ECHO IDAHO: ADOLESCENT SUBSTANCE USE DISORDER

Trauma and Addiction
April 12, 2023
Ryan Billington, MD
St. Luke’s Hospital System
Psychiatrist

None of the planners or presenters for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.
Disclosures

• I have no financial disclosures
Learning Objectives

• Briefly discuss “trauma” and “addiction”: clinical difficulty of present unknown
• Explore data: association between them in adolescents
• Explore models of clinical thinking to increase clinical judgment, utility, & significance
• Case presentation?
• Questions
“Being traumatized is not just an issue of being stuck in the past; it is just as much a problem of not being fully alive in the present.”

“If the elements of [_______] are replayed again and again, the accompanying stress hormones engrave those memories ever more deeply in the mind. Ordinary, day-to-day events become less and less compelling. Not being able to deeply take in what is going on around them makes it impossible to feel fully alive. It becomes harder to feel the joys and aggravations of ordinary life, harder to concentrate on the tasks at hand. Not being fully alive in the present keeps them more firmly imprisoned in the past.”

Bessel Van Der Kolk, The Body Keeps the Score
Background: Me

• I am an adult psychiatrist

• Emphasis & particular interest: sustained trauma & personality disorders, psychotherapy, psychiatric diagnostic constructs

• Passion: How people to heal?
Background: Me

- I crave more for psychiatry and mental health
- Over course of career, given talks such as these:

**Being human:**
themes and targets for healing interaction in the face of clinical and therapeutic uncertainty

Ryan Billington, M.D.
Psychiatry Resident, PGY-3
September 2017 Case Conference

**Beyond a Relief of Symptoms:**
Treatments for Quality of Life and Function in Major Depressive Disorder

Ryan Billington, MD
Resident Psychiatrist, PGY-4
UW Psychiatry Residency Idaho Advanced Clinician Track
March 23, 2019

**Burnout and Resiliency in Medical Students:**
The Paramount Opportunity of Perceived Support

Presented by Ryan Billington, MD
Harborview Psychiatry Noon Conference
Harborview Medical Center
June 20, 2016

**Anxiety, Hatred, Anger:**
and Other Things that Enrich my Life
(The Art of Human Transmutation)

May 4, 2021
Ryan Billington, MD
Psychiatrist
St. Luke's Health System
Background: The Topic

• There is very little data to guide clinically integrated approach to (not-PTSD) trauma & addiction in adolescents
  • “Research about the relationship between [adverse childhood events] and substance use disorder diagnosis in adolescence and adulthood is still scarce.”

• Despite a common sense of connection between trauma and addiction/substance use disorders, practicing of evidence-based medicine/psychotherapy is hard

• Key point: Substance use & sustained trauma interact, but we have little guidance about “how” and what to do about it

Background: The Topic

- 109 papers over last 20 years on adolescent SUD & adverse childhood events
- “We did not deliberately omit experimental studies, though the review did not turn up any that were within the outlined parameters.”

Background:  The Topic

• 1 Intervention Paper!
• Shin: 2021
  • 7 pages, 2.5 pg references
• Rise Above RCT: an in-process trauma informed, e-cigarette preventive intervention study

Background: About DSM Diagnoses

• Premise: The point is diagnoses per the DSM-5 is mental health creation.

• Diagnosis: symptom criteria that impairs quality of life (significant distress) &/or functioning (functional impairment)
  • Example

• DSM criteria can be insufficient to separate health from illness

• A diagnosis must:
  1. be augmented with clinical judgment
  2. be clinically useful and clinically significant – which are not defined
  • DSM-5-TR: “is an inherently difficult clinical judgment

• “Therapeutically useful diagnoses”

Background: About DSM Diagnoses

- In certain psychiatric conditions, the “absence” of illness is NOT recovery

  - The DSM is insufficient for many mental illness experiences for bridging to health, by its own admission

  - History: rich with examples where stigma, mechanisms of illness influence mental health experts => treatment is unhelpful, even harmful, for mental health creation
Background: About DSM Diagnoses

- Trauma and addiction: the challenge before us is the art of “how”
- Metaphor & meaning
- Resilience: specifically, coherence, agency, safety

- What suffering is worth experiencing?
Overview:
Augment Clinical Judgment, Utility, & Significance

