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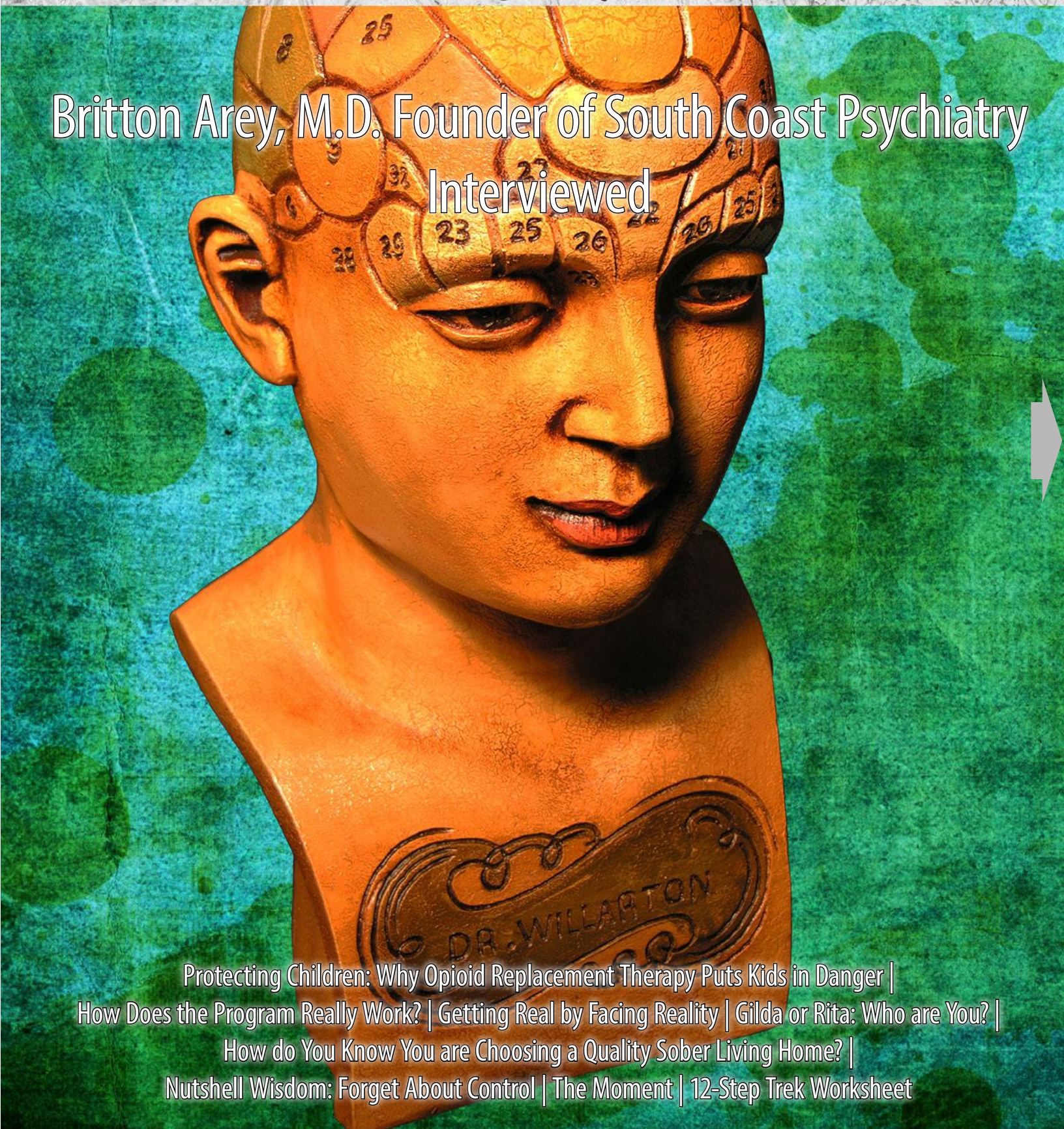
Serene Scene



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Britton Arey, M.D. Founder of South Coast Psychiatry Interviewed

By
Andrew Martin, MBA, CADC II, SAP, CA-CCS

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Andrew: I have the distinct pleasure of speaking with Dr. Britton Arey, the founder of South Coast Psychiatry. Dr. Arey is a concierge psychiatrist in Costa Mesa, California, providing psychotherapy and medication management to adults in a wide spectrum of mental health needs. Thank you so much, Dr. Arey, for joining us today at Serene Scene Magazine.

Dr. Arey: Well, thank you Andrew for having me and it's an honor to be here and to be able to speak with you and answer any questions that I can about our field and to help get good information in the hands of people who need it.

Andrew: I have a question right off the bat for you. What is a concierge psychiatrist?

