Season 3 Episode 9 Gabrielle Annett

Voice over – Season three of the Options Save Lives podcast is brought to you with the support of our presenting sponsor R Street Institute and is hosted by Executive Director, Jenny Williamson.

Jenny Williamson – Today we want to welcome Gabrielle Annett to the Options Save Lives podcast. Gabrielle, thank you so much for agreeing to come on to our podcast today.

Gabrielle Annett – Thanks for having me again. I'm happy to be here.

Jenny Williamson – So I want to get started by letting you introduce yourself to the audience and tell us a little bit about your professional background and how you came to specialize in both traumatic stress and alcohol use disorder.

Gabrielle Annett – Sure. Well it was maybe a little bit of a windy path I think as often it can be for folks. So therapy and counseling is a second career for me, and I went into the field after having just such a profound personal experience with trauma therapy. So when I went into the field I knew that I wanted to focus on trauma and so I actually moved, you know, almost completely across the country and went to a school that allowed me to concentrate and focus on that in my master's program. So I did that. And during the program I realized that there weren't too many, there were a lot of people that didn't know that they had trauma I think is the best way to explain it. Like we're all familiar with, you know, combat trauma and things like that, but there are people that were, that have experienced trauma or major stressors and maybe don't realize it. And I just started doing more research and I kind of did my practicum in substance use and I went, Oh, this is the place where I really feel like I can make an impact. And at the time there was very little coordination between mental health and substance use, in trauma and substance use, they were like these two completely separate things that were treated separately. Fortunately, that's changed in the years, but it's not changed enough. So that really started my passion for really being combining the two. So I'm actually duly licensed both in mental health and substance use. And I started working in the field and was quickly discouraged and burnt out as I think most therapists are in traditional treatment, and recognized that the statistics are that traditional treatment has a 2% to 8% success rate, and that that really bore itself out in my own personal experience. And it was hard to get up every day and work in such an intensive field when you felt like you weren't even helping or making a difference. And it was right about that time that a colleague approached me and I had always kind of known him to be kind of on the cutting edge. He worked in the field and he told me about the Sinclair Method, and asked me if I knew anything about it, which I didn't. And kind of fast forward and I ended up being a part of a center that he owned that was specifically about the Sinclair Method outpatient, and really studied under the physician there for, you know, a couple of years, two to three years and learned so much about how to do the Sinclair Method properly, and all the kind of like, you know, like potential pitfalls that can happen or the things that people can experience in doing it. And so at that point I was sold. I haven't looked back and in my concierge counseling practice now I really specialize in, you know, alcohol use disorder and the Sinclair Method as well as trauma.

Jenny Williamson – Your first reaction to the Sinclair Method was positive because of the way you were introduced to it.

Gabrielle Annett – Yeah.

Jenny Williamson – Can you talk a little bit more about how that helped you help facilitate for others to learn the Sinclair Method and how to support it? Because you didn't learn about this randomly. A lot of people, even in the therapy world will learn about it through Claudia's TEDx talk.

Gabrielle Annett - Sure

Jenny Williamson – And then they immediately dismiss it. But talk about the power of learning about it from a trusted source.

Gabrielle Annett – Yeah, it's a great point. And, you know, I think it had, it made such a huge difference for me. And then of course connecting with his partner who was the physician who had had experience with that was also really helpful because, you know, I felt like I was getting training from, you know, somebody that had been using it and was seeing success. And, you know, I think to your point of, you know, a lot it's dismissed easily, we really have to understand the context of why that is, and that's because of the alcohol use disorder treatment history. Like we have to understand the history to understand why that keeps happening. And the history is that, you know, substance use and alcohol use was not a medical condition until the last, I don't know, 15 years I want to say and I might be a little off on that time frame. But for 100 years it was this identifiable problem, but not in the medical community. And it was in the religious and spiritual communities that attempted to treat, you know, alcohol use disorder with AA and so it wasn't designated a medical problem or a medical condition. And that's why there are so many I think folks that are so ingrained in that history and ingrained in that treatment approach. And in fact, most treatment centers again, up until probably 15 years ago, were modeled after a non medical model for substance use. You would never see that in eating disorder. You would never see that in depression. You would never see that in anxiety. You would never see treatment that was not based on some medical model, but it was in substance use. And so people are just very attached to that history. And thank God it's changing, and thank God, you know, therapists are being trained on harm reduction models and other models. But many therapists were trained that that is the model, that that is how you treat substance use, and I think that's why we have so many that just dismiss the other models.