• Goal: to augment clinical judgment, utility, & significance

• Take a look at some of the literature
• Discuss “bridges” from mental illness to mental health creation:
  • Attachment and Mentalization
    • DSM-5 Alternative model for personality disorders
  • Neuroscientific model
  • Adverse childhood events and Positive Childhood Events
  • Demoralization and resilience
Substance Use Disorders & Trauma: Relationship via DSM Diagnoses

• Borderline Personality Disorder:
  • 87% substance use disorder comorbidity

• PTSD:
  • “As many as 50–75% of combat veterans with PTSD also have drug or alcohol use disorders (Kulka et al., 1990),
  • ... and structured interviews detect PTSD in up to 42.5% of patients in inpatient substance abuse programs (Cottler et al., 1992).”


**FIGURE 1** Possible etiologies for comorbid post-traumatic stress disorder (PTSD) and substance use disorders (SUD). Different categories of explanations are depicted as being distinct from one another conceptually but overlapping at the level of the individual patient.
Substance Use Disorders & Trauma: Relationship via Adverse Childhood Events (ACEs)

• ACEs – “adverse childhood experiences”
  • “one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being”
  • “include childhood emotional, physical, or sexual abuse and household dysfunction during childhood” (0-17 years)
    • Categories: verbal abuse, physical abuse, contact sexual abuse, a battered mother, household substance abuse, household mental illness, incarcerated household members, and parental separation or divorce.

• Original study was Kaiser study in 1995-1997
• In 2009, CDC began collecting data across 5 states about ACEs prevalence via the Behavioral Risk Factor Surveillance System.
• By 2022, 26 states collecting data

Substance Use Disorders & Trauma: Relationship via Adverse Childhood Events (ACEs)

- ACEs – “adverse childhood experiences”
  - 1 in 6 individuals has ACE score >4
  - ACEs can predict earlier age of drinking onset (Rothman, Edwards, Heeren, & Hingson, 2008)¹
    - “… Therefore, underage drinking prevention programs may not work as intended, unless they help youth recognize and cope with stressors of abuse, household dysfunction, and other adverse experiences”
  - each ACE increased the likelihood of early initiation into illicit drug use by 2- to 4-fold. (Dube et al, 2003)¹

3. Lanius R, Vermetten E, Pain C, editors. The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic. 2010; Cambridge: Cambridge University Press. doi:10.1017/CBO9780511777042
Substance Use Disorders & Trauma: Relationship via Adverse Childhood Events (ACEs)

- Hoffmann JP, Jones MS (2022):
  - Lit review of 109 papers over last 20 years on adolescent SUB & adverse childhood events
  - Various findings
    - 84% of results show s.s. (statistically significant) association between cumulative stressors and substance use
    - "... that each one-unit increase in stressful life events (range 0-13) was associated with 4% increase in risk of drug abuse"
    - Dose dependent relationship: adolescents w/ 4+ ACEs were *four times* as likely to initiate alcohol or cannabis use than 0 ACEs group
  - Mediators: studied in few (4-5) studies
    - Peer substance use
    - Barnes et al. (2005): “an ‘addiction-prone personality’—which included high novelty seeking and low self-regulation—mediated much of cumulative stressors on heavy marijuana use”
  - 16% of results failed to show statistically significant association

Substance Use Disorders & Trauma:

- Key Takeaways:
  - though we are still learning, trauma and substance use are associated, & likely interwoven
  - Diagnoses can be problematic for creating healing
Overview: Augment Clinical Judgment, Utility, & Significance

• Goal: to augment clinical judgment, utility, & significance

• Take a look at some of the literature
• Discuss “bridges” from mental illness to mental health creation:
  • Attachment and Mentalization
  • DSM-5 Alternative model for personality disorders
  • Neuroscientific model
  • Adverse childhood events and Positive Childhood Events
  • Demoralization and resilience
• Mentalization
  • **Key Point: mentalization is what heals attachment patterns
  • stops insecure/disorganized intergenerational transmission (kids have secure attachment)

• Discovered by Peter Fonagy
• What is mentalization? “the process by which we realize that having a mind mediates our experience of the world.”
  • ... realizing our thoughts, feelings, desires, and other mental state experiences are merely representational of reality.
  • this “representational system is what allows an individual to understand, interpret, and predict the behavior of others, as well as their own behavior.”