Dr. Arey: That is an excellent question, and I think that term is so widely used and I think there are probably a lot of different ways to interpret it. I think psychiatry, we have kind of our own definition of what concierge means. There's a lot of medical practices that are popping up that are called concierge practices. And what that means in those particular practices is that they're usually out of network. They have a membership fee that you pay and for that annual fee you get It was considered a higher quality care, more access to your physicians. You get to be able to reach them after hours and you're part of a more boutique practice. And so we have kind of adopted a little bit of that definition, but then changed it slightly. So we're concierge in what we consider to be all the right ways, in the sense that we're trying to provide a much higher standard of care for psychiatric patients.

We have more of a boutique practice, which means that we're not that "pill mill". We don't see patients for five or ten minute med checks. We don't believe in those. We don't think that that's a good standard of care. To be able to know our patients and even understand their medication needs in that period of time. Our visits are much, much longer. So that's one part of it. So, and then the other piece is, is that we are available to our patients on a 24-7 basis. All of the patients in our practices have the cell phone numbers of their clinicians, so they can text, they can call, and they can email us. We're available to them both inside and outside the walls of our practice. We have a firm belief that when we enter into a therapeutic relationship with our patients that we go on a journey with them and we want to be part of their lives and a partner with them on that journey.

Whether it's toward recovery, or kind of on a journey to better understand themselves, or better deal with their life stressors, or change patterns, or a journey toward sobriety. And often time as well we are seeing them quite frequently and as a physician for example all the MD's on our practice do psychotherapy and medication management so there's no need to fragment care which is another big part of what we think concierge psychiatry is about. It's about the doing away with fragmentation of care so that the therapist and psychiatrist are normally, in normal conditions, you can get patients who are seeing multiple providers who aren't speaking to each other, and our goal is to create a one-stop, multidisciplinary practice where all of the providers who are touching one patient are in constant communication and collaboration with each other.

Even as an MD, most of my patients are weekly therapy plus or minus medication patients. But even in that one hour that I see them, often times life or crisis, or stresses, or questions come up in between sessions. And so the one hour out of the entire week, that I get to spend with them, and we're processing, and we're learning, and we're trying to move their journey forward isn't quite enough. And so we think that access beyond that hour helps us continue to help the patient on their journey at times where they need us. And those times don't always necessarily happen in the context of that one hour appointment. And our patients, we're so blessed, they don't typically abuse that privilege, so if they call us they really need us. And we want to be there for them when they do. So that's the other part of it.

We have a limited number of patients we provide. So it's a more boutique practice, much more intense, much higher level care, and much longer visits. Our preferred intake of the 90 minute intake for a bio psychosocial evaluation. And then our follow up visit the minimum amount of time we'll spend with the patient and this is for medication only visit; it's 30 minutes. And during that time, obviously, we're doing a lot

more than just, hey, how's your med going? Great, here's your new prescription. I mean, we're really you know doing therapy in probably every interaction we have with our patients, so they are much deeper much more high quality interactions.

So that's the other and another facet of the concierge principle, we don't have a membership fee, we don't believe in needing to pay additional fees just to become a member of our practice. We practice that across the board with all of our patients, we practice that across the board so you don't have to pay to be part of our practice, it's just part of our routine standard of concierge care.

We also have a very collaborative team. So what that means is that we have a suite that's full of, it's a multidisciplinary practice. We've got Psychiatrists, we have a Nurse Practitioner, and we have a Licensed Marriage and Family Therapist. Are continuing to grow and expand and bring on more people with different therapeutic backgrounds, and different skill sets. And so a patient who comes into our practice as opposed to, going to see a therapist, or a psychiatrist will have the benefit of, all of the minds in our practice because we all get together once a week for something called peer supervision where we spend an hour of our day, all of us will take an hour unpaid out of our week just to sit down with one another and collaborate. We pick each other's brains about cases that we're struggling with. Ask questions about, what do you think, what's been your experience with this medication? Here I've tried all of these resources, do you guys have any thoughts about what else I can do to help this patient? I feel like we're hitting a wall, how do we break through that? So we're, you don't just get one Clinician at South Coast Psychiatry, you get what we like to call a brain trust so you're getting the benefit and the weight of everybody's talents and experiences and it's of course, it's anonymous.

We don't use names when we collaborate like that unless we're sharing patients. But, you do get a lot more than just one doc kind of in a room, and all of their experiences. So, we like and we pride ourselves on our collaboration and how meaningful that is and how much more patients get from the brain trust than they do from, I don't care how highly educated one particular person is, there's a lot more value in kind of a pile of well trained, experienced clinicians all putting their heads together to help one patient move forward.

And then the other part of it that, and again there are so many aspects of our definition of concierge care, but we like to say we really are kind of the one stop shop for all of your psychiatric, outpatient needs. We can't be everything to everybody, and we don't try. But for the patients that do, that are at a place where they can benefit from outpatient care. We want to be the place that they can go to because we can now offer psychiatrists to perform the full biopsychosocial evaluations and be able to refer to primary care doctors.

