Talking to Change: An MI Podcast
Glenn Hinds and Sebastian Kaplan

Episode 42: MI for People with Opioid Use and Stimulant Use Disorders, with Roy Stein, MD

Glenn Hinds:

Hello again everybody, and welcome to Talking to Change, Motivational Interviewing Podcast. My name is Glenn Hinds, and I'm based in Derry in Northern Ireland. As always, I'm joined by my best friend, Sebastian Kaplan in Winston-Salem, North Carolina.

Sebastian Kaplan:

Hey, Glenn. Good morning.

Glenn Hinds:

Yeah.

Sebastian Kaplan:

Well, good morning for me, bright and early here.

Glenn Hinds:

Well, you know what, it's just turned, in fact, it's, I'm looking at my clock here and it's telling me it's quarter past 11, but my clock hasn't been turned forward. We went forward an hour this week, and it's a beautiful bright day, spring has definitely sprung. Spirits are starting to bubble, there's expectations that the world is going to get a better place, people are getting vaccinated, our hopes are things are going to be different in the very, very near future. Golf clubs are starting to open, which people like me seem to enjoy.

Glenn Hinds:

What about yourself, how's things over there?

Sebastian Kaplan:

Yeah, good. It's bright and early, a little after 7:00 AM. Morning weather's really kind of cold here, actually. We had a freeze warning. It's April 2nd, and in North Carolina, that's a bit rare, to have freeze warnings this late. Yeah, things seem to be turning a little bit more hope, with maybe some push back on the hope too. Caution about other variants, and new strains, and this and that.

Sebastian Kaplan:

Overall, vaccinations are rolling out here, and the kids, our kids are going back in school four days a week, starting in two weeks, so that's pretty significant, at least for our region. I know that's not an easy decision for the schools to make, but yeah, things are beginning to inch forward maybe.

Glenn Hinds:

So, it'll probably be closer to May by the time people first hear this episode, and we hope everyone is doing well and staying safe.

Glenn Hinds:

So, you're all very welcome to this episode, and we're delighted to introduce Dr. Roy Stein to the podcast. Hello, Roy.

Dr. Roy Stein:

Hi, good morning. I'm glad to be here.

Glenn Hinds:

Great, it's good to have you. Thank you, thank you. So, as we were saying just off air before we came on, as we normally do in each episode, because we just say, "hello", and we're curious about your journey into Motivational Interviewing, before we find out a bit more about yourself and your work with opiate and stimulant abuse disorders.

Dr. Roy Stein:

Appreciate being here, and I was thinking back to how did I find my way into Motivational Interviewing, and I feel like I'm a little bit unusual in the MI world, because I'm a psychiatrist and there are certainly, there's a lot of interest in Motivational Interviewing now within psychiatry, but I find, say, within Motivational Interviewing Network of Trainers or in the people who are more actively involved, I'm often the only psychiatrist in the room.

Dr. Roy Stein:

So, my background and path are a little different. I was thinking back, when I was growing up, I think, I don't know exactly how I got exposed, but I was made aware of the thinking of philosopher Martin Buber, and his so-called I-Thou or I-You philosophy, as opposed to the I-It relationship. I hope I'm not going too far on a tangent, but the idea of an I-You relationship is between one's self and the other, fully appreciating the other person's existence and reality as a fully experiencing entity, versus an I-It relationship where we'd relate to the other person as an it, as an object to act upon. Somehow in my growing up, that was really stressed for me, or resonated for me, that's how one should live one's life. So, I think that does kind of provide a foundation that leads one to be very open to Motivational Interviewing.

Dr. Roy Stein:

Then, the next step, I suppose, was as a freshman, in a freshman psychology course at the University of Alabama, where I grew up, I was introduced to the client-centered therapy of Carl Rogers, and a humanistic approach to working with people. That, I think, sunk in, that was a foundational experience.

Dr. Roy Stein:

The next thing is, I think about experiences leading in this direction, is when I was in medical school, and this suggests that somehow I was ripe for Motivational Interviewing, even though I don't know that it had been developed at this point, is as a third year medical student, I was in a volunteer group that wanted to do some outreach into the community, do something useful beyond medical school.