Jenny Williamson – Before we get into the meat of our questions, share a little bit about your clinical experience working with the Sinclair Method.

Gabrielle Annett – Sure. So as I mentioned, I started with the outpatient center, and that was in 2016 I think is when we started so about seven years. And so that center was around for three and so during that time I worked closely with, as I mentioned, the medical provider, and their program was therapy, as well as the medication for the Sinclair Method. There was no option to do one or the other, it was both. And so as I mentioned, I learned so much about what works and what doesn't work and how to help people succeed with the Sinclair Method. I've continued to use it in my own private practice really since then, and make it a point to connect with providers who are aware of as well as educate providers. I just started working with two psychiatrists about six months ago. They had never heard of it. And it was such a joy to talk to them about it, educate them about that. They did in fact, we shared a client and started that client on the program of therapy as well as seeing that provider. Client's doing fantastic. You know, just a complete success story with the Sinclair Method, you know, I was able to share with them literature, they've passed it along to all of their colleagues. So, you know, I just again, over and over. my experience has been to see how the Sinclair Method is successful. And of course you know, I've worked with clients where it's been unsuccessful and so I've been able to, you know, really kind of pinpoint what some of those things are where you know, people struggle.

Jenny Williamson – Going back to the history of therapy and the traditional success rates, many people are coming to the Sinclair Method having tried so many different things and they are, a lot of them are very disillusioned maybe when it comes to the even the thought of speaking to a therapist, because they have been stigmatized, they have felt shamed. They have felt blamed, and so there is a very large resistance within a lot of people and for good reasons.

Gabrielle Annett –Absolutely.

Jenny Williamson – Why they are hesitant to speak with and to use a therapist while they're on the Sinclair Method journey, because in some cases, their therapy has actually traumatized them even more. So can you contextualize why it is so important for someone to come to find

that good supportive therapist who can help them along with their journey and why they should give it another shot and look for someone new who will actually support them.

Gabrielle Annett – Yeah, for sure. It's such a great question and I really feel for people who have gotten so discouraged, and to your point just actually blamed and shamed, you know, in trying to get help, and it's unfortunate that it happens as much as it does. And before I kind of answer the question I just want to encourage people like, if they are looking and might be ready to try again, is just right from the beginning, before you even set up an appointment, ask that therapist if they are familiar with harm reduction models. Just ask that right off the bat and if they say no, then move on, you know, like, because that's going to just be kind of a clear indicator of at least some of their education and training.

But to answer your question, I really do feel it's important. I, you know, I've worked with a lot of people that have come to me and said they've tried Sinclair on their own and felt like they were not as successful as they wanted to be. And I've seen that change as we start, have started working together. And I think it's for a couple of reasons. The main reason being that again, just in my clinical experience, the number one reason why people are unsuccessful with the Sinclair Method is their ability to manage stressors and triggers. So many people use alcohol to manage their stressors and their triggers, and even people who don't have an alcohol problem, who don't over drink, use alcohol to manage stress and triggers right? We had a long day at the office, let's open a bottle of wine. It's built into our culture, right? And there's lots of reasons why people do that. It, you know, it's the sedating effect on the brain initially. So all of that to say that's where I think a therapist can be very helpful is one, in helping a client identify what those stressors and triggers are, and two, then developing alternative coping mechanisms, because as you're doing the Sinclair journey and you are changing your habits with alcohol, that is essential, because if you're not managing your stressors and triggers in another way, it's going to continue. Your brain and your body are going to continue to point you to alcohol to manage those stressors and triggers. So it has to be a very active process to develop, you know, alternative coping skills. I also think a therapist provides accountability. And, you know, if we look at any type of habit change, you know, somebody's trying to change their diet, change their relationship with alcohol, start exercising, whatever that habit changes, accountability in the beginning is really key for people to be successful and I think a therapist can provide that. And then I also think a therapist, now one who is not TSM trained might not be able to do this, but in terms of TSM specific but another thing that a therapist can do is help somebody with their goals and using SMART goals, which is an acronym. And I think that that's another reason why people, I've seen people be unsuccessful or give up on the Sinclair is they think in week two they're going to be at their goal and they don't have realistic, you know, realistic goals, and I think a therapist can help somebody with their goals in general for habit change. And then of course if you know you have a therapist that's familiar with TSM they can actually really help with those specific goals. So I think those are the ways that a therapist can be helpful.

