INTERVIEW

An Interview With Addiction Psychiatrist Dr. Christoffel Le Roux

Interview by Oliver Glass, M.D., Editor-in-Chief

Dr. Christoffel Le Roux is a South African military veteran who immigrated to the United States to develop his career in psychiatry. He completed fellowship training in geriatric and addiction psychiatry at Emory University in Atlanta and is one of only a few psychiatrists in the United States with this skill set. Currently, Dr. Le Roux is an addiction psychiatrist at the Atlanta VA Medical Center. He is also Assistant Professor and Program Director for the Addiction Psychiatry Fellowship Program with the Department of Psychiatry and Behavioral Sciences at Emory University.

Dr. Glass is a forensic psychiatry fellow at Emory University, Atlanta, and the new Editor-in-Chief of the American Journal of Psychiatry Residents' Journal.

Dr. Glass: Thank you for agreeing to be interviewed. I am curious to find out what your reasoning was for pursuing a career in geriatric and addiction psychiatry?

Dr. Le Roux: Thank you for your interest, Dr. Glass. Well, I moved from California to Georgia in 2009 as a fourth-year psychiatry resident with Morehouse School of Medicine. I did well on the geriatric psychiatry rotation, which was hosted at Emory University. I was offered a geriatric psychiatry fellowship position, and I was interested in improving my skill in diagnosing cognitive disorders. The geriatric psychiatry fellowship and addiction psychiatry fellowship programs at Emory University happened to share the same program coordinator, who helpfully suggested I additionally do the addiction psychiatry fellowship. The addiction psychiatry fellowship led to my employment at the Atlanta VA. The attending psychiatrists I met during both fellowship trainings significantly influenced my first employment and early career in positive ways. So, to answer your question, life unfolded more, rather than me necessarily having had any particular reasoning for combining these two subspecialties. As you saw on rotation with us, recovery in late life can be very challenging.

Dr. Glass: For the trainee who encounters a patient with frequent relapses, what advice can you give?

Dr. Le Roux: Addiction can be a chronic, relapsing illness if not contained well. I usually review the medical, substance use, psychiatric, "personality," and social (housing, employment, family, legal) dimensions again to confirm I have accurate diagnoses. For example, a patient with mild cognitive disorder (medical) might not be registering well. [A patient with] severe opioid use disorder (substance use) might need medication to suppress cravings to allow for usual recovery activities to proceed. Opioid addiction is different from other addictions in that the cravings are notoriously severe. Methamphetamine addiction can also be horrific and devastating. Most other addictions and recoveries are relatively straightforward. I use the word "personality" in a broad sense, which includes readiness to change, level of cooperation, being teachable, being organized enough to assimilate treatment. One should also think about attachment style under this heading. Then, I reconfirm [that] the treatment level matches the level of addiction severity. It is often also helpful to ask a colleague for help or to get another perspective. Residents are encouraged to review the American Society of Addiction Medicine (ASAM) website to refresh on the ASAM definition of addiction, ASAM criteria/dimensions, and the ASAM levels of care. These are three very helpful instruments and often required in medical documentation.

Dr. Glass: According to your perspective, could you please explain the process in which an individual may develop an addiction?

Dr. Le Roux: I was taught and have observed that most people are fragile creatures and can reach [a] "breaking point" during difficult junctions in their lives. It, interestingly, seems both genetically and environment predetermined which psychopathology will develop in a particular individual. The recognizable "ways of breaking down" are depression (internalizing), substance use disorders (internalizing), or behavior that may violate others' rights (externalizing). Stated differently: mental illness, addiction, and personality. Again, the term personality is used in a broad sense as explained [earlier]. Therefore, if you internalize your pain and are unable to process it, you may become depressed or start using substances, depending on what is written in your genes and environment. You may externalize the pain, blame someone for it, and go after them, with personality-type violation of another's civility. Often a patient presents with signal in all three areas (mental illness, addiction, personality), and our task is to determine which predominates or is primary so we can choose an appropriate treatment setting. Needless to say, there can be medical complications too, but I do not practically consider that as

[a] fourth area, for it does not usually determine the treatment setting. Unless of course the medical issue is major cognitive disorder (dementia), in which case treatment as normal would not work. In these cases, referral to a personal care home or memory care is more helpful.

Most patients enter the stress and trauma phase of addiction with a history of adverse childhood experiences and do not have much emotional reserve to begin with. This is described in the literature that considers attachment (relationship) disorders to predate or complicate the stress and trauma hypothesis of addiction. That means the homes we were raised in can have effects on our worldview and our relationships that can set us up to later develop frustration and addiction.