Dr. Roy Stein:

My role was to volunteer as the science teacher for a seventh-grade class in a public junior high school. So I was given an hour with these kids every day for a week, and the topic was use of tobacco and alcohol, hoping that we would prevent kids from getting involved. So I went to the pathology lab at the hospital, I knew the people there, I was able to borrow from them a lung with a big cancer in it, and a liver with cirrhosis, as well as a normal liver, in glass cases with formaldehyde. I thought, "man, this is really going to shock these kids", and "look what can happen to your organs".

Dr. Roy Stein:

So, I brought all this over to the school and then I'm at the blackboard, and I was also doing pros and cons of, let's say, smoking, so I was already into decisional balance at this point. I had all the kind of stuff that I could come up with, but of course I invited them to share their pros and cons. The one item that really made an impact, was a girl got up and said, "well the bad thing about smoking is that if you kiss a boy who smokes, it really stinks". That really got everyone's attention. It was a lesson about what I came in with as a future health professional, and what I thought was important and would resonate, was not what got their attention. It wasn't the lung cancer in the case or the cirrhotic liver or, "you're going to die", it's, "this could impact on your seventh grade romantic life". So I think that just kind of goes to show that we need to hear from people what's important to them, what's going to drive their behavior, because often it's very, very different than what we're going to see as the key issue.

Dr. Roy Stein:

The next thing in my path was in residency, tells you how old I am but, a lot of my most respected and revered teachers and supervisors were from a psychoanalytic orientation. I'm not a psychoanalyst, but I was exposed to that way of approaching things, and particularly the work of the psychiatrist, Karen Horney, and also one named Heinz Kohut, K-O-H-U-T, that people may or may not be familiar with. Kohut was very much involved in what's known as self-psychology, and what stood out for me with Kohut was the absolute importance of accurate empathy and mirroring in therapy, that was right at the core of working with people. Kohut described empathy as the tool par excellence which allows the creation of a relationship between patient and in this case analyst, he defined empathy as the capacity to think and feel one's self into the inner life of another person. So this was the stuff that kind of really resonated for me as I was genuinely becoming a psychiatrist.

Dr. Roy Stein:

Then finally, he talked about empathy as what allows an individual to know another's experience without losing one's objectivity. So I'd say I was brought up in that way of looking at things. So then I went on to start practicing psychiatry, I sort of by chance got involved in working with people with alcohol and drug problems in a Veterans Affairs hospital in the United States. I will tell you that at that time, the thinking was about people coming in for alcohol or drug treatment, is they were either ready, they were either motivated for treatment and change, "do you want to get off alcohol and drugs, or not?" It was not to condemn them if they didn't, but if they basically said, "no, I don't think I really am ready to do this", then our response, our well-intended response was, "well, okay, we understand, it's your choice, sounds like you're not ready for treatment, so please come back when you're ready. Goodbye. We wish you well, but come back when you're ready". That was, you're thinking, we're talking early 1980s. That was how we operated. You either are or are not ready for change.

Dr. Roy Stein:

So then, somewhere along the way there, I got exposed to a presentation from a group at the medical University of South Carolina. They were part of Project Match, which was, M-A-T-C-H, which was a very large, multi-center trial that was really what demonstrated that a Motivational Interviewing based intervention could be just as effective with very few sessions, as some more intensive treatments for alcohol use disorder. I think that's what really rocketed Motivational Interviewing into having a lot of attention, because they showed that four sessions of the MI based intervention were as effective as 12 sessions of a cognitive behavioral or 12 step-oriented interventionism.

Dr. Roy Stein:

People say, "oh, wow, if you can do this in four sessions, that's really great". I think that really expanded MIs in the professional world. So anyway, the group at Medical University of South Carolina was one of the MET, Motivational Enhancement Therapy, sites. That was really the first time I ever heard a presentation, and it made a lot of sense to me. Then, a little bit later, I was very fortunate that, this was in the year 2000, that Cathy Cole, who is a very active MI trainer and active member in this community, was a colleague of mine at the Durham VA Medical Center where I worked, she was a social worker and I was a psychiatrist. She told me about an opportunity to apply to be a subject in a study of training methods for Motivational Interviewing.