We can order lab works, MRIs. We can refer to neurologists if we suspect that there's a neurological underlying ideology. So you got the ND component, and then we can also offer, if needed, medication management to help with the biological and the chemical part. We have, our therapists and our nurse practitioner offer, and our psychiatrist all offer individual psychotherapy. We can offer couples therapy, family therapy. We now have brought a number of group therapies online so patients who come to our practice who are struggling in multiple areas of their life, it's often not just that one patient alone. It's a patient in the context of their social setting which often involves marital issues and marital conflict or family conflict and family issues.

And we can offer family therapy to that patient and marital counseling. And we can offer individual therapy for the patient and their spouse. And we can offer them groups, if it's addictions they're struggling with, or an eating disorder, or a men's group, or a divorce recovery. So whatever a patient presents with, we can round out a 360 degree view of what we think outpatient should involve which in most cases is way, way, way more than come and get a script, see you in three months.

That will never happen at South Co Psychiatry and that was never the intention of our company so we're just built very differently than the normal outpatient psychiatric practice. And kind of the final bit of it I think I want to give credit to our staff which I think is a big part of what makes our group concierges.

When I graduated residency I had a real vision for what I wanted my practice to be, and I know it was very different than a practice that I had ever seen. My nightmare was a patient walking into a poorly lit room flicking a light switch to let their doctor know that they were there and waiting alone by themselves for you know that clinical interaction. So when you come into South Co Psychiatry we have three full time administrative staff, you're greeted warmly, you get to know the people behind the desk, they know you they ask if you want water or coffee or tea. It's like you're almost embraced by the feeling of a warm hug the first time you call in to the practice, to the first visit that you have.

And you're never alone at our practice. When you're waiting we've got a very plush waiting room and classical music playing, we've got our admin staff who either if you want to talk, they're there, if not, they've got magazines and water and chocolates and tea and coffee. And so we've created a very therapeutic space, for patients, and patients come an hour early just be in that space and kind of soak up the vibe. And then when it's time for their appointment, then the clinician gets to kind of take it from there and continue the experience. And then we do our job with the patient and the patient gets to check back out again, and is again surrounded by a kind of the love, compassion, and support of our admin team.

And so if the patient calls while we are in session it never just goes to voicemail, you know with three staff, the likelihood is somebody's going to pick up the phone. So when you're part of our practice, and you need something, like you ran out of meds, or you need to reschedule an appointment, you're never going to end up having to leave a message, and just cross your fingers and hope that somebody will get back to you in the next couple of days.

Either somebody's answering the phone dealing with your issue right in real time or if it's something that they need to get a doctor to pay attention to, they'll interrupt us in session if it's urgent. If not, they'll be telling us about it in between patients and so there's always a sense that your needs are being attended to.

So know that's a very long winded explanation, but that's the standard that we've set for ourselves in terms of why we consider ourselves concierges, and what that means to us. And it's way more than we've got a good degree from a good institution, and you'll be getting good care. I don't think that's enough to be called concierge, I think you got to go way, way, way above and beyond that.

Andrew: Well, it's sounds to me like your treatment philosophy is very personalized, and individualized. As a follow on to that philosophy I want to address something that really is problematic for the behavioral health industry. And that is, it appears to be so commonplace today that someone that suffering from addiction is also suffering from one or more mental illness symptoms. How do we go about treating someone that has these comorbidities in place?

Dr. Arey: Yeah, that's such a great question and that's such a great recognition of the fact that these, treating substance abuse in isolation, trying to imagine a patient who only has a primary substance abuse disorder, and nothing else, is probably a myth. I think the way we conceptualize it, at our practice, is that we think of every patient with a substance use disorder, or addiction. Or an eating disorder, everything is a symptom of a larger, deeper issue that needs to be addressed. And you can send the patient to recovery. You can get them sober. You can address the symptom. But if you don't understand the deeper underlying cause of what led to that symptom, of what led to the addiction, of what led to the eating disorder, what to led to whatever where, obviously is the most important and first line in a life-threatening thing that's to be addressed, which often times is substance use because that can be extremely dangerous, and often fatal.

Obviously you prioritize that first but I think oftentimes treatment centers say, okay, we've got the patient sober, they've been sober for 30 days, we're done. And I think the truth of the matter is, okay, obviously address the, I think you cannot make a diagnosis of an underlying condition until somebody is sober because substances can mimic so many psychiatric conditions. If you're using you can look depressed. If you're withdrawing you can look depressed. And if you're using, withdrawing you can be anxious, you can have mood swings, you can look paranoid and psychotic. So I

think until somebody's sober, it's hard to make a clear diagnosis. And I think because of the life-threatening aspect of it, the substance use has to be addressed first. But I think the concept of, okay now that we've got you sober our work here is done, I think needs to be completely changed around to, okay, now that we've gotten you sober, now our work gets to begin. Which is, okay, now that we've gotten the substance use, what we think is in some place where we can start the relapse prevention work.

