The Urge with Carl Erik Fisher

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And you can't think your way out of those biases. They're just, they're so deep in us that it would be impossible to just somehow like come up with your own fresh psychology, whole..

Yael Schonbrun: That was Dr Carl Erik Fisher on psychologists off the clock

Diana Hill: We are four clinical psychologists here to bring you cutting edge and science-based ideas from psychology to help you flourish in your relationships, work and health.

Debbie Sorensen: I'm Dr. Debbie Sorensn practicing in mile high Denver, Colorado, and coauthor of ACT Daily Journal

Diana Hill: I'm Dr. Diana Hill coauthor with Debbie on ACT Daily Journal, and practicing in seaside Santa Barbara, California.

Yael Schonbrun: From coast to coast, I'm Dr Yael Schonbrun a Boston- based clinical psychologist and assistant professor at Brown University.

Jill Stoddard: And from [00:01:00] sunny San Diego, I'm Dr. Jill Stoddard author of Be Mighty and The Big Book of ACT Metaphors.

Debbie Sorensen: We hope you take what you learn here to build a rich and meaningful life.

Diana Hill: Thank you for listening to Psychologists Off the Clock!

Hi everybody. It's Diana here and it's with mixed emotions, that I want to share with you that I'm leading psychologists off the clock to start a new venture in the new year. I'll be talking more with Debbie in a future episode to say goodbye and reflect on my time here.

And I want to let you know about where I'm headed. I'm launching a new podcast called your life. And what it is, is an opportunity to take these ideas from modern psychology and contemplative practice, and really apply them to your daily life. I'm going to be having authentic and exposed conversations with thought leaders and scientists and spiritual teachers.

And I'll be having judge brewer on as my regular contributor. the reason why I'm doing this podcast is because life is messy and unpredictable, and [00:02:00] it's nice to have a partner with you as you learn new strategies to adapt and thrive. And that's what I'm hoping to be for you. You're a psychological flexibility guide. I even have a segment each week with bite-sized skills that you can try out at.

Podcast you can subscribe to the podcast for free at yourlifeinprocess.com. And if you do, you'll get the first five episodes in your podcast player. When it launches in the new year, please help me out by sharing this news with friends or colleagues you think may be interested and listened to the trailer at yourlifeandprocess.com.

Yael Schonbrun: Well, we're sad to see you go Diana. We'll have one less cohost, but Debbie Sorenson, Jill Stoddard and I are. Going to be doing some reinvention while continuing to offer the same great in-depth interviews and science backed psychology content with leaders in.

The field. Our new directions will involve opportunities for us to get more interactive with all of our listeners. Including with the off the clock book club that we'll be launching as well. Several other exciting developments we have in store.

So we hope you stay tuned for details from psychologists off the [00:03:00] clock.

I'm here with Debbie to introduce a new episode that I'm really excited about. I got an opportunity to speak with the psychiatrist by the name of Dr. Carl Erik Fisher. Who's just come out with a brand new book called the urge, our history of addiction.

And it was a really terrific read. And what I loved about it was that it's focused on history really was this way of thinking about the context of illness and addiction in a way that I hadn't really thought about before, which is kind of interesting because the kind of therapy that Debbie, Jill, and Diana and I do is

acceptance and commitment therapy. It falls under the umbrella of what we call contextual behavioral science, and these are therapies that really pay a lot of attention to the context. Often we think about context is like our social environment or our family environment or educational environment or our cultural environment.

Sometimes context is internal, whether we have, you know, [00:04:00] illness but what, what I think was really novel for me was thinking about the historical context and this book really dives into that.

And Debbie, I know that you think a lot about context as well.

Debbie Sorensen: Oh, Yeah. I mean, I love the saying that we have in our field that all human behavior makes sense in context. And I think addiction is really interesting in terms of that big picture, social and historical context. And when you think about things like stigma and treatment, and I was really interested in thinking about the context, also the historical context of treatment for addiction. I can't tell you how many times I've heard mental health providers say something along the lines of they. Work with a client who's actively using. Right. I think that the tendency is to refer to a really intensive substance abuse treatment program. And absolutely those programs are really helpful for many people, 12 step programs, inpatient programs. [00:05:00] Intensive programs can be helpful for some people, but to think that you can't work with anyone when you know, mental health and substance use are so intertwined.

And I think a lot of times people are scared to work with them, but really, you know, a lot of people aren't going to find those, those more intensive programs, either helpful or necessary, you know, an outpatient. Therapy might be better for some people and more helpful, but if we're looking at it as this like separate, scary thing, you know, it's not really going to benefit anyone.

So it was just really interesting to think about that and how historic that is. Like, he talks about why those got separated in the first place and the stigma behind that, which I think was super interesting.

Yael Schonbrun: Yeah. And I think you're bringing up a point of the way that we contextualize addiction that we often see it as like an isolated thing, as opposed to. You know, something that exists within a person that is just like one feature among many that make a [00:06:00] person, a person and that different

people have different relationships with alcohol and drug use and that we have a tendency because we're at this point socialized.

And again, there's this long history behind it to see it is this very dichotomous binary thing. You have an addiction or you don't and what he talks a lot about in the book and in our conversation, is that the more productive way to see addiction is on a continuum. Um,

Debbie Sorensen: Yeah. You know, I was thinking about that a lot with my own life, whether it's caffeine or alcohol, it's like substances are ingrained. And, you know, I like a lot of people, you know, parents. During the pandemic. I have been, you know, drinking wine a lot of times at the end of the day, I've actually talked about this on the podcast before.

So I decided to do dry January and right at the moment that we're recording this intro, I'm past the halfway point, right. I'm getting toward the end of dry January. And I really wanted to try that. I don't think I have a big problem with alcohol in my life. [00:07:00] You know, I'm pretty moderate drinker. I don't drink every day.

I don't very often, not never, but not very often do I drink excessively? It's usually just like one glass of wine or something like that. And I just wanted to try it to see what it would be like. And it's been an interesting. You know, process to just play around with this idea and see what's showing up for me around that.

And there's moments when it's hard and uncomfortable, but I kind of wanted to just get more flexible and curious around alcohol. I know a lot of people are kind of in a similar situation where it's like, it's not that big of a problem really, but it's also like, you know, maybe good to take a breather once in a while.

So I think that that does speak to how it's, it's really on a continuum. It's not always this, like, this is pathological you're, you know, I think there is that sense of like, you're a bad person, if you misuse substances. And it's like that sometimes just speeds the shame cycle and it can be problematic in its own.