The process would look something like this: it could begin with worsening of day-to-day human stresses (e.g., hunger, anger, loneliness, and tiredness [HALT]). When these then fatefully collide or coincide with additional trauma, an individuals' coping skills are overwhelmed and stay overwhelmed. Trauma typically presents as one or more severe losses, abuses, or neglect. It seems to me this activates the process of worsening mental health into mental illness, addiction, and/or personality trouble.

There are other hypotheses of addiction. I refer you to a recent book titled *RecoveryMind Training,* by Paul Earley, M.D., that discusses addiction (first half of the book) and recovery (second half) concisely. I want to acknowledge Dr. Jack Krasuski of the American Physician Institute, who taught me with clarity how trauma manifests.

Dr. Glass: Does religion or spirituality play a role in the recovery process? If so, what if the patient is atheist?

Dr. Le Roux: These are good questions and not easily answered. In the book *Alcoholics Anonymous, Fourth Edition,* the author shares how he and others recovered from alcoholism and discusses this very question in great detail in chapter 4, titled "We Agnostics," on pages 44–57. The short answer is, there are many atheists in 12-step recovery programs. An atheist believes in the nonexistence of God. In my experience, 12-step groups teach an appreciation for sacredness, rather than anything to do with God, despite the fact that "God" is the language Bill Wilson and Bob Smith, M.D., chose when they drafted the 12 steps in 1935. You may safely tell patients that God in the 12 steps is sometimes said to stand for "good orderly direction" and points to a sacredness, rather than anything else. From a dialectical standpoint, two seemingly opposing concepts can then coexist, meaning a person may be an atheist and may decide to attend 12-step meetings if nothing else has worked.

Dr. Glass: What recommendations can you provide for the trainee who is hiding his or her addiction and is afraid to get help?

Dr. Le Roux: That can be a painfully difficult and shame-inducing situation to be in. I would recommend reaching out to the local state's professionals health program (PHP). Most states in the U.S., but not all, have a PHP. These programs are designed to treat and protect professionals by limiting direct medical board–related repercussions. So much so, that if you follow the treatment recommendations/5-year contract with a PHP, the PHP might authorize you to be able to answer "no" on the 2-year medical license renewal question that asks about recent addiction and/or treatment for addiction. Unless of course if there were workplace problems or legal problems, then the better answer would be "yes" and the explanation to include, "I am receiving treatment and monitoring with the PHP." In states where there are no PHPs, trainees can reach out to the local chapters of their physician or specialty societies or to an addictionologist.

Dr. Glass: Does guilt play a role in addiction? How can someone just erase their past mistakes and get beyond guilt?

Dr. Le Roux: Guilt [comprises] negative feelings that impl[y] [that] what I did was not good enough or [was] horrific. Shame implies [that] who I am is not good enough. You are correct in asking, and yes it is central to addiction. Very specific skills are taught in recovery to assist with processing guilt. . . . Patients learn that most recovering persons, at some point, carried a huge guilt burden. Twelve-step groups, for example, encourage repairing interpersonal damage by, for example, paying back what is owed (however slowly), if appropriate. The appropriateness or inappropriateness of these actions gets cross-checked with a sponsor or in a meeting, because no one wants to be charged with harassment for having reached out to repair damages in an unwanted manner. Twelve-step groups further teach [that] these amends are more than just a "sorry." It is an attempt to repair and reduce conflict, if appropriate. It is meaningless if not backed up by real behavioral change for the better. Lastly, some things cannot be mended and are processed through what 12-step groups call "living amends." For example, a person staying sober (a sacrifice of sort) keeps attending meetings as a way of expressing (live) his ongoing profound regret. This is better than to have to blot out guilt with the fake reassurance of addiction.

Dr. Glass: Thank you for answering all these questions, Dr. Le Roux. Lastly, what should a psychiatry resident with an interest in becoming an addiction psychiatrist look for in a fellowship program?

Dr. Le Roux: I would say, consider choosing a program in a city or state where you might have an interest to stay, because fellowships are great ways to form professional relationships. I prefer programs that are well organized, with responsive program directors and program coordinators. Consider attending the American Academy of Addiction Psychiatry annual conference, because [it] is a meeting where residents can meet [people in] programs from all over the country. I would also look for a program that is a good fit, meaning a program that offers what you need.