Now let's also focus, in addition to relapse prevention and addiction recovery, let's talk about what got us here in the first place. Were you depressed and self-medicating? Did you have a history of trauma that you've never dealt with that came out in the substance abuse and the addiction? Have you suffered with anxiety your whole life that led to this drug of abuse that then you became dependent on? You know, there's always a why and I think the lack of looking for the why, the lack of paying attention to the lie to focus on sobriety, solely as an end point as opposed to the, this led you to treatment. This was the red flag that helped us understand you've been suffering with something for probably quite some time, obviously our number one priority is to get you sober. Then we have to understand you know what's really going on with you, make a proper diagnosis, and then we get to begin our journey.

And I think that's the part that's our philosophy. That's what psychiatry is. It's a coupled journey of understanding the how do we continue in sobriety and relapse prevention, but understand what lies beneath the tip of the iceberg, so that we can really prevent relapse. Because that's the ultimate goal is treating patients and gearing them towards happiness and healthiness and understanding and treating anything that may have led to it and then that helps by default in relapse prevention.

Andrew: In my experience, I don't think I can recall any patient entering into treatment that hasn't also been suffering from depression and or anxiety. How do we go about treating the depression and the anxiety in conjunction with trying to get someone into recovery?

Dr. Arey: That's so difficult, and that's one of the, when I went to UCLA and I actually spent a year. And it was an amazing year, with Tim Fong who's one of the gurus of addiction up at UCLA. And one of the things that he taught me and that I've learned since is that it's very, very hard to treat everything all at once, because there are a lot of variables in the mix and you don't know what's causing what. So I think that you're exactly right, that there is so much co-morbidity with substance use and depression, and substance use an anxiety. And substance use and mood swings, and substance use in psychosis. And I think often times you want to get somebody sober, you want to get them through the early phases of withdrawal, and as quickly as possible you want to make an appropriate diagnosis. Because if they have an underlying depression, getting them sober, getting them through the withdrawal, those symptoms are going to start to emerge rather quickly. And so I think within the first couple of days after sobriety, after withdrawal, I think you can really assess and make a diagnosis and start to treat a patient for whatever else is going on with them.

And I think it's a big miss in a lot of the treatment centers that I actually have a lot of respect for when I've visited them. And I don't like to refer to facilities that I haven't seen. I don't like to refer to colleagues or providers that I don't know. My standard, and our standard at South Coast Psychiatry for a facility that we refer a patient to, or a neurologist, or a primary care doctor, an OBGYN, is would we send our own family member there. If it was my daughter, if it was my husband, would I be willing to send them to this place for recovery? And so that's our standard for our referral network. So we really prize our referrals, and we treat them like gold, because they are gold to us. And I've been surprised in the ones that don't quite make our list, that they're very rigid about, well, if the patient doesn't come in saying they're depressed and they're addicted to opiates, we don't bother having a psychiatrist even see them. Or if he had been on Prozac for 20 years, and they came in to get off alcohol, and they've been stable, we don't have a psychiatrist see them. Well, how could you not? You know obviously something lead to this addiction, this relapse. And they've got identified mental health issues or they will have by the time you get done with a good evaluation.

So, I think it's imperative that we couple substance

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abuse treatment with, and good psychiatric evaluation, and good comprehensive diagnoses and treatment. And that's a lot of what I think the recovery centers are missing. They're focusing so heavily on the sobriety piece and they're not it doing in tandem with these patients, probably 99% of which need treatment for something besides just addictions. And they're so focused on the addictions, they miss the forest for the trees.

Andrew: It is quite common for someone to come into treatment, and during their evaluation to disclose that they might be on some medications for depression or for anxiety. And they don't understand that these are things that may or may not be associated with their illness. And, and until they get into recovery, until they get sober for a while, then we need to reassess.

Dr. Arey: Absolutely, that's why it's so important that you cannot take a patient who even has identified issues and say, oh, they've already had them, they should stay on those meds. Because it's a kind of a chicken and the egg thing. As I mentioned, the substances can mimic and cause psychiatric manifestations. So, alcohol can cause depression and cocaine can cause anxiety. So, you cannot make an accurate diagnosis of a patient who was actively using or actively withdrawing because they will manifest psychiatric symptoms that will look like a psychiatric diagnosis.

But as soon as they're clear, which doesn't take very long after, because a lot of these substances wash out quite quickly, then you can start to really dig deeper and find out, okay, let's talk about in the absence of substances, what's left? And that's where you can make a clean diagnosis.