Yael Schonbrun: [00:08:00] Yeah. So, you know, we hope that this episode gives people a lot to think about in terms of contextualizing . And to think about, you know, really. Unhooking from the judgment and just being curious,

and maybe even developing some flexibility around relationships with addictive behaviors and substances in your life.

So we hope that you get a lot out of this really eye-opening conversation with Dr. Carl Erik Fisher.

Carl Erik Fisher is an addiction, psychiatrist, bioethics, scholar, and podcast host of flourishing after addiction. He's also a writer and author of the just released book, the urge, our history of addiction, which we'll be discussing today. Welcome.

Carl Erik Fisher: Thanks so much for having.

Yael Schonbrun: So your book, the urge offers a really fascinating dive into the history of culture, politics, art, and science, as they relate to addiction. And it also interweaves your own very personal experiences with addiction during your training, as an addiction psychiatrist at Columbia. And I have to say the book is an eyeopening read, but [00:09:00] it's not.

The kind of book that we typically have on a podcast about psychology. Um, but as I was reading it, it occurred to me how often we neglect to spend time understanding the history of various mental illnesses and how costly that really is. And you write, and I'm quoting from your book, understanding addiction in the present requires looking to the past.

And I think you can argue the same is true about any kind of. Illness. And so I'm just kind of curious what brought you into the place of realizing how much we've neglected to look at the history of addiction and why it's so very important to overcome this neglect.

Carl Erik Fisher: Yeah, thank you. And first off, thanks so much for having me on your podcast. It's really nice to connect and to get the chance to talk. About this in a psychological focus. I've learned so much from the science of psychology and psychologists who often know psychotherapy a lot better than a psychiatrist.

So I appreciate it. Uh, I really needed the history for myself. That's where I started from. I needed something beyond the already very [00:10:00] good information I was getting from science and medicine, and I couldn't have

articulated it to you at. But I think that I had a sense that there was something culturally contingent about addiction.

Uh, when I read about, and when I learned about addiction, it seemed like there was this history lurking. Um, and I had a suspicion that there were certain influences and some ideas tacked onto the idea. And indeed, when I, when I looked at the hidden. Uh, one of the best lessons I got as a practitioner, as a clinician, as a scholar, was this notion that all mental disorders are not essential throughout time.

They're culturally contingent. What that means is my addiction is not the same as a bill W's addiction in the 1930s. It's not the same as the addiction that people were seeing back in say, Benjamin Rush's day in the 1780s, he wouldn't have even called it a day. [00:11:00] Uh, it's there, there are things there that are comparable, and I could certainly identify personally with people in the past, but there's also this layer of cultural and social understanding that was really useful too, to see sort of prismatic early, reflected through all these different times.

Yael Schonbrun: Yeah, And I think that that's something that we don't often think about is just , how culture really influences what we call an addiction. What we call an illness. And one example is homosexuality, right? At one point we called that a mental disorder, and I think you make this important argument in your book, that what we call addiction has some normalcy, right?

People using substances, uh, has been a true throughout human history. In fact, on the cover of your book, there's a kind of a ancient Greek guy that looks, you know, a few shots past what's comfortable.

One of the problems in the modern way that we understand addiction is how we treat [00:12:00] it. And one of the threads throughout your book is that we understand addiction to be different than mental health disorder. So this kind of gets to the cultural understanding that we have of what addiction is and what it isn't.

And so I was wondering if you could speak to this question of why it's so problematic to treat addiction so differently than mental health disorders.

Carl Erik Fisher: Yeah, thank you for asking. It's such an important question because like the water. I was swimming in, I didn't even perceive it as an odd thing to be doing back when I was training. And I think many of us in the

mental health professions have this experience that it's just intuitive, that people with general mental disorders get treated over here.

And there's this totally separate clinic for addiction down the street. And it's really dangerous. It's really harmful. And it's actually a legacy of the medical professions, wholesale abandonment of people with addiction multiple times throughout history. It had been most recently in say the 1920s, 1930s, [00:13:00] the AmErikan medical association following largely xenophobic and racist panics of the time came out and said that addiction was not a disorder.

It was just bad behavior. It was a vice. And we're still living with that. We still have that separation. And one of the most urgent needs in mental health care is to mainstream addiction. Meaning if somebody goes to the emergency room with opiod disorder, that they get the opportunity to get treated, uh, ideally with buprenorphine right there, if they want it.

Uh, but at the very least to get connected to care, but usually people are just given a little sheet and said, you know, go, go somewhere else.

Yael Schonbrun: Right. And you, you give this example of a supervisor earlier in your training, who, when you had, I think it was a young man who came in and there was kind of a dual diagnosis situation of depression, but also some substance, you said the supervisor said, you know, we're not equipped to handle that here.

Send him elsewhere. And you write about this response, internal [00:14:00] responsive, you know, I really could have helped him. He was sort of active. He was showing up, he was ready to do something. And yet we're taught often as mental health providers, that addiction should be treated separately.

Carl Erik Fisher: That story really encapsulates a lot about not only my own experience and training, but, uh, the way we. Addiction in general, the bottom line, like you mentioned, is that this guy was a better patient than I was when I was active. When I was earlier in residency, I was deep in denial and I was refusing care.

That was offered me. And I was trying to do it all by myself because I thought there was something virtuous about that. I thought that it meant something about. Uh, to do it without treatment, which speaks to one of the deeper challenges of treating people with addiction. And we see this in other mental

disorders too, but, um, the, the sort of volitional denial and hiding and, um, the, the disorder of a fractured [00:15:00] will over time.

Meaning, I might say in somebody's office, I want to stop drinking, or I want to stop using this drug, but then my wheel takes on a totally different flavor on Friday and I make a totally different, uh, choice.

Yael Schonbrun: Should a patient who is feeling really depressed and also struggling, you know, to manage their alcohol use. Should they really look for somebody who only specializes in addiction? Or can you go, or would you recommend just find somebody who's a good provider who can develop a close relationship with you? Who can be open to what you have to share?

Carl Erik Fisher: Uh, yes, I answer is yes. Do something get help. It's hard to find help. And it's hard sometimes to find quality help, even when you find quality help, it's hard to find a fit. And the reason I give that sort of weaselly answer is because I do think we need specialized training to work with people with addiction.

