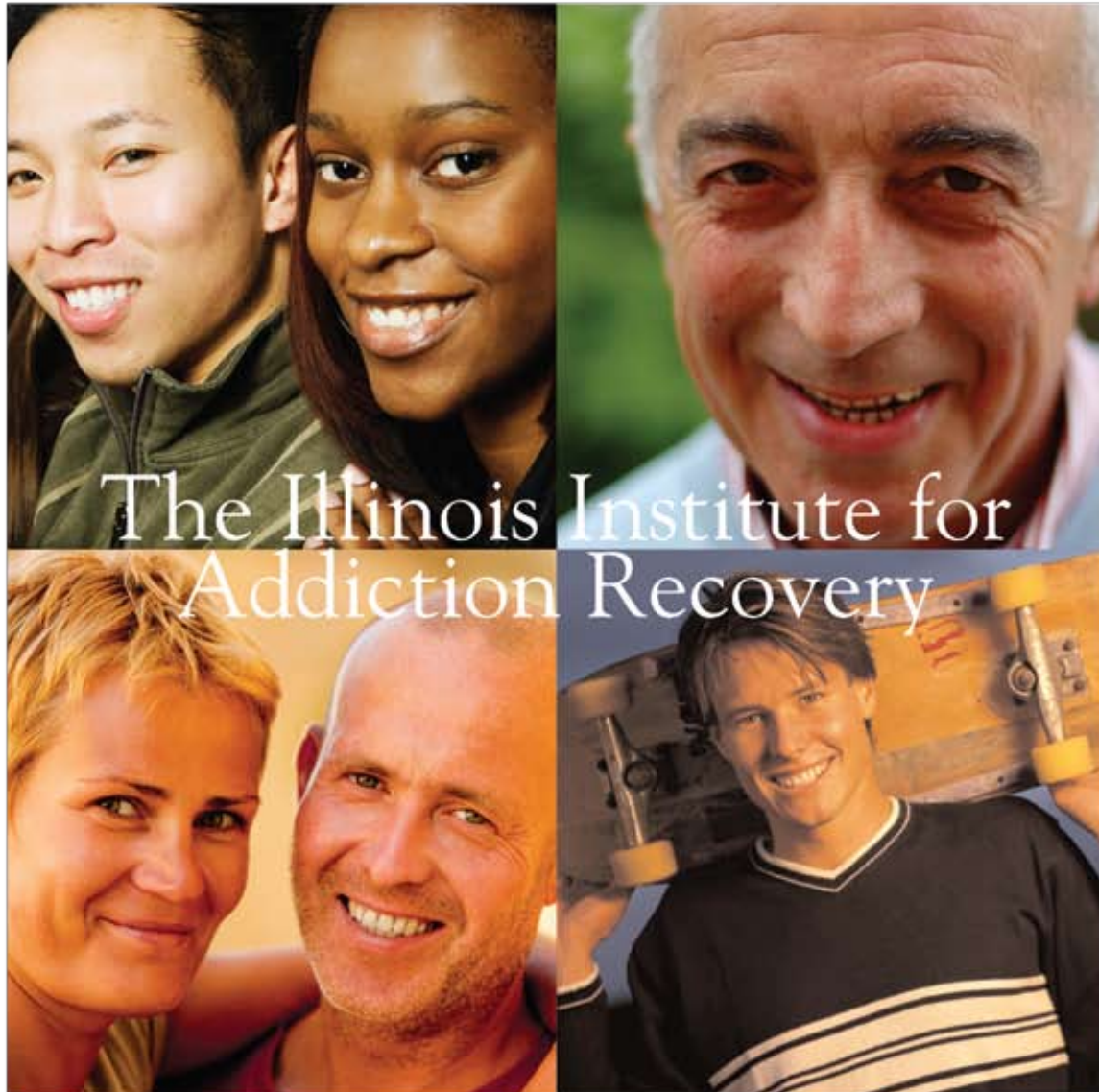
The Joint Commission

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

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