And that's where it's so important to pick it apart. For somebody that's been on drugs for 20 years of their life and has also been diagnosed with depression for the last 10, again, it's hard to say did they have a substance induced depression? Were they in chronic withdrawal all the time, because they didn't have access to their drug of choice? So that put them into a depression, or was the depression feeding the substance use? And it's so important to separate those two out. Get a patient clean, and then understand what's left over that needs to be treated. And like you said so often there is a lot left over that needs to be treated.

Andrew: You have a unique perspective, and unique practice in that not only are you doing medication management but your also doing psychotherapy along with it. And that's not very common nowadays. So many individuals are prescribed medications, without really knowing why they're being prescribed the medications. And without really knowing what the effects of those medications will be in their lives. And spending ten minutes with a psychiatrist doesn't give the psychiatrist enough information so that they can make, in my opinion, valid judgement on how this is impacting their lives.

Dr. Arey: Oh my god, that wrinkles me. That makes my skin crawl when you say those things. And I know that it's out there and I guess I'm so entrenched in my own practice that I forget that still happens. It makes me sick to think that anybody would put somebody on a medication that has so much potential impact on one of the most fundamental organs in their body, their brain, without spending enough time with them to fully understand what their needs are. And also I'm a firm believer that medication alone is never an appropriate treatment plan. I feel like everything we see in psychiatry is biopsychosocial, which means it's got a biological or physiologic component. They may have a genetic predisposition. Their brain may just run low on certain neurotransmitters. The brain is an organ like any other organ system in the body. It can, just like in a diabetic whose pancreas doesn't produce enough insulin, somebody's brain can just on its own, not produce enough dopamine, serotonin, norepinephrine, gaba glutamate.

You know, it can go awry, so sometimes we do have to address the chemical imbalance, but Leaving out the psycho social bits, is doing patients an enormous disservice, because, like I said, everything that walks into our practice has a bio, psycho, and a social component. And if you just try to address the bio, you're missing at least two-thirds of the equation. And I tell all of my patients I say look I'm going to create a comprehensive treatment plan for you, and my treatment plans I tell the patient what I think they're struggling with, what their diagnosis are, or what the rule outs are. I tell them exactly what my plan for them is, and I

let them pick which pieces of it makes sense to them.

But I also say here's my ideal plan for you. And my plan is usually 10 or 15 items long. It's okay, let's talk about the role of medication and what the risks and the benefits, the side effects, and the alternatives are, each of the medications that we can consider, and which ones I would recommend and what you can expect from each of these. And how long we think you'll need to take these. And what the long term data shows on all of those. And then we talk about the psychological component. So much of what we see in our practice is about how patients have learned from very early on in their lives. How they've seen themselves reflected in their earliest attachments, how they've understood their place in the world, how they relate to other people, whether they have self-confidence, self-esteem, self-compassion, self-love. And we don't have pills for any of that, so again, to miss that piece is so unbelievably damaging to patients.

That's why in our practice, I think we have very few patients who are actually being treated with medication alone. If we're seeing them for medication, often it's because they've been referred to us from a therapist with whom we are in close collaboration, but if a patient is in treatment just in our practice, they're being seen for psychotherapy and medications and often times with the same provider if not with one of our colleagues with whom we're working very closely.

And then the social aspect of let's understand your support systems, because those are critical in, you know, maintaining your mental health and your sobriety. So let's talk about, you know, who your friends are, and, and what your family relationships are like, and, and what else you're doing that might be compromising your, your health and well-being. Are you exercising? What's your sleep look like? Tell me about your nutritional status. Tell me about your, the structure and the schedule in your day. All of those things can cause anxiety and cause depression and all of them need to be addressed. Are you practicing mindfulness? Are you cultivating gratitude mindset?

See, I think there's so much beyond throwing meds at patients that we not only can but we should be doing for our patients. And so when I say I have a 15 component treatment plan, all of those things are on my plan. And I say this is what I want for you, this is the ideal journey that we can go on together. But it's up to you how much of this you want to participate in and how much of this makes sense to you.

Andrew: With an appropriate diagnosis and appropriate psychotherapy, there are those patients that do require medications to improve the quality of their lives. I have seen individuals, that without medications, have a terrible quality of life. With medications - they thrive. How do we, encourage these individuals, that sometimes medications are really positive things for them? And despite what maybe some of the people around them say, medications really are needed.

Dr. Arey: There is such a stigma around psychiatric medications because we're medicating behavior and thoughts which if you talk with the Scientologist that think that psychiatry is evil and psychiatric medications are tools of the devil, you won't get the same opinion but if you talk with somebody who really does understand what neurobiology, and neurophysiology, and psychopharmacology.

We understand that the brain is an organ. And the organ, again like I mentioned, and I use this same analogy with my patients who are resistant to going up in medications or who go to AA groups that tell them that being on psychiatric medications means they're not sober.