And simultaneously it has to be mainstreamed [00:16:00] and most general practitioners vastly underestimate their capacity to work with addiction. So many people I see in private practices around New York and otherwise say, oh, I don't know if I could handle this. Or I'm concerned about this person's history and that's fine.

I've such total compassion for those views. I don't fault anyone for thinking that way if they think that way, but people with addiction are not so. It's one of the key themes of my book. There isn't such an us them idea. And in fact, that was one of my major barriers to getting care and treatment in the first place.

I thought addiction was something so special, so extreme, and especially with the historical examples, I've come to feel that addiction isn't all of us. It really is just one expression of a set of vulnerabilities and a set of tendencies we have for working with ourselves.

Yael Schonbrun: I think that's put so well. And you really do put an important magnifying glass on this sense of addiction as other, and [00:17:00] how problematic that is both for somebody who's struggling to manage their use, but also in those of us treating any do think that the separation of mental health and

addiction as has caused kind of like a fear for a lot of practitioners of like, oh, I'm not equipped.

I can't. And it is. Pathologizing way of seeing addiction. And that is a huge part of what I love about your book, that it really does say, you know, this is a part of all of us and we don't need to be afraid of it. Um, and you read a lot about, you know, the criminalization of addiction and this sort of like moral narrative of, of what it means.

And, and that is an important reason that we need to look into the history of. Evolved into an understanding of addiction is so other is so problematic is so, um, almost untreatable, unless you have some magic potion, which none of us do.

Carl Erik Fisher: Yeah, the criminalization of addiction is in many cases. But the notion of addiction was wielded. Like a weapon addiction can also be caused by oppression, [00:18:00] racism, white supremacy, xenophobia, patriarchy, all those things. It can, that can exacerbate addiction. And the notion of addiction itself can be wielded like a weapon.

Even when there isn't really addiction. We can pathologize normal drug use and use it as an engine that keeps mass incarceration rolling. And I think it's so important to look very carefully at how the notion of addiction is used in that way, uh, to, to be careful about our assumptions, about what.

Yael Schonbrun: Totally. And I wonder if you can, even just off the cuff, pull out an example of, um, a way that addiction has been weaponized in a way that, you know, serves either a politician or a corporation,

Carl Erik Fisher: sure I'll go with the corporation because I think that's the one that doesn't come to the surface. There's there's such a great expansion in consciousness, around the misplaced war on drugs, but what most people miss is the way similar ideas are weaponized by powerful [00:19:00] corporations, wielding asymmetrical market forces to take advantage.

And the example that comes to mind is a way that, uh, alcohol industries have repeatedly throughout history. And when I say history, I mean decades and decades and decades and decades, um, alcohol industries have repeatedly used this notion of putting the problem in the industry. To absolve themselves a blame.

And whether that is some sort of nascent psychology in the 1930s and forties, or whether it's genetic research in the 1980s, or whether it's neuroscience today, a massive corporations that I call addiction, supply industries, the industries that feed off of our natural desires. Um, these industries like to use these individualized notions to say the problems on.

The problem is in the person. They're sick people over there. Most people can use it responsibly. And, um, it's a really dangerous notion, uh, because it obscures that vast middle ground where most people have some issues with some [00:20:00] things, but also most people don't fall all the way off the far end of the spectrum into the kind of addiction that.

Yael Schonbrun: It's pretty clear that politicians and corporations have a particular stake in the game of how to understand addiction. In other words, you know, politicians might sort of vilify it to to provide themselves with a sense of like, I know how to conquer this thing and corporations might try to sell a substance, but what's maybe more surprising is how scientists can really get entrenched.

And either promote or fight science that emerge as you give a number of examples that I just thought were really fascinating about how science can almost unwittingly be a part of why we vilify or how we vilify addiction. Um, and, and one of the examples was this giant study called the Rand report that I learned about when I was in graduate school.

And then, and it really. Fascinating demonstration of what can happen in science. When people have started to adopt a particular view, and then we get information that says something different. So I wonder if you can walk through that historical example.

Carl Erik Fisher: absolutely. Uh, so the [00:21:00] Rand report came out of the Rand think tank, but it was a study based on federal research. And to properly tell the story. I just have to back backup just one or two babies that, uh, in the 1960s and 1970s, there was this huge groundswell of support for expanding addiction treatment services.

And like we were just discussing it. Didn't get all the way. It didn't quite finish the job of mainstreaming addiction treatment. And in some ways they were doing a better job in the early seventies of providing federally funded,

distributed, low barrier. Uh, mostly alcoholism treatment. Cause that's the thing that was more palatable then.

So after a few years, all of the data were collected and deposited in Southern California and Rand, and they ran the numbers on what actually happened to people, people who were seeking treatment for alcoholism and, uh, what they found. Well, they found a lot, it's a large book-length report, but the upshot was alcoholism is not.[00:22:00]

Meaning people who identified as even really severe alcoholism, sometimes got better and sometimes could return safely to moderate drinking, not everyone. And there've been generations of epidemiological research, uh, validating this notion and strengthening this notion, but it's still overlooked because we have such a powerful cultural idea of what addiction is.

But you mentioned the backlash. And so when, when the study came out first, it was a little bit leaked and there were actually some people very active in 12 step recovery advocacy on the board of the Rand corporation who hated the idea of it. They didn't care what the science was. They didn't care what the methods were, but, um, it just defacto on the face of it.

They thought this is dangerous. We can't let this out into the world. And there was a concerted campaign to the point where there were dueling press conferences and sort of dueling, um, uh, PR campaigns to try [00:23:00] to convince the public. On one hand that science is science and this is a real finding. And on the other hand that, uh, we should immediately dismiss these findings right on the face of it.

And, um, It was a really powerful episode, not just because of that individual episode, because it set off a chain of sort of reactionary advocacy leading all the way up to the point of professors being villainized and almost chased out of the country, uh, in order to, to do the kind of alcoholism research that they want it to do.

And to this day, there's certain types of addiction research that aren't really studied in the United States. Uh, Great example is harm reduction, harm reduction, research, things like serene service programs or overdose prevention sites really underfunded in the United States.

Yael Schonbrun: Can you actually define what is harm reduction? Because I think that actually is a term that very few people have heard of, which is kind of

amazing because there's so much science backing up. Um, the, the value of taking a harm reduction approach. [00:24:00]

Carl Erik Fisher: My definition of harm reduction is any positive change. And people have written entire books about harm reduction. So there are other views, and I want to shout out Maya salivates. Who's written recently a history of harm reduction. There are also theorists who talk about harm reduction as a liberatory philosophy as something that is.