• Mentalizing “modes”:
  • Psychic equivalence
  • “Pretend” mode
  • Mentalization

• Emotion regulation is necessary for mentalization

• Resource: PsychologyToday article by Drevitch
  • Understanding the Other: Mentalizing with Attachment Theory [link]

---

Dr. Billington’s Model
for Active Mental Health Creation

Thought World:
(& Drivers of Trauma):
1. Thought labels
2. Shame

Hierarchy
Has Power
Judged w/ + labels
“Right”
“Good” / “Perfect”
Pursue

Lacks Power
Judged w/ - labels
“Wrong”
“Bad” / “Broken”
Disregard

2 Resulting Patterns for Relationship:
1. Attack (label) pattern
2. Passive Withdraw
(passive) pattern

**Worth** *(Vulnerability)*

Needs & Values
- Connection & Belonging
- Safety
- Power / Agency
- Clarity / Coherence
- Meaning / Purpose
- Joy (Enjoy & Be enjoyed)
- Loss

Reality / The Present:
What’s happening, right now, in each of us?

Actions
Emotions
Emotion Regulation

Need: shared by all humans. Absence of need creates suffering, and a loss of function/life.
Value: specific to an individual. Temperament, love language, moral fiber. Personal compass; shows what matters: what suffering is meaningful. Individual. Ex: love languages

Boundary: an invitation to accept a part of me, here. Can I still add to your life if I feel _____ have limits/needs, believe or find meaning in ______, etc)? Is not an attack, nor withdrawal.
• Attachment Theory ... in 5 minutes
  • Is predominant model of human social development
    • A two-person psychological, evolutionary, and ethological theory
  • Impact on society is difficult to overstate: legal system, hospitals, social services
  • Gross oversimplification: attention to relationship vs. attention to environment
  
  • An “individual’s working model of attachment enables him or her to recognize patterns of interaction with the caregiver that have repeatedly occurred and thus to ‘know’ what the caregiver will do next.”\(^1\)
  
  • 4 attachment patterns: Secure, 2 types of insecure—avoidant and preoccupied (anxious)—and disorganized
  • is a continuum. Shifts minute by minute; general “theme,” but exposure to interpersonal interaction shifts pattern
  • Pattern is adaptive when it develops
  • Pattern is actively invited/implemented

Attachment Patterns

*Attachment Pattern Name = Infant or Strange Situation pattern / Adult Attachment or AAI pattern

(*) = alternative pattern name in either infants or adults

**"Mother’s behaviors" below refers to the infant’s primary attachment figure. In the Strange Situation experiment, the infant’s observed attachment figure was the mother.

Secure / Secure (or Autonomous) Attachment — have equal access to impulses to explore when feeling safe, and seek solace in connection when they do not.

  Mother’s behaviors: reflect sensitivity rather than misattunement, acceptance rather than rejection, cooperation rather than control, emotional availability rather than remoteness. Is able to repair ruptures to the relationship, without leaving, escalating to frightening behavior, or seeming frightened by infant.

Adult Attachment: Secure/autonomous

Avoidant / Dismissing Attachment — incessantly exploring and appearing to not care about mother’s departure or return. Inhibit virtually all communication that invites connection. Go limp when held, look away from mother. Despite blasé appearance, had higher physiologic markers (HR and cortisol rise) than the distress-displaying secure infants.

  Mother’s Behaviors: actively rebuffed infant’s bids for connection—withdraw when infants appear sad, inhibit emotional expression, aversion to physical contact, brusque when physical contact occurs.

  >> Why infant’s response is adaptive: infant’s anger could increase risk of rejection, and threaten to push mother further away when infant’s needs were frustrated.

Ambivalent (or Resistant) / Preoccupied Attachment — too preoccupied with mother’s whereabouts to explore freely, and react to her departure with overwhelming distress.

  Mother’s behaviors: unpredictably and occasionally available to infant; subtly discourages infant’s autonomy.

  >> Why infant’s response is adaptive: persistent and unmistakable expression of distress might create pressure for attachment figure to keep up care.

Disorganized (or Disoriented) / Disorganized (or Unresolved) Attachment — discovered by Mary Main 20 years after the Strange Situation experiment.