Jenny Williamson – I want to key in on your comments about goals and expectations. We see this so much, even in the peer support groups, where people have unrealistic expectations. How much of that do you feel is coming from the traditional treatment mindset, because in an abstinence only modality every abstinent day is perfect success. And the Sinclair Method and many harm reduction models operate in more of a gray area where success is not quite so easy to define. So can you talk about that a little bit?

Gabrielle Annett – Yeah, yeah, it's a good point. And again I think, you know, when we look at the success rates of abstinence based programs, the success rates the first 30 days when somebody is inpatient, well, that's 100%. Everybody's abstinent, but then once they leave, that's when you know long term success rates drop to less than 10%. And, you know, the reason being is that for me, how I see it, is alcohol when we're using it to cope, then removing the alcohol leaves untreated whatever that may be, untreated anxiety, untreated trauma, untreated depression. Maybe somebody's in an unhealthy, toxic relationship. So those things, those deeper issues that are underneath the alcohol use, take time to really sort out and take time to, you know, develop healthy coping mechanisms and you know, make healthy choices. And that's kind of how I explain it to people is like, alcohol really isn't the problem. It's the

symptom of the problem. And, you know, there's great relief, you know, of course in starting TSM and, you know, in the initial kind of phases and seeing, you know, some changes there, but ultimately, it's all of the root causes that are what needs to be addressed. And I kind of, you know, just phrase it that way. And again, I think, you know, those are the areas that a therapist can be really helpful with. And, you know, for people who are looking for that immediate, you know, immediate success, I think that's also where being familiar, having a therapist that's familiar with TSM can help them see the success they are having, you know. And that first, you know, I kind of break the Sinclair journey into three phases, and for me, that first phase is just about all about being compliant with the protocol, nothing else. And, you know, I can then help people, you know, track and see that if they're doing that, every day that they took the pill before they drank, every day they waited 60 minutes, every day they stopped drinking when the window closed, every day that they do that is success. And that is the equivalent to the abstinent, you know, having a day sober is kind of how I look at it.

Jenny Williamson – I'd love to continue to explore this line compliancy being the first. What are your other two phases that you break it down into?

Gabrielle Annett – Sure, and I'm really clear with people, there's nothing else to do in that first phase. And if you try to do something else, then it's, you know, it's not following the, well let me rephrase that. It's potentially setting yourself up for disappointment and potentially trying to rush the process and set yourself up to have a setback. So now again, because I'm also, you know, a mental health counselor, then there's the mental health goals in that first phase, which is identifying triggers, which is starting to develop healthy coping skills, which is, you know, getting proper assessments to really understand the bigger picture, history, assessments, things like that. All of those things are kind of happening in that first phase, but you know, that first three to six months depending on the person, to me it's all just compliance until the compliance is second nature. It's not even something you think about. You've adjusted your routine, you've adjusted your schedule, so that it's easy and it's comfortable.

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Gabrielle Annett – And then the second phase is where we start to implement those SMART goals and we start to actually create goals around quantity, frequency, habit change, and we start to implement them. And there again, using that SMART framework, there's small, measurable, attainable goals, right? Again, where I see what happens so often is people reduce their quantity way too quickly. And it may be okay for the first couple of days or first couple of weeks, but then their cravings really increase after that. So we do very small, you know, measurable, attainable goals and that next three to six months is the actual reduction, but using, you know, small steps to attain that, right? And at this point, now they're having, you know, an even bigger toolbox of coping skills, right, better able to handle triggers and things that come up, and so continuing to really fine tune all of that as well. And then I sort of see phase three as maintenance. So somebody's reached their goal, and then what does that look like in terms of Sinclair for maintenance here, you know, here on out, and then that's where I begin, like trauma processing. So like deeper kind of trauma work we'll do once somebody has kind of reach their goal or in their maintenance. And what I find is that people's goals change. I know you know this, you know people, it's a relationship with alcohol, it changes over time, it changes as things in your life change. And so that maintenance is not, may not be just at the same point from here on out.