Uh, seeking to overthrow and trans power dynamics and return power to the marginalized and the harm, especially drug users and people who have suffered from drug addiction. So. Harm reduction encompasses a vast fast territory, but the kind of harm reduction I'm talking about in terms of funding is concrete harm reduction practices.

And those are interventions that aim to produce any positive change in the health of somebody suffering. Negative consequences either from drug use or from the negative consequences of criminalizing drug use, because sometimes, uh, [00:25:00] people wouldn't have negative consequences if it weren't for the really harsh prohibitionist crackdowns.

So examples include syringe service programs, where people are provided with clean syringe. While also engaged in care or overdose prevention sites, which are also known as safe consumption facilities in some resources. Those have existed in other countries since the 1980s, but the United States has only just started to investigate these things now.

And, uh, there's tremendous research that these things really do save lives without increasing drugs.

Yael Schonbrun: Yeah, and I think it's amazing. I mean, both the evidence that you can have a substance problem at one point in your life and sort of age out of it, mature out of it. There's a lot of. It's sort of, there's like an age trajectory for you of use for a lot of people that you might use, for example, really heavily.

And unhelpfully in college and that as you reach your thirties and forties, that use tends to drop off that's again, as you're pointing out, not true for everybody. If you [00:26:00] have an addiction at one point in your life, that doesn't mean that you will necessarily have an addiction at another point in your life.

And then from the harm reduction point of view, there is some evidence that people who have an addiction at one point can learn to use in moderation in safe ways. And I think what the Rand study shows and, and you talk also about, um, this research, couple mark and Linda Sobell, who are really well known in the addiction field.

That they found that you could teach people behavioral techniques to moderate their use, and folks in response to those research findings, you know, really wanted to tamp down because, you know, there was just such a dominant belief that people who have an addiction can't learn to use in moderate, more sustainable, healthy ways, which is interesting.

I think, as somebody with a scientific background, you know, I always want to believe like science rules of the day. When we believe so strongly, sometimes the findings that we should be paying attention to can get pushed under the.

Carl Erik Fisher: Absolutely. I. [00:27:00] My mind is actually going to, uh, earlier scientists who discovered the same thing decades ago. And we're constantly discovering and rediscovering the same elements of care and healing because cultural shifts obscure what's, um, that doesn't fit into our framework. So, for example, Lauren's cold.

Was this a physician in the 1920s, 1930s, he was active, who was charged by Congress to go out and study opioid addiction is a huge problem around that time. And he found that if people were maintained on regular doses of things like morphine, uh, they were functioning really, really. And that was not a popular study.

Back then in a time of harsh prohibition is crackdowns and it was not a popular finding in the time of mark and Linda Sobell, who were trying to intervene with very severe cases of addiction, um, and did show some marginal benefits and in health. And, uh, it's not a [00:28:00] popular finding. Now we have great current epidemiology that says that there are some people, not everyone, uh, but some people.

Who can really improve their functioning in life without even changing their use at all. And, um, you were talking before about how science is socially contingent and I, I just think it's hard to escape those frameworks as scientists, uh, always have to be careful about what sorts of cultural beliefs they're onboarding, because you know, for us, for people who are interested in psychology, Uh, the, the core ideas about human psychology and human

behavior are deeply, deeply shaped by centuries and centuries of theology and philosophy.

And you can't think your way out of those biases. They're just, they're so deep in us that it would be impossible to just somehow like come up with your own fresh psychology, whole.

Yael Schonbrun: Yeah, I think that's so true. And that is why it's so useful to look into the history and, and, you know, we can't [00:29:00] undo the biases, but we can deepen our understanding of them. And I think that's where your work comes in. So handy. Um, related to that, I wanted to talk a little bit about this really commonly held belief that addiction is a brain disease, right?

That there's something very fundamentally biological about it. The science on that is kind of mixed. So I was hoping that you could share a little bit about that. And, and also still, you know, there's this broad question of why we're so hungry to believe that it's a biologically derived and exclusively biologically driven disease.

Carl Erik Fisher: Sure thing. Yeah. The first thing to say is that I think just calling addiction a disease period is misleading. So that's even before we get to the notion of brain disease. And perhaps even sort of a lower bar than brain disease, but even just to call it a disease, I feel unfairly narrows the scope [00:30:00] of addiction.

It makes it too individualized and it overlooks the broader social context and the way that we're all interconnected. Um, but then brain disease takes it. A step farther brain disease became popular. Basically in the 1990s, when there was a big boom in interest in neuroscience research and people were able to nourish the brain in a different way, but the story actually begins earlier because it also co-existed with the crack epidemic and.

Not a lot of people were making the connection at the time, but here's another example of how people have trouble identifying the biases. They carry into the scientific endeavor. It's hard to put ourselves back there, but I grew up in this time, I grew up in north Jersey in the eighties and nineties, and I still remember just the pervasive fear and how my parents were so scared of just like going into Manhattan, you know?

And all of that thinking infused research on addiction because a lot of research on addiction back then was research on crack. [00:31:00] And sure enough

crack is a very powerful stimulant. It's really just cocaine. It's not a different drug. It was, it was kind of portrayed as a different drug for the purpose of certain, uh, political moves.

But it it's just a different form of cocaine and it, it strongly activates a series of neuro-transmitters that powerfully interacts with. And then dopamine became the sort of central figure in this story about hijacking the brain. And that's the thing that brings us up to brain disease because by the 1990s, there's very good scientific research, describing different brain circuits that were active in crack and other stimulant addiction on the basis of that scientists said.

Addiction is a brain disease. Like any other disease, we can locate the problem in the Oregon and therefore you should give us more funding for research and you should treat people with the disorder more, fairly. And I think it did succeed on certain grounds. It wasn't some sort of. [00:32:00] You know, awful criminal campaign.

Uh, they, they had real purposes for using that language, but the downside of a brain disease narrative is that it overlooks all of those broader social forces that go into, for example, uh, the crack epidemic in the eighties and nineties, which was not the function of like some evil drug hijacking people's brains.

It was also the function of, chronic. Impoverishment and oppression of the urban poor. It was a function of the bad job we had done of building up our addiction treatment infrastructure. And it was a function of economic changes, like the loss of jobs and the opportunity for meaning and purpose among the urban working class.