I tell my patients look, expecting all the organs in your body to function perfectly all the time is, that's never going to happen and there's so many examples of organ system failures that we all accept. That we would never say boo to someone taking a medication for kidney disease or for a liver dysfunction or because they were diabetic or for a heart condition. There would be no question that a patient with arrhythmia or high blood pressure would be on a medication. But the minute you start talking about psychiatric medication, then there's a different tone and the different resistance attached to that. And I think that the more education that we can provide about the fact that the brain is an organ. That it can go wonky, that there can be disequilibrium and neurotransmitters that can be fixed. And that nobody assumes these to be silver

bullets, but, when I talk to patients about who don't want to go on meds, who want to do the therapy, the exercising, the nutrition, the sleep, everything but meds, I compare it to okay, we can go on that journey, but it's like we're going to be running uphill. And you're going to be wearing a pair of lead boots, while you're doing your, your part of the running up hill. And medication allows us to take those lead boots off and put some running shoes on you. It doesn't mean the journey's not going to be rough. And it doesn't mean that there's not a long ways to go. It just means we're going to make it that much easier for you to, to do the work you need to do to get yourself better, and if you choose not to, it's going to be a lot harder.

Andrew: You just referred to resistance to medication, and I know that with certain populations, specifically schizophrenia, schizoaffective disorders, and bipolar disorders. it's difficult to get patients sometimes to manage their medications appropriately: to keep taking it, because once they start to feel better, then they kind of stop taking it. How do you handle that?

Dr. Arey: That's really hard - really, really, hard. And you know what, that doesn't just happen in psychiatry. That happens in every field. I mean, you talk to a primary care doctor and they'll have a patient who had high blood pressure and they worked so, so hard to find the right kind of medication and the right dose to finally get their patient's blood pressure under control and the patients like, my blood pressure's great and so I stopped taking my meds. It happens in every field. And I think the important piece of that is education from the get go about, you have a chronic condition. It's likely to require medication, you know, probably for a long period if not indefinitely, especially if they've had multiple occurrences of relapses into mania or depression or anxiety throughout their lives.

You're talking about a patient who probably has a fundamental chemical imbalance that needs to be treated. And so for those patients, from the educational piece about when you feel better, that's not the time to discard your meds, that's the time to say, wow, these medications are probably doing what they were supposed to be doing and look how far I've come.

And we can you can bring up thoughts about the possibility of going down or discontinuing medications. But that's not a decision that a patient should be making by themselves. That's an opportunity for discussion with your doctor, but I think as long as, again if you're in a treatment plan like we have, with our patients. You're seeing us weekly anyway, so we're on top of those discussions with our patients. So we're constantly asking them, okay, tell me what your thoughts are about your medications. Tell me how you feel on them. Are the benefits continuing to outweigh the risk? Because we have to ask that all the time.

And there are patients who, in the extreme state of their disease, when they were horribly depressed and suicidal. They didn't care about the weight gain, or they didn't care about the sedation, and they didn't care about some of the side effects. They just wanted to feel better. And so we get them feeling better, and now they want to go back to work. But their confidence is shot because they've gained weight, or they can't function through their day because they're too tired. And those patients are likely to discontinue. And instead we'd rather them, again, if we're initiating the conversation, tell me how you're feeling. Tell me how you're feeling about the medications. Tell me how you're feeling about continuing on the medications. Let's talk about the risk-benefit equation. How does that equation feel to you? That's an opportunity for them to say, you know what? I'm feeling like the risks are now outweighing the benefits. I like feeling better, but I also want to be functional.

And instead of just quitting their meds, let's talk about, okay, how do we fix the liabilities? How do we make the benefits continue to outweigh the risks at every juncture? And that's partly our job, so I have a hard time blaming it all on patients. I feel like we need to do a better job of educating them about the continuity issue being important, about these sometimes being lifelong conditions that require treatment and constantly assessing the risk-benefit ratio.

And engaging in that dialog with patients so they understand the reasons why they want to stay on their meds. And if the benefits aren't outweighing the risks, it's up to us to come up with another plan to reverse the dynamic.

Andrew: Let's talk about some of the therapeutic inter-

ventions that work well for the other symptoms that go along with, particularly, addiction. And I'm talking about things like perfectionism and self-hatred and narcissism, impulsivity. These are things that, as you said before, there's no medications for these things. We have to work on this things. How do you help individuals with these things? What kinds of therapies work well?

Dr. Arey: That's a really great question, and I wish there was one answer. I think that's the part of it that requires you got to do more than a ten-minute med check. You've got to know your patients. I mean, you have to be connected with them on this journey. And the more you truly understand, are connected to, partner with your patients on their journey, the more you're going to understand where these issues come from. And that's why in our practice, we all practice kind of eclectic psychotherapy, which means we borrow bits of multiple different theoretical disciplines. So at certain times on our patients' journeys, we'll use cognitive behavioral therapy techniques. So if we find them engaging in a lot of thought distortions about themselves, a lot of inner criticisms, a lot of automatic thoughts that just aren't correct about themselves, that are driving themselves to feel badly about themselves.