Jenny Williamson – Honestly, I love that you have broken this down into going into that trauma in that third maintenance. Can you talk about the rationale behind waiting until that maintenance time to dig into the trauma, as opposed to trying to start tackling trauma day one on the Sinclair Method?

Gabrielle Annett – Yeah. Well, and let me kind of clarify because there's, you know, there is some nuance to this, is that we are starting with trauma therapy from day one. We're not starting with trauma processing. That's the difference. And I think that's what people

oftentimes get confused, like they think trauma therapy is processing trauma, going into the memories, talking about trauma on that very kind of intense level. And actually, trauma therapy is multiphasic as well. And I was trained in the triphasic model, but even therapies like EMDR, they have eight phases. There's eight phases to EMDR, it's not one, right? So the beginning is very similar to kind of what I was talking about in terms of I'm assessing where, what somebody's trauma is. And because oftentimes people don't either identify that they have trauma, or it's like that was so long ago and I don't have memories and I don't think this applies to me. But I have all of these really kind of cool, handy assessments that help us see, including one that's about trauma symptoms. Doesn't ask you about anything that you experienced, it just assesses your symptoms. And so those first two phases when somebody is in Sinclair, is we're really getting a handle on what is it that we want to address on a deeper level? You know, doing assessments, doing history, identifying patterns, identifying triggers, and a lot of sort of education, and then we're also learning how to cope with all of that. And in any model of working with trauma, you have to do all of that before you process, because otherwise you're potentially destabilizing somebody. You're opening up, you know, something that they're not prepared to deal with. And I think it syncs up so nicely with the Sinclair, and again, this is, you know, this has taken me years to kind of really put this into practice, is that by the time somebody is at their goal with the Sinclair, they've had enough experience that they're not going to continue to reach for alcohol when they're dealing with something that may be highly stressful, and when they may have temporary, you know, experiences in doing trauma processing where they feel activated, right? And so if you're doing trauma processing before somebody gets to that point, then you're risking that they're going to continue to over drink, because that's what their brain knows. That's what their brain is going to tell them to do. So we need all of this time to develop new habits, new awareness, new coping skills, before we go into that deeper work.

Jenny Williamson – So safe to say if I were to recap that briefly, that first you figure out what the issue is, then you build the toolbox as fully as you can, and then you go to work.

Gabrielle Annett – Perfect. Yes. Perfect. It's like actually get a correct diagnosis. What is really going on, right? Because most people it's just like, well, I just drink too much. Again that's not, that's the tip of the surface, right? Like it's what's going on underneath. So get that proper kind of assessment diagnosis, get the toolbox, then we can kind of, you know, jump in and do some deeper work.

Jenny Williamson – And of course, when it comes to trauma and addiction, it can go in multiple different ways. You can have people who develop addiction because they have had trauma in their life.

Gabrielle Annett – Right.

Jenny Williamson – And you can have people who go through traumas because of their addiction. And so, like, how does that usually, like how does that conversation usually go as you're trying to help someone figure out whether they are, to recognize the traumas that they may have had in the past that help lead to this that maybe they have self invalidated their feelings over the trauma, versus the trauma that they're continuing to inflict on themselves through the addiction that they may not be able to identify as trauma in the real and now time?