And so to reduce it all to the brain disease story, really I'm inclined to call it. Causes us to miss all those other social forces. So maybe it works when you're trying to get an addiction treatment program in your hospital, but, um, it comes at a high cost.

Jill Stoddard: [00:33:00] Psychologists Off the Clock is proud to be partnered with practice. Continuing education practice is the premier provider of evidence-based training for mental health professionals. Practice offers both live and on-demand courses with options for beginner as well as more advanced clinicians practices also known for its top acceptance and commitment therapy trainers.

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Yael Schonbrun: You have a term that's originated by a German brain research or Ernst Pöppel, called monocausotaxophilia and well, let's, I'll have you sort of answer what the term means and why it's so important to kind of get in on the joke of this disorder.

Carl Erik Fisher: Yes. Yeah. It's a made up term. That means the love of single causes that explain everything. And we have that in mental health. We have to admit

Yael Schonbrun: Totally.

Carl Erik Fisher: but we especially have in an addiction. Uh, people really want villains, especially when, uh, [00:35:00] substance addiction and other forms of addiction really hurt. I think we have to acknowledge that too.

It hurts, hurts the individuals who are suffering from addiction, but it hurts other people too. People do go out and, um, sometimes commit unimaginable. Uh, damn. To serve as their addiction. Uh, so people are naturally looking for villains and those villains can be found in a drug company. They could be found in, uh, the drug itself.

They could be found in some particular set of other social causes, but one of the big surprises from the, from the book was that, uh, drug epidemics are nothing new. We've had drug episodic epidemics for at least 500. In human history. And every time we've had a drug epidemic, whether it was crack or whether it was the first AmErikan opiate epidemic, which was around the time of the civil war in the mid 19th century, or whether it was when tobacco rushed across Europe and Asia, after Columbus returned from the so-called new world, uh, [00:36:00] people have searched for that single.

And it never really works. Uh, whether it's a prohibition has cracked down or whether the pendulum swings to the other end and people are looking for some sort of therapeutic or scientific or supposedly more compassionate response.

Yael Schonbrun: Yeah. And just one other fascinating anecdote that you share is. It's the history of cocaine, right? Freud was one of the earliest proponents of it. I actually, after I read your book, I went and looked up his, that paper, über coca. I'm sure I'm mispronouncing it. It was really fascinating.

It's a really fascinating study. It's one of his earliest published papers where he. Goes on and on about the, the miraculous properties of cocaine. And he is you, right. Was prescribing it also to a friend who had a morphine addiction as sort of a substitute and a less, um, problematic substitute for morphine.

Um, At many points in history we've identified substances that we think are very, very helpful. And then there's sort of this backlash, you know, from morphine to [00:37:00] cocaine to sedatives that are, that these substances are sold as safe, only to backfire in pretty tragic ways. And so one of the questions that I wanted to pose to you is the modern world of managing mental health.

Prioritizes medication. And as a practicing psychiatrist, how do you approach prescription given your in-depth knowledge of the history?

Carl Erik Fisher: Because addiction and mental health service, other mental health services are so segregated. There's two different answers to that. I think most general medical general mental health prescriptions are both over prescribed and under-prepared. Meaning, there are a lot of people who really benefit from life-saving medications.

Antidepressants can be life-saving in some circumstances. And also they're there too often, the tool of first resort, and especially because of resource shortages, sometimes a hairy general practitioner might reach for a prescription

pad and write someone an antiemetic. Rather [00:38:00] than say, connecting with counseling that doesn't exist or social services that don't exist.

Um, for addiction, they're mostly under prescribed. We have great medications, really help people with addiction. And I see this in psychiatry for general, practicing psychiatry, as many people balk at prescribing medications for alcohol use disorder or for even others substance use disorders, because they have this idea that it's complex or that it's uniquely challenging.

think that's a great example of where care could be more mainstreamed and we have an urgent, urgent need, uh, to offer at least for the people who want it. And for whom it would be a good fit, the opportunity to say, turn down the volume on certain cravings or to, to otherwise get, um, get access to a tool that can really be saving in some circumstance.

Yael Schonbrun: Right. I think that there's this feeling in the field that if somebody has an addiction, Having a prescription will lead them to just, you know, misusing [00:39:00] another dragon.

And I think what you're saying is that, you know, the evidence doesn't show that, that a lot of the medications that we might give to somebody who has an addiction are really, really helpful. And when we don't provide them, we're actually contributing to the stuff.

Carl Erik Fisher: Yes, absolutely. And also I can understand why people might have that view because there are so many cases of really, um, irresponsible prescribing again. Yes. I mean, there are examples and this kicked off some really bad prohibitionists, uh, legislation back in the early 20th century when opioids were essentially outlawed, um, because people would have pill mills and you'd go in and pay by the pound for morphine.

And we have equivalence of that nowadays. So it is important to be careful about inappropriate prescribing. one of our big blind spots nowadays, I think is benzodiazepines things like Xanax, Klonopin. Those are probably still prescribed to.

Yael Schonbrun: Can you actually speak a little bit to that? Cause I, so this is an interesting, because they're so commonly prescribed. So what should a [00:40:00] consumer know about those kinds of prescriptions?

Carl Erik Fisher: Sure thing with the general caveat, this is not medical advice and

Yael Schonbrun: Right? Fair.

Carl Erik Fisher: Of course, uh, benzodiazepines are really useful sedatives and they're actually the first treatment that we use for alcohol withdrawal. Alcohol withdrawal can be fatal. Uh, people can get seizures or even die.

So. We use benzodiazepines in a lot of clinical settings and hospitals. And then also as an outpatient intervention for anxiety problem is for outpatient anxiety. It can often just become an avoidance mechanism. I know your podcast you're really into act therapy. I love act. Um, I love the framework of thinking about avoidance and.

Finding the purpose in your pain and, uh, working with pain and accepting pain rather than, uh, just trying to manipulate it or control it or exile it in some way. And what benzodiazepines sometimes do is they allow people to just totally eradicate their suffering, totally eradicate their anxiety. And [00:41:00] of course, I understand why people would want to do that.

And. That also doesn't mean that everyone should run off, run out and get off their benzodiazepines too. Right? Because not only is there withdrawal, uh, there can be some real challenging, personal growth involved in that. Uh, but I think that that's a subtle kind of psychological risk. That's often missed that people are missing the opportunity to work with their pain, their pain.