  - Infant’s behaviors fit other attachment patterns, but additionally had behavior of freezing, rising upon parent’s entrance than falling prong, clinging and crying while leaning away with averted gaze.

  - Mother’s behaviors:

    - Main proposed infant was caught in simultaneous impulses to approach and to avoid attachment figure, as the infant’s experience is that “the attachment figure is simultaneously experienced not only as the safe haven but also as the source of danger.”
      
      o  >> “infant disorganization is the outcome not only of interactions with parents whose anger or abuse is self-evidently frightening, but also of interactions in which the child experiences the parent as frightened.”

Substance Use Disorders & Trauma: Bridge #1 Background

• Attachment Theory ... in 5 minutes
    • the attachment behavioral system: biologically-based, evolutionary necessity. In response to threat, infants (mammals, human beings) seek physical proximity to promote both physical safety and emotional security.
    • Creates unconscious, pre-verbal blueprint for predicting human behavior (the internal working models of relationship”
  • Mary Ainsworth (1913 – 1999): Canadian developmental psychologist
    • Worked for 40 years empirically testing Bowlby’s attachment hypotheses
    • Research: observed behavior in specific [mother-infant] relationships : The Strange Situation -> 3 patterns of attachment
      • Set by age 12 months
  • Mary Main (1943 – Present): one of Ainsworth’s most recognized students.
    • Found 4th “disorganized” attachment category
    • moved Attachment Theory beyond Strange Situation’s observation of behavior in a specific relationship to the study of mental representations (through language patterns) of relationship
    • Adult Attachment Interview--made empirical study of the internal working model possible in adolescents and adults
    • Refined understanding of Internal working model: best understood as “structured processes serving to obtain or limit access to information” (Main et al, 1985, pg. 77)2
    • These models form literal conscious and unconscious “rules to live by.” Such rules are actively implemented in relationship
    • “Intergenerational transmission” of attachment patterns

Substance Use Disorders & Trauma: Bridge #2: Alternative Model for Personality Disorders

- Incorporate Personality Functioning into Substance use Disorder treatment:

**Table 1. Elements of Personality Functioning**

**Self:**
1. **Identity:** Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience.
2. **Self-direction:** Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively.

**Interpersonal:**
1. **Empathy:** Comprehension and appreciation of others’ experiences and motivations; tolerance of differing perspectives; understanding the effects of one’s own behavior on others.
2. **Intimacy:** Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior.

**Table 2. Level of Personality Functioning Scale**

<table>
<thead>
<tr>
<th>Level of Impairment</th>
<th>Self</th>
<th>Interpersonal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1—Some Impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0—Little or No Impairment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Self:**
- Identity: Has ongoing awareness of a unique self; maintains role-appropriate boundaries. Sets and aspires to reasonable goals based on a realistic assessment of personal capacities.
- Self-Direction: Has consistent and self-regulated positive self-esteem, with accurate self-appraisal. Is capable of experiencing, tolerating, and regulating a full range of emotions.

**Interpersonal:**
- Empathy: Is capable of accurately understanding others’ experiences and motivations in most situations. Can reflect on, and make constructive meaning of, internal experience.
- Intimacy: Maintains multiple satisfying and enduring relationships in personal and community life. Is able to establish enduring relationships in personal and community life, with some limitations on degree of depth and satisfaction.
Substance Use Disorders & Trauma: Bridge #2: Positive Childhood Events (PCEs) & Resilience

• PCEs – “positive childhood experiences”
  • Have a dose-dependent relationship with adult mental and physical health, no matter ACEs score\(^1,2\)
  • What are PCEs? -- There are 7:
    1. “feel able to talk to your family about feelings;
    2. feel your family stood by you during difficult times;
    3. enjoy participating in community traditions;
    4. feel a sense of belonging in high school;
    5. feel supported by friends;
    6. have at least two non-parent adults who took genuine interest in you; and
    7. feel safe and protected by an adult in your home.”\(^2\)

“… are the experiences that help children learn to trust others even when life is uncertain, difficult or frightening. They happen when we are willing to talk honestly about things that are hard to understand, scary, embarrassing or painful. When adults are willing to have these types of conversations with the children, the result is that children feel reassured that they are not alone in their struggles and they are better able to find meaning or purpose in their struggles.”\(^1\)