Gabrielle Annett – Yeah, because it's really this kind of vicious cycle, right? It's, you know, trauma creating over drinking, and over drinking creating more trauma, which creates more over drinking. It's just this kind of vicious cycle, and you know, it's, I do a lot of education, right? and sharing resources and you know, books and things that people can read to really educate themselves. But, you know, we kind of talk about two different types of traumas. So, there's what we call big T traumas, and then there's what we call little T traumas. So the last completely sort of randomized poll that they did of Americans off the New York subway was like 15 years ago was quite a while ago, maybe even 20. And at that point, 76%,73%,76% of Americans stated they had experienced one or more traumas. So the reality is 100% of people have experienced trauma. There's just, there's no way to be in this world and to escape any

trauma whatsoever. And that includes, you know, all the things that we think of, you know, when we think of trauma, but it also includes things like natural disasters. It includes things like divorce, like loss, like these are all things that, you know, psychologists know are challenging to cope with and affect a person significantly.

So I kind of start there, right, you know, with what people are aware of, and then we kind of go on and do again, a lot of history taking, and a lot of assessment to see, are there some lasting effects from little T traumas? So these are traumas that may be in and of themselves, they do not impact somebody significantly, but if there's enough of them, if you have three little T traumas all happening at the same time, the brain and body responds in a big T trauma way, right, in traumatic stress way, and so we kind of go through those as well. And, you know, and I think the other thing is really important for people to understand, trauma is not about what happened to you, it's what your brain and body did in that experience. And so yes, we understand and we know that there are certain things that everybody is going to be traumatized by, but this is where, you know, working with a trauma therapist is so helpful because it's helping them see if their brain and body is reacting in traumatic stress, regardless of what occurred. Whatever happened is less important. What's more important is how is your brain and body functioning? You know, how, what are the panic patterns of your thoughts, your emotions, your behaviors, your physical symptoms. If you're in traumatic stress, then we just have to deal with that, whether or not we think we should be, right? Whether or not we think something significant happened to put us there, if it's happening, we got to deal with it.

Jenny Williamson – So what you're saying and I know this is going to be obvious to you, but just in case it's not for anybody listening, traumatic stress is not something you can logic your way out of.

Gabrielle Annett – Correct. Correct. And we've all been taught that we can in some, you know, indirect or direct way, and that's such a harmful message that all of us received, because the brain doesn't work that way. There's three parts to the brain. There's the brain stem, you know, that controls all of our functioning, our bodily functioning. This is because we don't have to, you know, this is why we don't have to tell ourselves to like, digest that food and, you know, breathe, because all of that happens automatically. Then there's the emotional brain and then there's the logical brain. The emotional brain is nine times the size of the logic brain. It operates in completely different ways than the logical brain does. And it is hard wired in traumatic stress to override the logical brain. Because when you are, you know, I actually had this happen fairly recently, when I was hiking, and I saw something in the path ahead of me. And before I could figure out what it was, my limbic system, my emotional brain, my, you know, reptilian brain took over, and I started, you know, running the other direction. And I got maybe 10 feet and sure enough, it was a 10 foot snake in the path. If my logic brain was in charge in that moment, I would have walked closer to investigate, and I would have gotten bit. But the limbic system engaged and this is how we are all hardwired. There's no way around it. This is hard wiring. The limbic system engaged, and so when that happens, and that's when what traumatic stress comes from the limbic system being engaged in fight, flight or freeze traumatic stress response. There is no, you can't logic yourself out of it. It's more powerful and it's designed to override your logic. Does that makes sense?

Jenny Williamson – It does. And then I want to just kind of continue this a little bit from the sense of trying to de-stigmatize and de-shame. Everything that you are saying is that this is set up to protect us.

Gabrielle Annett – Yes.

Jenny Williamson – So when someone is feeling these trauma responses, this is not something to be ashamed of. And so talk a little bit more about that, of why there is a benefit to this and how you learn to rein this back to something that is healthy and a productive way of dealing with it.