That's trying to show them something worthwhile. And I had something similar with Adderall. I think people's antenna are up a little more about Adderall, but not totally. Again, unfettered means in general. Uh, and I was using Adderall to medicate like a crushing sense of scarcity and a profound need for external validation.

Like I really needed to keep on working. If only I wrote enough papers. If only I succeeded enough in my residency, then I would be okay. And, um, that was also a type of avoidance mechanism. It was a way of me avoiding, facing up [00:42:00] to. Yeah. W the deeper feelings that were driving those thoughts that I wouldn't be okay.

It just being Carl, just being myself. Uh, so I think it really takes wisdom and discretion with using these medications while at the same time, like we were

just talking before there's tremendous stigma against them too. And some people can really be tremendously.

Yael Schonbrun: Yeah, I have a couple of questions about that. So I'm curious in your practice, when you see somebody who's experiencing tremendous amount of anxiety. You know, how, how do you approach that? How do you sort of straddle the line between helping them to confront it and not avoid it and sort of use it as information and a point of growth versus sort of dampening it down a little bit so that they can turn towards it because it can be so paralyzing. Um, and, and not as medical advice, but I'm just kind of curious, like how, how you sort of think about it. How do you approach it? How do you balance that over time in your treatment? [00:43:00]

Carl Erik Fisher: most people in my practice have a substance use problem history. So. Many, not all, but many have really deep history of finding refuge in substances to escape from anxiety. And that may be, is a twist. Um, my practice, I don't think it's different in kind, maybe it's a difference in degree, but people can be really terrified of anxiety.

And I see that in myself, I can be really uncomfortable in my own skin. I really don't like discomfort. Um, it sounds almost banal to say I don't like discovered, but I, I, I can deal with other forms of suffering. Like, you know, even despair. I don't have that much of a problem with sadness and hopelessness about the fate of the world, but when I'm just like anxious and queued up, or even if I've had too much coffee, that can be really uncomfortable for me.

And I just say that because I think that not everyone, but a lot of people with an addiction

Yael Schonbrun: it's very relatable. Yeah.

Carl Erik Fisher: So, uh, I [00:44:00] think it has to be approached very gingerly and I really try to take the principles of harm reduction into that therapeutic practice to meet the person where they are. What are you looking to change?

How is this anxiety affecting your life and what is it doing for you? What is the function it's serving for you? I think that anxiety can often be like a impulsive addiction to be volitionally engaged. In a worry loop is a way of trying to protect the self sometimes against future problems, 2% rate to return over and over again, to some sort of problem in the hopes that, um, maybe a problem gets

resolved, but at the very least you can convince your mind that you're doing something about it.

And, um, the first step is often recognizing the role of choice and the space between stimulus and response. That worry is not like a thing that's happening to us. It's often something that we're actively engaging. And, you know, I say that as I say, and I'm conscious of the fact that I never want to put my worldview on somebody else to, so if [00:45:00] somebody is not into that, then fine, you know, we'll talk about other ways to work with it.

But I think fundamentally often there's this element of, um, the relationship to the self and the relationship to suffering that, uh, needs to be approached very, very gingerly and careful.

Yael Schonbrun: Yeah, So I love that you approach that gingerly and, and recognize that it is very act consistent, right. To sort of be curious about the emotions and the. Re-engage with our values and then be willing to experience discomfort. But as you're noting, like that discomfort can be really, really tremendously

Carl Erik Fisher: Yeah.

Yael Schonbrun: uncomfortable crushing. Yeah, And so to, to really sort of acknowledge that at the same time, as, as you sort of, um, you know, try not to enable the use of avoidance, um, and you know, I am kind of curious, so you, if it's okay for me to kind of get personal with you.

Carl Erik Fisher: of course. Yeah. I wrote the whole book. I put it out there.

Yael Schonbrun: so, so let me start there. I mean, [00:46:00] what was that like for you to share some of the more vulnerable, intimate pieces of your journey through addiction and into recovery?

Carl Erik Fisher: I'd be lying. If I said it, wasn't also crushing and really fearful. And I was helped in the process because. It felt intuitive to me in the sense that I really wanted this book. This is the book I wanted for myself. And I couldn't find, I wanted a general overview and a historical look at the idea of addiction.

And there's so many great examples of deep dives into one individual time period, but no one trying to put it all together. And I really wanted that. And I

recognize that it would be totally arrogant and grandiose to say that I'm going to write the definitive book about addiction and tell you how it all is and put it all together from ancient Greece in India to the present day.

So it was necessary for me to bring in my personal story, not just to connect it to the, the human factors and to, to bring back the story, [00:47:00] to what really mattered, but also to, to disclose my own biases and to say addiction is deeply. Addiction depends on who you are, where you were born, the kind of privilege you grew up with and your inherent cultural values and biases.

So I was sort of led in that way. It just felt like the right way to do it. And so I didn't, I just try not to think about it too much, frankly. Um, and then once I was down that path, it was really terrifying because I spent so much of my life looking for external validation and doing the right things, writing.

Bioethics papers and research papers and getting accolades and rewards within a hierarchical patriarchal system. So to all of a sudden be doing the thing that a lot of more traditional therapist tell you not to do to self-disclosure is a, to say it's really dangerous. Plus add on the natural stigma attached to addiction.

And it was terrifying. There were [00:48:00] moments. I thought that. Not literally, but there's a part of me that thought that I couldn't survive it. Like there there's something deeply dangerous. I would not be okay if I let this out. And you know, I should say, we're recording this right now. It's January 12th. Uh, my book is not out yet and there's still a part of me in that it's terrified this morning I woke up and I was terrified.

I felt this huge knot in my chest, like, uh, Oh my God. How could I have done that scissor anyway, pull it back. Um, but I can recognize after working with it, I'm so grateful for the opportunity to work with that fear. Um, because it's no different than the other types of like self-protective fears. I've had that, like, I need to put on a show or acting authentically or kind of like manipulate myself and my actions to get other people's approval to.

Because I have more of a sense. I'm not, I'm not enlightened floating on a cloud right now, but I have more of a sense that I'm okay. I'm okay. As I am, there's nothing, you know, deeply awful about me. And if people know the truth [00:49:00] about me, it's not going to come back and haunt me in some way. It's okay to show up as I am.

Yael Schonbrun: Yeah. Yeah. And it sounds like you're able to even coach yourself, like it's okay to wake up with that feeling of terror and that knot in your stomach and to kind of proceed. Um,

Carl Erik Fisher: I had a therapy session last night, so that helps.