Dr. Roy Stein:

I applied and I was accepted, so I got to go and have a three-day training by some of the top people in the field, as a research subject. I was lucky enough in the randomization that I was randomized to get the full training and coaching, versus just being sent the tapes to watch. That really opened my eyes to Motivational Interviewing, and what I really want to stress from that training, is at this point, I'd been a psychiatrist in practice for 15 years, and I felt like I was a pretty humanistic guy. I felt like I listened carefully to patients, I think I'm pretty good with empathy and all this, relatively speaking. When they put us through the various exercises on reflective listening, and really honing down on the skill of excellent reflective listening, I found out, "wow, maybe I'm not as great at this as I thought, maybe there's a lot more I can develop around this skill". The other thing, of

course, I ran into is my question habit, my habit of asking lots of questions was something that I could really work on.

Dr. Roy Stein:

The basic philosophy, the attitude, the approach of MI seemed very familiar, seemed very natural to me. I think it was a good fit for me, but what I really appreciated was that they're saying, "here's how we can offer you way of being so much more effective in functioning with patients when you do come from that MI spirit". The other thing that was a challenge for me initially, was this teaching to be hesitant about giving advice and information, because I am medically trained, and I was brought up, took Latin when I was in high school, and doctor, the word doctor means teacher in Latin. So I was very much brought up in the idea that one of the really good things we do as doctors, is to teach our patients. I think that seems like a moral and ethical, desirable thing that we inform our patients.

Dr. Roy Stein:

So, the idea that, I was being told that you should ask permission to give information seemed a little bit hokey to me, but this was unfamiliar. As I started to try it out and started to fit it into the bigger framework of Motivational Interviewing, now it makes complete sense and it's become... But that was the biggest sort of change in approach, is the idea that just giving people information without permission is something that one could make a change.

Dr. Roy Stein:

So, anyway, to wrap up this part of the story, so I got this MI training, and then I was lucky enough to get the train the trainer training, but I didn't really have a huge opportunity to do a lot with it other than in my own practice, and in teaching medical students in residence, until the VA, in about 2011, decided to really implement MI training on a large scale throughout the VA system, the VA, the Veterans Affairs system is one of the largest health care systems probably in the world. So then they looked around for people in, who are already working for the VA, who are familiar with MI, could train people, so that really launched me into a very rewarding 10 years of active training of VA healthcare and substance use disorder staff. I've learned a lot and gained a lot from that. Particularly, because it involved coaching the six month consultation phase after an intensive training. I've been very, very fortunate in the opportunities to develop as an MI practitioner and trainer, so that's kind of a long story.

Dr. Roy Stein:

Now, a year ago, I moved into a clinic at the University of North Carolina that really focuses on medication treatment for people with opioid use disorder, and that kind of brings us to today's topic.

Sebastian Kaplan:

Wow, thanks for that really rich story, and one of the things that struck me about it was a lot of these time points that you described were experiences where you could have approached an experience as an expert. So, even as a third year medical student, you

maybe didn't feel quite like an expert in that sense, but I can just picture you, excitedly going to the pathology lab, with this wonderful idea that's surely going to knock the socks off these kids who are just using substances that they have no idea what the harm that's going to come to them. I can imagine it took quite a bit of effort on your part to gather all the materials and bring them over and have this big reveal, and come to find out that the biggest impact is stinky breath when someone tries to kiss somebody.

Sebastian Kaplan:

Other examples too, where what you were saying about, the idea of doctor as a teacher, and that was something that you really valued tremendously, later into your career, but still being open to the possibility that, not to disregard that completely, just like you might not disregard the potential impact of showing somebody a cirrhotic liver and that might have some impact, but just being willing to have some, a different perspective influence you and affect kind of how you operate, I imagine just is a great foundation in the day to day work that you have. You might have a sense of what another person needs to do to get better, and they might have some other kind of input or some other parts of their story, that since you are open to receiving different points of view, that it would just naturally contribute to a more productive session, and ultimately, a more productive career, I suppose.