Gabrielle Annett – Yes, and you know, our hard wiring was developed through our evolution when you know, we were running from bears, right and we needed to have, you know, this system engage in a second to protect us and to override and so that we would just react right. And unfortunately, it really hasn't updated as modern life has updated. That's the challenge, right? And so now, for many people, the bear is now their phone going off, you know, 18,000 times a day, buzzing. It's their traffic. It's, you know, challenging meetings with clients or bosses or co workers that keep triggering that system, right as if it's a bear. And so it's right to take away the stigma. This is just our hard wiring. This is really kind of old sort of hard wiring that hasn't, you know, our genetics haven't updated. It is there to protect us. And while we can't just think our way out of it and say Oh, stop responding in that way, it's not that simple. We can engage our logical brain in other ways to help us turn that system off, as well as other tools that really are designed to, you know, to kind of work on the somatic level, to work on the physical level, to work on the nervous system level, and all of those tools really help with turning that stress response off. And then there are some people where what is actually triggering the stress response is that prior trauma. So that's the other component that a lot of people may not understand, is that you may have put that away in your mind. In your mind it's in, it's compartmentalized. It's, you know, in a spot right here. You don't ever think about it, you don't. However, it can still be activating the limbic system. It can still be triggering that stress response even though in your mind you think it's put away. And so for, you know, folks that that is the case, which again, this is all part of what you know, I help sort of somebody figure out, you really have to process that trauma to get it to stop triggering the traumatic stress response. And the way our brain works is it looks for current circumstances that have some link or some match to that prior trauma. And then once it finds it, it activates that prior trauma. And then we're in the traumatic stress response. So an example could be, you know, let's say somebody kind of grew up with a dad that yelled. So then you have a difficult meeting with your boss who's a male, and he's kind of raises his voice, right? Not really yelling, but maybe gets animated, raises his voice. Your brain goes, Oh, wait, I know what that is. I need to protect myself. I need to trigger this traumatic stress response. And when that happens, then we have to ultimately process that original material in order to not be triggered in the present.

Jenny Williamson – A lot of traditional recovery focuses on willpower and strength and like forcing yourself through things and yet, the Sinclair Method and to a large part, trauma, dealing with trauma really relies on resilience instead. Can you talk a little bit about the differences between trying to will yourself through addiction or a traumatic response versus learning resilience, which we know can be learned, which is also a wonderful thing, so if someone doesn't feel resilient, there are ways they can change that. So why don't you talk about the difference between those two mentalities of tackling the addiction and trauma responses?

Gabrielle Annett – Yeah, it's a great question. So you know, I mean, I'm pretty vocal about, you know, the shortcomings of the traditional model because I've just seen, you know, too many people suffer and people not get better. And, you know, one of the shortcomings is if you just stop the problematic substance, then everything's fine and you just have to willpower yourself through it. Well what ends up happening is you have people walking around with untreated PTSD, untreated depression, untreated anxiety, whatever the thing is, and then trying to willpower themselves through that. And we would never say to a diabetic, Well you need to willpower yourself and get your insulin down. You need to willpower and, you know, just kind of tough it out as the only thing that you do. We say hey, it's a combination of things. It's habit change. It's yes having, you know, the resolve and the accountability and the support to make changes, but it isn't, you know, feeling like you're just hanging on and just trying to get through the next moment because that's not true change right? That's suffering, and that's what I've seen 1000's of people go through is just utter suffering. And then eventually, you know, they just can't do that any longer. So, you know, resilience is about having the tools, the knowledge and the support and the commitment to continue to make progress and to move forward. Like that's what resiliency, I think resiliency is right? It is an inner strength, but that inner strength comes from having all of those things. It's not doing it alone, human beings were never meant to be alone. We were never meant to go through difficult things alone. We are hardwired for connection, right? So it's having support. It's having connection. It's being

able to talk about things. We know from research that when people go through natural disasters, and it's a community event and people talk about it, they are less traumatized for that reason alone, is when people are not alone and they talk about it, it impacts them less significantly. So when we have things like community and support and we talk about things, we build resiliency. When we develop skills to be able to handle our emotions, we develop resiliency. When we make a commitment to ourselves not to be perfect, but to make progress, we build resiliency. And that's what I love so much about the Sinclair Method is it really is tapping into those tenants, which, as you said, are also the same tenants that are really important in trauma therapy. And you know, the No pain, No gain is not something that works when it comes to mental health. It doesn't work in substance use, and it certainly doesn't work in trauma therapy. Like the more painful it is, then the more people regress, right? So I think that it is, I think really resiliency is a great word to describe, you know, what the Sinclair Method can do.