Yael Schonbrun: Which I actually, I wanted to ask you a little bit about your own therapy, so I hope that that's okay too. Um, so your book is very grounded in science. I mean, you, you sort of do a deep dive into the long history of science And addiction, But one of the things that struck me is that the kind of therapy that you pursued was internal family systems.

And you, you write in the book, you know, that you're aware that it's not an evidence back to treatment, and yet you found a lot of. Productive help from it. And so I think that's kind of an interesting point from the psychotherapy point of view that on the one hand, we want to look for treatments that have evidence backing them, that we know they work and yet different things work for different people in science [00:50:00] doesn't have the answer for any given person.

And so I think that's sort of an interesting general, um, question to be pondering is like how important is it to. Treat people with, uh, treatments that we've tested in randomized controlled trials. And how important is it to kind of be open to allowing individuals to explore what works for them?

Carl Erik Fisher: And what is our yard stick? Right? Because when I wrote that, I was thinking I'd be embarrassed to tell one of my supervisors at Columbia, that I was going to ifs because it doesn't have the status base. Seal of approval and that's not the right yard stick, just to be totally obviously clear. Uh, but I'm with you that I think that evidence-based treatments are really important and it's important to be humble about what we know and what we don't know me.

I just went to, uh, uh, a person that I [00:51:00] really loved and respected in my Zen center, who herself is a therapist. And I said, I need some help. My mother is dying and I, I need help. So you know, me, you know, my situation, you have a sense of who I am as a person. Who do you think I should go to? And I left. Which is very different from before when I was in academia.

And when I was studying this stuff, I would say, I would like read all the books and I would say, Hmm, you know, like maybe AEDP, but I don't know about

this. And like, maybe I'm not a good match for it. And thinking about personalized medicine, what is the theoretical underpinning and what can I get behind?

And I think there's something to that, you know, I think that, and I really love it when. People seeking help in my own patients are seeking information. I think it's good for people to be empowered and to really learn about the modalities. We shouldn't live behind this veil of secrecy, like and opacity about what our techniques are supposed to [00:52:00] be, but it was really a relief just to relax and say, just tell me what.

And letting go. And that, for me, that for me is really important. And I don't know that it's true for everyone, but for me, I really needed to let go of the notion that I was running my own show. I would fix it myself. I can get 90% of the way there. And I only needed like a little coach to get me across the way big theme in my recovery was acceptance.

And. And others have written out in feminist writers have pointed out. For example, in the case of, um, the experience as many women in recovery, that's not the answer for everyone. It's not the answer for traditionally marginalized communities. And there are a lot of people who don't want to say I'm. They instead want to say, like, let me identify what my sources of power are within this awful experience.

So I think it's very, it's very individualized. I just had the benefit of, um, building a community in recovery that I could draw on for support because that's the other piece. It wasn't just me. It wasn't that [00:53:00] I went out and got a therapist in a way. I was throwing myself onto the collective wisdom of my community and saying, this is not, it's not a me problem.

This is a we problem. Please help me. And that's always been easier for me in my life than just trying to solve it myself.

Yael Schonbrun: Yeah. And what's interesting, there is that there's so much scientific evidence to support the importance of community of, of having, you know, these social ties as well. I mean there there's strong evidence suggesting that the most important element of successful therapy is a connection with your therapist, that the modality, the, the sort of theoretical underpinnings of the therapeutic approach matter.

But the most important thing is really feeling connected to the therapist. And I think, um, that, that, that is sort of reassuring to know.

Carl Erik Fisher: reassuring and humbling. W we can go to workshops and we can go away for weekend retreats and study and [00:54:00] practice and get supervision. And all that stuff is wonderful. And I, for one, I think we have a moral obligation to go out and do the best we can and trying to practice our profession well, and also for me, at least I can chill out a little bit.

I can chill out because if I show up as a whole person and treat the person with respect and decency and really pay attention to their story and their situation, then that's already a long way there. And we all know that, um, there are people who are unable to give that to their patients for whatever reason. So. You know what a gift to.

Yael Schonbrun: Yeah, right. Showing up as a, as a, as a whole human in that room and being willing to really connect. I mean, that's sort of like all the way back to Carl Rogers who was so pivotal in helping us to understand that the most important thing that we can do is just , connect to the person that's in the room. Cause they're a person, not just a disorder, you know, set of challenges that need help.

Carl Erik Fisher: Yeah. And it's, I love that line of thinking and I think it's really, well-represented in certain branches. [00:55:00] Today. And it's been so hard to bring it into addiction treatment. It's really been a challenge because addiction exists at this borderland between social control and also health condition. There have been such debates about whether or not it even is a health condition that addiction treatment is so long been tied up.

Um, coercion. And a lot of my addiction treatment experience as a provider was in say, criminal justice affiliated programs where people were court mandated or people were there. Otherwise in response to like parole or probation. And, um, it's really hard to escape that. And I know a lot of people are out there working in those types of environments where people are showing up for treatment because of coercion, even informal coercion, like, uh, a friend or a family member or spouse says, do this, or else I'm gone.

Yael Schonbrun: Yeah.

Carl Erik Fisher: And I think all we can do and maybe like the best remedied for working within those systems is connecting to that insight of [00:56:00]

showing up as a whole person and unconditional positive regard, as much as you can and promoting someone's self-efficacy as far as they can actually exercise it in whatever circumstance or coming up with.

Yael Schonbrun: Well, let me ask a followup question to that because you know, part written addiction is so multiply determined. There are so many cultural factors, but there's also within a lot of individuals, a strong element of denial, right? That, that can be a really dominant feature for people who are struggling and not quite ready for treatment.

And yet. They're wreaking havoc on their own lives and on the lives of people around them. Um, so you, right. You know, and this is another quote from your book, but denial is a profound obstacle to treating addiction of all the people who have a substance use disorder and are not getting help fewer than 5% think they need treatment.

And yet, you know, coercion, isn't the right answer. And so I you know, my question to you is when you were not yet ready to admit that you had a problem, what do you imagine would have been [00:57:00] helpful in sort of opening you up to, to, um, I don't know, admitting that there was something that you needed help with.

Carl Erik Fisher: I just don't know what would have helped me because I got a lot of help. I was treated extremely well within the Columbia residency program and got a lot of opportunities to receive help. And I don't know how I feel ultimately about coercion in the strict sense. The. The informal sense of coercion is it's something harsh and tough criminal justice affiliated, but we can also talk about coercion simply as a hard choice, do this or else you will have to deal with the consequences of that.