Substance Use Disorders & Trauma: Bridge #2: Positive Childhood Events (PCEs) & Resilience

• Resilience: the ability to grow from the stresses we experience

Table 1. Existential Postures of Vulnerability and Resilience to Illness

<table>
<thead>
<tr>
<th>Vulnerability</th>
<th>Resilience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>Coherence</td>
</tr>
<tr>
<td>Isolation</td>
<td>Communion</td>
</tr>
<tr>
<td>Despair</td>
<td>Hope</td>
</tr>
<tr>
<td>Helplessness</td>
<td>Agency</td>
</tr>
<tr>
<td>Meaninglessness</td>
<td>Purpose</td>
</tr>
<tr>
<td>Cowardice</td>
<td>Courage</td>
</tr>
<tr>
<td>Resentment</td>
<td>Gratitude</td>
</tr>
</tbody>
</table>

*This listing of existential postures is not an exhaustive one but does include most that are of frequent concern for hospitalized medically ill patients.*

Substance Use Disorders & Trauma: Bridge #2: Positive Childhood Events (PCEs) & Resilience

• Resilience: the ability to grow from the stresses we experience

Substance Use Disorders & Trauma: Bridge #3: Neuroscientific Psychoeducation & Experiences

- Incorporate psychoeducation about the brain: effects of trauma, brainstorm healing experiences:
  - Van Der Kolk’s book: *The Body Keeps the Score*
  - Fava NM, Trucco EM, et al. Childhood adversity, externalizing behavior, and substance use in adolescence: mediating effects of anterior cingulate cortex activation during inhibitory errors

Substance Use Disorders & Trauma: Bridge #3: Neuroscientific Model

• Van Der Kolk’s book: *The Body Keeps the Score*

- **Thalamus**: “cook” – relays all sensory information, integrates sensory info to autobiography memory. Sensation is root of emotion.
- **Amygdala**: “smoke alarm” – instant: is this going to kill me? Outside awareness. Activates hippocampus, and brain stem for fight-flight.
- **Hippocampus**: center for memory integration. Comes online age 2-3, so initial memories all thalamus/amygdala without watchtower view.
- **Cingulate**: bridge between “watchtower” and memory. May be responsible for conscious experience of emotion, moment-by-moment direction of attention.
- **Prefrontal cortex**: “watchtower” – enables prediction & planning, sense of time/context, conscious choice.
- **Insula**: within middle prefrontal cortex: “interoception” – awareness of body state.

---

van der Kolk BA. *The body keeps the score: Brain, mind, and body in the healing of trauma.* 2014; Viking.
Substance Use Disorders & Trauma: Bridge #3: Neuroscientific Model

• Dr. Billington’s tips:
  • Use the model to frame need for action: emotion recognition & regulation (that creates pride), suffering that is worthwhile, boundaries, etc.
  • Do NOT frame individual as having “broken” mind; directly address this thought
    • Shame is horridly addressed within psychiatry
  • Normalization, normalization, normalization
  • Validation: values seen in individual now—self-worth, courage, agency

Key Points

• Trauma and substance use disorders are associated & likely interwoven in adolescents
• Data is limited, yet we can use clinical judgment to increase utility & significance
• Mental illness absence isn’t enough
• Have several “bridges” that patients can learn to see, and use to walk toward mental health
Papers Shown in Slides


Resources for Understanding Trauma – Seminal Experts:

1. The Body Keeps the Score by Bessel Van Der Kolk
2. In An Unspoken Voice: How the Body Releases Trauma and Restores Goodness by Peter A. Levine, PhD
3. Trauma through a Child’s Eyes by Peter A Levine and Maggie Kline
4. Trauma and Recovery by Judith Herman, M.D.
Resources for Sustained Trauma / Personality Disorder Healing:

1. Recovering from Emotionally Immature Parents by Lindsay Gibson
2. Self-Care for Adult Children of Emotionally Immature Parents by Lindsay Gibson
3. Doing Dialetical Behavior Therapy by Kelly Koerner
5. Handbook of Good Psychiatric Management for Borderline Personality Disorder by John G. Gunderson
Resources for Mental Health Creation

Books for Healing:

1. Book to heal the world – Nonviolent Communication, 3rd ed, by Marshal Rosenberg
2. “Graduate” book to NVC – Say What you Mean by Oren Jay Sofer
3. What breaks the world – The Anatomy of Peace: Resolving the Heart of Conflict by the Arbinger Institute
4. Wisest book, piercing quality about how we create our suffering. Complex trauma healing – The Lies We Tell Ourselves: How to face the Truth, Accept Yourself, and Create a Better Life by Jon Frederickson
5. My favorite book for grief – Read This Till You Believe It by **M.H. Clark
6. Funny, motivating actions to improve life – How to be Miserable: 40 Strategies You Already Use by Randy Paterson
7. Beautiful short poems on internal experiences – Inward by Yung Pueblo
8. Acceptance, mindfulness, suffering – Falling into Grace: Insights on the End of Suffering by Adyashanti
Case Presentation

17 y/o F w/ PMHx ADHD, combined type, polysubstance abuse (alcohol, cannabis, nicotine, cocaine), history of cutting and remote suicide attempts presents to BSU Student Wellness after ADHD testing, requesting treatment for ADHD with stimulants.

- Suicide attempt at age 13, resulting in hospitalization
- History of cutting for ~3-4 years
- Binge alcohol use pattern, previous blackout drinking
- Cocaine use for ~20 times over 3 months. None for >1 year.
- Not currently in psychotherapy
- Has rules for alcohol use, related to stimulants

- Safety:
- Alliance:
- Availability
- Goal, tasks
- What happened?
Dr. Billington’s Summary of Psychiatric Treatment for Named Problem Patterns (Diagnoses) that Interfere w/ My Quality of Life or Ability to Do What Matters

**Personal Strengths**
- How do I allow, move through, and change my internal experiences? How do I value myself? (thoughts, feelings, wants, needs/values, boundaries)
  - Daily routine: exercise, diet, sleep, “adulting,” in ways that create sense of pride
  - Pleasurable activities: hobbies, interests, learning, play
  - Distress tolerance skills: choosing suffering, ice holding, Prog. Muscle Relaxation, intense exercise, mentalizing skill
  - Relaxation skills: creativity, art, mindfulness practices, music, time in nature, time with animals
  - Reflection skills: journaling, religious rituals, reflect
  - Gratitude, humor, complimenting others, listening

**Meaningful, Supportive Relationships**
- With whom do I find relationships who accept me? Who helps me feel worthwhile? Supports my growth? Who helps me change?
- Psychiatrist, talk therapist, or wellness coach
- Physician, NP, or PA, PT/OT/Speech therapist
- Personal trainer, yoga teacher, exercise partner
- Family, close friends
- Acquaintances, activity/hobby friends
- Community: AA/NA/CelebrateRecovery, Meet Up & interest groups, church groups, work friends

**Substance Intentionality**
- Do substances I take into my body worsen my problems? Are they a way to numb emotions, or try to escape/avoid?
  - Food or caffeine
  - Alcohol
  - Rx medications: pain pills, psychiatric meds, anxiety pills
  - Recreational or illegal substances

**Psychiatric Meds**
- Pills do not help emotions.
Dr. Billington’s Model for Active Mental Health Creation

- Connection & Belonging
- Safety
- Power / Agency
- Clarity / Coherence

- Meaning / Purpose
- Joy (Enjoy & Be enjoyed)
- Loss

**Worth**
(Vulnerability)

Reality / The Present:
What’s happening, right now, in each of us?

Actions
Emotions

Thought World:
(& Drivers of Trauma):
1. Thought labels
2. Shame

Hierarchy
- Has Power
  Judged w/ + labels
  “Right”
  “Good” / “Perfect”
  Pursue
- Lacks Power
  Judged w/ - labels
  “Wrong”
  “Bad” / “Broken”
  Disregard

2 Resulting Patterns for Relationship:
1. Attack (label) pattern
2. Passive Withdraw (passive) pattern

Need: shared by all humans. Absence of need creates suffering, and a loss of function/life.
Value: specific to an individual. Temperament, love language, moral fiber. Personal compass; shows what matters. What suffering is meaningful. Individual. Ex: love languages
Boundary: an invitation to accept a part of me, here. Can I still add to your life if I feel _____ have limits/needs, believe or find meaning in _____, etc)? Is not an attack, nor withdrawal.