We'll use CBT to help them record their thoughts, challenge their inaccurate thoughts, and replace them with more accurate thoughts that then change their moods. We do a lot of dynamic psychotherapy, so we can go back into their long ago histories, and understand their earliest attachments, and how they were reflected in their parents', or whoever was taking care of them, their eyes so that we can understand what was reflected back to them about their sense of self and how they learn to understand what their place in the world was. Because those are the things that lead to all the things that you mentioned, the self-hatred, the narcissism, and the lack of self-esteem.

All the personality components are formed very early in life, and traumatic experiences can greatly affect those. And so when you learn patterns of coping with your world that work for you based on the situation you grew up in, and it may be narcissism or perfectionism or those things that worked for you growing up. And then you get into the real world, and you find that those same coping skills, now not only don't they work for you, they cause you significant pain and suffering and a lot of disruption in your interpersonal relationships. Those are the ones that we need to go back, trace back to their origins, go back and understand it, so that we can, in real time together, practice new ways of relating to ourselves and to other people. So that we can develop new coping mechanisms that are more adaptive for their world today as opposed to playing out the ones that were adaptive to them way back when, that they no longer need. So I know that's kind of a long-winded question, but the patients that are in my practice, I'm so blessed.

I've been able to go on these very, very long journeys with them. So I've known the patients, most of them have been in my practice since I started my practice. So I've had the privilege of knowing them for almost a decade. So I go on these really long journeys with them. And I know them, and I've met their parents, and I've met their significant others, and I've met their children. And I feel like I have such a good depth knowledge of where they came from, of what their struggles are. And I can see a vision for how to break the patterns and get them unstuck and get them out of that, but it's a true partnership. And there's no one answer to, here's how to get out of perfectionism, here's how to break out of narcissism. The therapeutic relationship, that's te strongest and the best tool that we have in our toolbox to help our patients break their patterns. If they can relate to us differently than they've related to anybody else in their lives, then it's proof of concept that they can have different relationships in their lives. And then they can take that and generalize it to other people, other situations, and hopefully new patterns.

Andrew: One of the things that we run across in primary treatment settings, usually, is something that I don't think is well understood within the behavioral health community, and I'm wondering if you can speak to it. I'm referring to self-harm and self-mutilation. Where does that come from, and how do you deal with that?

Dr. Arey: Yeah, that's a really difficult one for all of us, and for people who aren't in the field it's really scary. A lot of people can't separate that from suicidal

thoughts and gestures, and sometimes they're related, and oftentimes they're not. And there is no one answer for why all patients self-harm or self-mutilate. As scary as it is to see, oftentimes it's not a red flag that somebody's going to go off themselves, or it's not their intention to demonstrate that. But oftentimes the patients that I have who engage in that tend to fall along what we call the borderline kind of spectrum, or continuum, and tend to use self-harm and self-mutilation as a release.

They report that when they cut or they injure themselves in some way, that some of the emotional pain is transferred to physical pain, and there's a momentary relief of the emotional pain that they experience on an almost chronic basis. And to get even a couple seconds of relief from that emotional pain is so euphoric that they will engage in behaviors that people who don't understand what it's like to live in that much emotional pain would not understand why someone would want to hurt themselves. But if you can put yourself in that situation where you're struggling with that much pain, and the best example that I usually share with family members is, when you stub your toe, and it really, really, really hurts. And then at the same time, sometimes you'll get a paper cut, and the paper cut just a little bit hurts, but it distracts you from your stubbed toe. And now how painful that was. This is kind of the same, that's two examples of physical pain. But it's the notion that one can distract from the other, and so I think a lot of patients do that for that reason. Other patients say that it's a release of anxiety, that their anxiety goes way, way down when they perform acts like that.

Other patients, for a small segment of patients, this is why we never ignore this symptom. For some segment of the population it's a cry for help. They're literally doing an act to say, I'm in pain, you can't see my pain, it's inside me. It's something that only I can feel, there's no x-ray for it, there's no lab test for it. But I can show you how bad this feels by cutting up my arm, or doing something to demonstrate it. So it's a very outward, a very physical representation of emotional pain. And it's meant to either provide relief or to get attention from people who they either feel don't understand them or who they want to recognize their emotional pain more, or it's a cry for help. And sometimes they're saying, look at me, I'm in pain. I know you can't see that part of it, maybe you can see this and notice me, help me. So those are all, in my experience, those are all the reasons why I've seen patients self-harm. And it's usually patients who are in fairly large amounts of emotional pain and need significant help.