And that's a common feature, even in the most compassionate and scientifically grounded forms of addiction treatment. They talk about that a lot in craft, for example, um, when a family member sometimes has to step back and. W [00:58:00] the words they use are allow the natural consequences of someone's used to progress.

And that doesn't mean withdrawing all care and letting them hit, hit rock bottom far from it. And it really is such a difficult choice and I've had to do it myself in my own life. Uh, and I've had, I've seen patients and patients' families have to struggle with this, and there's no easy answer there. But I say that I don't know

how I feel about coercion because I ultimately received coercion, not, not in a harsh way.

It was probably the number one absolute best case scenario for the treatment of addiction, because I was a privileged white guy at an Ivy league school who is reasonably well connected and I could afford treatment. And I was lucky enough to be in a state, uh, uh, state of the United States that had a physician health program where I was given the opportunity to get treatment rather than.

Face licensing problems and that's coercion. It wasn't a harsh coercion. Like someone waving a stick in my face and saying like, I'll send you to jail. It was like, [00:59:00] Hey, if you would like to practice a medical license is not, um, it's not a right. It's a privilege. And if you'd like to have that privilege and you should go ahead and go to treatment, and I am immensely grateful that I had that opportunity because I don't know what would have got me into treatment otherwise.

And at the same time, The treatment I was coerced. He was not evidence-based. And I saw a lot of harmful things in it, a lot of outdated and harmful treatments. And, uh, often the way it is with contemporary forms of coercion. And, um, again, I was very lucky people in the general criminal justice system are coerced into so-called treatment facilities, where their heads are shaved and they do pushups in the snow and that stuff is that.

Decades and decades to when the medical profession committed its wholesale abandonment of the treatment of people with addiction around the mid century. Uh, and so all of these other sort of, kind of random [01:00:00] treatment programs sprung up to take their place. So I understand why people are really, really careful about coercion by and large coercion probably does more harm than good.

And I don't know, I just don't know how we deal with the fact that there are some people with severe addiction who seem to require some form of that more benevolent or that less sort of like moralized form of coercion. That's just a hard choice or allowing the natural consequences to proceed so difficult.

Yael Schonbrun: Yeah. I mean, I think it's a fine line, but to me, coercion seems different than natural consequences. I mean, I think about this, like from a parenting point of view, You can coerce your child to clean their room, or you

can say, you know, it's up to you, but if you don't clean your room, then you know, I'm going to be grumpy.

And, and that's just a natural consequence because we all live in the same space and, and it pains my eyes to see your room. That's sort of a silly example, but hopefully the point is made clear. I think that there are, there [01:01:00] are ways to. make clear the natural consequences that are compassionate and they feel different than coercion. That is more, um, punitive,

Carl Erik Fisher: Yeah, I couldn't agree more as a parent, it's such a struggle and it's also a struggle not to just bribe people with gummy bears. Yeah. Do you do your piano lesson or no gummy bears? Uh, not the right kind. I think you're right. That we also, we probably need a better word than coercion, uh, in the, in the legal and the bioethical literature, we use the word coercion and it's very dry way, but it doesn't capture all the nuance and all the varieties of, um, those types of hard choices.

Uh, but yeah, I mean, it gets back to an even deeper question, which is how do we change anybody else's behavior and how do we help people working for change?

Yael Schonbrun: Right. How do we motivate people to want it for themselves, which is ultimately what we as providers want and what people who are struggling, you [01:02:00] know, need to have, they need to have the internal motivation. Well, one interesting thing that I think about too, and, um, I know we're running out of time, but I come from a research in addiction in couples.

And one of the findings is that. Uh, real important motivator for many individuals with an addiction, uh, to seek treatment is their partner threatening to leave. Whereas if both partners are using, the addicted person has a harder time finding the motivation to make any changes.

And I think. Can be coercive. I'm going to leave you unless you change? But again, it could be a natural consequence like this isn't healthy for me. I can't stay here. I love you. But, um, if we're going to stay together, you know, we need to create a healthier household. And to me, those feel different. Um, but again, you know, the line can grow very, very blurry quickly.

Carl Erik Fisher: Yeah. And it makes me think about acceptance at bottom that, uh, I don't think that addiction really ends. I don't think people are [01:03:00] cured. I don't think I'm cured. And that, that was one of my big

takeaways from looking at the history is that we've routinely returned to this desire to stamp out addiction or to cure addiction, whether it's through some kind of special, magical pill that takes away opioid addiction, or whether it's through some sort of new mutual help revolution, or whether it's through some sort of policy response.

And we need all those things, we need to do a better job on all those things. On research clinical care and policy changes because the death toll is immense. We're leaving a lot of lives on the table. And I think we have to recognize that we will not end addiction, uh, addiction, uh, is not something that we'll see the end of that it's something to work with.

And at least my own experience has been. My worst kinds of addiction are directly contiguous with all the other things that we were just describing about just like being fearful about external validation or, um, [01:04:00] sensitive to rejection, or, uh, even just worry. That's all the same for me. And, uh, there's a lot for me, at least there's a lot of, uh, relief that comes with just like giving up the search for the end or the perfect resume.

Yael Schonbrun: Right, right. Accepting it as a human problem is actually paradoxically empowering. And that's definitely the sense, the feeling that your book left me with. It's this really in-depth exploration of the history of. The ultimate conclusion is that this is a human problem that we need to accept. And that when we do we're much better positioned to manage it and healthy, sustainable ways. So it's, it's a terrific book. Um, where, where can people go to find out more about you and your work?

Carl Erik Fisher: Yeah. Thank you. Thank you so much. Thank you for the kind words. I really appreciate it. It's been nice talking with you. Uh, the best place to find out stuff about me is my website. It's Carl Erik fisher.com. I know there's different ways of spelling that, but if you Google it, it'll [01:05:00] come up.

Yael Schonbrun: And we'll, we'll put a link in our show

Carl Erik Fisher: Awesome. Thank you. Um, and I've got information about my book. It's called the urge, our history of addiction. It comes out January 25 and I've got plenty of links and information there. And while we're on this podcast, I should mention, I also have a podcast, uh, about, about addiction and recovery. It's called flourishing out of addiction.

So if you like, if you like this one, go check out that one. And, um, it's really nice to meet you. I really appreciate your kind words and your thoughtful questions about this subject matters.

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