Jenny Williamson – And then just to go ahead and wrap things up. So hopefully we have laid out a lot of really good reasons why someone should consider a TSM supportive therapist at some point in their journey. If they're able to come in right away, that's wonderful. If they need to work themselves up to that event, that's also wonderful. It's not when you start it's that you do. But one question that I do want to have you answer because there is a very large black hole when it comes to TSM knowledgeable therapists right now. It's nowhere near as widespread as TSM medical providers. What is the difference between someone who is TSM friendly as a therapist, and a TSM informed therapist?

Gabrielle Annett – Yes. I think there is a difference and I think both are great. What the difference is, a TSM friendly therapist is a therapist who has some experience and some training in harm reduction models, So they may not know TSM specifically, but they're familiar with, you know, the overall MAT, medication assisted treatment umbrella, and they have some experience with that. They have some knowledge with that, and therefore are supportive of somebody doing a harm reduction model, right? And, you know, I think that there are more and more as I would call them, TSM friendly therapists. Again, they may have never heard of TSM, but they're harm reduction, they're aware of harm reduction. They're supportive of that and I think that's great. And I think that that's probably the majority of therapists in terms of you know, the two different types of therapists. The majority are going to be TSM friendly, because they're, while TSM is not taught in school, harm reduction models now are, so anyway, so I think that's a TSM friendly therapist. And they are, you know, going to be supportive of and if somebody's working with a coach or has their TSM medical provider, I think all of that can be, you know, very helpful to have kind of coordinated care. And again, they may not be able to help with the TSM phases, but they can certainly be supportive in healthy habits and coping skills and all of those things that I mentioned previously.

And then a TSM trained therapist is somebody that's gone through, you know, the C Three Foundation training, or like myself has worked with a provider and you know, received training from that provider. And that’s somebody that you know, can really be sort of a TSM coach and a therapist all in one. And I wish there were more of us and I hope that that continues, you know, it continues to grow. I feel like I'm, you know, trying to champion, you know, in my field and other therapists I know to do that. But, you know, that's somebody that really can kind of guide you through the ins and outs of TSM and the therapy side of it as well.

Jenny Williamson – Do you have a preferred or a good resource if someone, because like I said, as much as I wish we had more people listed on therapists on our website, there's still a black hole in that area. There's probably only five or six I believe.

Gabrielle Annett –I think a handful in the whole country. Yeah.

Jenny Williamson –And so where would someone go to look for a we’ll just say a harm reduction or TSM friendly therapist in their area? Where would somebody even go to look for that information?

Gabrielle Annett – So I think Psychology Today is the best resource, you know. It allows you to search, you know, by so many different criteria including, you know, what issues people therapists treat. So there is not a harm reduction button or field, but there is substance use, and then as I mentioned previously, that can be followed up, you know, with an email inquiry asking them what models, what approaches do they use with substance use or alcohol use. So I think that's probably people's best bet. I also think if you have a TSM provider ask them if they know of therapists, you know, in their area or that they've worked with that they know are TSM friendly.

Jenny Williamson – And that's great advice. Thank you so much for spending the time with us today and sharing your insight. I hope everyone has truly gotten some great pointers out of listening to this episode.

Gabrielle Annett – Great. Thanks so much, Jenny. I always appreciate talking with you and just being able to share more about the Sinclair Method.

TSM Tip Voice over – This TSM quick tip is brought to you by the C Three Foundation with support from our sponsor, Alcure.

Claudia Christian – Medication adherence is so important on the Sinclair Method. Without it you cannot be successful, so what do you tell your clients to help them?

Sara Michael Novia – Three things. Number one, I suggest they get a key chain pill holder.

Claudia Christian – Excellent

Sara Michael Novia – Right on their car keys or their house keys so that they have a pill with them at all times. Number two is I have them set an alarm for an hour before they think they're about to start drinking. And they set a second alarm, number three, for when that hour is up and they can start drinking.

Claudia Christian – Great idea. So an alarm for when you take your naltrexone, an alarm when the hours up, and always have your medication on you so you can stick to medication adherence, which is the key to success on TSM.