Andrew: Thank you so much for that explanation. It really helps me to understand better what's going on inside the minds of an individual that partakes in those kinds of behaviors.

Dr. Arey: Sure, it's really hard, especially for somebody who has never been deeply depressed or deeply emotionally conflicted. And patients can't explain it very well. But they feel it like a lead weight inside of them, and wake up with it in the morning, go to sleep with it at night, don't get any respite from it. And so that's why I think this is their way of saying, either I want two seconds where I don't have to think about it, and this will distract me from it like a paper cut would, or please notice me, I know you can't see this pain but you can damn well see this one.

Andrew: Dr Britton Arey, the founder of South Coast Psychiatry located in Costa Mesa, California. I want to thank you so much for taking the time today to speak with us at Serene Scene Magazine and for sharing all of your knowledge and insights.

Dr. Arey: Absolutely, thank you so much for the honor and the privilege of helping to get information out. And we want to be a resource in our community. We're starting to sponsor. The company has grown and evolved over the years, one of our fundamental missions has been that we wanted to give back to our community. Last year we sponsored the American Foundation for Suicide Prevention Walk. Our whole company came out, walked, we had a booth, and we sponsored a team. This year we're going to do the Walk for Kids with Ronald McDonald House. So we're really trying to both give back to our community and be a resource. And we recognize that we're not the appropriate fit for all patients. And so even if a patient calls us and we're out of network and the patient needs to use their insurance, our front office staff is paid to stay on the phone until they can help that patient find a resource that they need, that they can afford.

So anybody who calls us if they're looking for a higher level of care or a facility, and that's a more appropriate level for them, we will help them find the place they're meant to be.

So we want to give much more than just here's who we are. If you're the right fit for us, great. If not, it sucks to be you. We want to help anyone who calls into our office. So even if we don't feel like we're the right fit, you can always call us for a resource and referral, help finding and navigating the community. I think you're doing a great job with that with the network that you're building and the resource finder. But we want to be that in real-time for patients as well. So anyone can call us at any time and we'll help them navigate to get to the place where they need to be.

And then the last thing is we have a Facebook page, and I'm the curator of it. So I post about 10 to 15 articles a day, and its Facebook.com/southcoastpsychiatry. And it's meant just for educational. So it's meant to educate patients, colleagues, other positions who need to become more aware of mental health issues and treatments, our peers in the treatment communities, it's meant for our patients. And I pull from all different resources across the Internet and Facebook, everywhere from NAMI, the National Alliance for the Mentally Ill, to the Bipolar Foundation, to Project Semicolon, to a lot of the mental health resources, and also to things like Inc.com, Success.com. It's all about wellness, health, moving forward on your journey, understanding and supporting and dispelling myths, the misconceptions about mental illness, and getting good information in the hands of patients and their loved ones, as well as providers.

So, again, that's something that people are welcome, it's free. And we put book recommendations and TED Talks, and all sorts of things out there, just meant to promote education about health and wellness in all of its various forms.

Andrew: Well, thank you so much for that offer, and keep up the brilliant work.

Dr. Arey: Thank you, thank you so much for this opportunity and it's really been a joy talking with you. SS


Andrew Martin
M.B.A., CADC II, SAP, CA-CCS

Andrew Martin began his entrepreneurial approach to business in 1982 at the age of fifteen. Throughout his career, Andrew has fulfilled his duties as a senior executive in viable business ventures in various industries including; health care, sound reinforcement and lighting, electrical safety equipment, commercial catering, specialty metal shapes manufacturing, and the entertainment overhead suspension industry.

Andrew's current business efforts are encompassed by Serene Recovery Network, a group of branded organizations with a common vision of helping people in early recovery to help themselves to a long-term rewarding quality of life without addiction. The individual businesses include Serene Connections, a publishing and professional educational conference production company catering to the field of addiction treatment: The Evolution of Addiction Treatment is the flagship conference. Locate Treatment, an online directory of professionals and organizations affiliated with the treatment of addiction. Serene Foundation, an educational institute for higher level addiction treatment learning. Serene Scene Magazine, a publication promoting long-term healthy lifestyles of recovery. Andrew Serene Institute providing educational opportunities to professionals.

Andrew has authored many articles related to addiction treatment, health care agency productivity, industry specialties, as well as business approach and leadership and has been published in Serene Scene Magazine, Behavioral Health, Freedom Newspaper, Sound & Video Contractor, Western Wall and Ceiling Contractors Association Bulletin, Connections Magazine (Australia), dB Magazine, EQ, Lighting & Sound International (Canada), Sound & Communications, Live Sound International (UK), Recording-Engineering-Production. Additionally, many patents and trademarks have been awarded to Andrew Martin for various business related products, brand names, and service marks.

Andrew is also very active on boards related to the treatment of addiction. Andrew also keynotes for many organizations and speaks internationally on many topics relating to the treatment of addiction.