Dr. Roy Stein:

Yeah, and I guess, as you mentioned, that I still would link it back to this sort of I-Thou or I-You concept, that you're not an it, the patient or the student is not an it, that I'm simply there to act upon, but I have to be fully, or one has to be fully open, to understanding their experience.

Glenn Hinds:

So the information that you picked up, it sounds like you were blending both information that you were getting from the I-Thou with the medical training that you were having. Potentially, the message was the I-It, you were integrating the two, so you were endeavoring to offer support, but you were always open to the possibilities that the other person had something to offer. That is something that was said was identifying how to, as the teacher, you remain teachable, and you went along, and you've kept your eyes and ears open for what it was, the environment, what research, and very important for you now as well, is what the clients or the patients are teaching you about what it is they need or what it is they want.

Glenn Hinds:

It sounds like that's where Motivational Interviewing fitted very well for you, that Motivational Interviewing came to you and fitted what was already there. It didn't have to change an awful lot about you, because it was consistent with the nature of who you are and what it was you were trying to do with the patients that you were working with already.

Dr. Roy Stein:

I would say the MI spirit, I felt just immediately, yes, I'm in the right place with MI spirit, but the technical aspects I found very helpful. The other thing I would say, again, coming from a medical background is MI really blends this genuine, deep, humanistic spirit and appreciation of the other, with a real focus on empirical research to understand the mechanisms and the linguistic aspects of how to be most effective in bringing about change. So this blending of humanism and a scientific approach, just naturally felt like, "oh, this seems right to me". I think that's a big appeal for a lot of people who are in helping professions, as it validates their basic humanistic desire to appreciate and respect the other, but also brings scientific objectivity to it.

Sebastian Kaplan:

Right, yeah, no, for sure. It feels good and we can cite evidence to suggest that actually, this stuff actually works and is helpful for people. I feel the need to follow up with what you said about Cathy Cole, you may have mentioned this or not. You're in Durham, North Carolina, correct?

Dr. Roy Stein:

Right.

Sebastian Kaplan:

I'm in Winston Salem, North Carolina, and Cathy seemed to be a big influence for you or at least an important person in your MI journey. Same for me, I consider her my first MI mentor and I took my first trainings with her, so anyway, just want to maybe acknowledge Cathy since she was influential to both of us.

Dr. Roy Stein:

Yeah, she really opened the door for me that then led to a lot of wonderful experiences.

Sebastian Kaplan:

Yeah, absolutely. One of the few, handful of people I can say changed the course of my life really, so very grateful for Cathy. So let's transition into the main topic here, which is working with people who have opioid use disorders and stimulant use disorders, we could sort of talk about these difficulties separately, but also there's some kind of overlap when people are struggling with both kinds of substances that present in kind of a unique way. Again, many of the people listening may not have a medical background, so maybe it would be helpful to break down in small steps, when you say the word opioid use disorder, or even the word opioid, versus the word stimulant, could you just give us a brief summary of what these substances are and perhaps what they do to people that are using them?

Dr. Roy Stein:

Sure. Opioids refers to any substances that bind to or interact with so called opioid receptors which are in our brains and throughout our bodies. Some of the common opioids include medications that are legally prescribed, like morphine and oxycodone, and a variety of other pain medications that have been used for hundreds of years, so they're legal, very effective pain medications who have an appropriate role in healthcare. It also

includes drugs like heroin, that I think are familiar, that are, well, actually, I think it is legally used, possibly in the UK, but in any event, it's primarily used as a street drug.

Dr. Roy Stein:

The effects of opioids are to create euphoria, just a wonderful, pleasant feeling that people describe as like no other, but also to relieve pain, which is why it's used medically, but in larger amounts, it depresses respiration and can have other profound negative effects on function, and ultimately, if a person uses too much of an opioid, then it will stop their breathing and they will die. The other thing is that opioids can induce a very strong addictive property, wherein if the person stops using, they go into a severe withdrawal state of having extremely unpleasant physical symptoms and intense drug craving, they just feel like they're dying and that is, once they have reached that state after prolonged use and have withdrawal, they will do just about anything to get another dose, simply to not feel sick.

Dr. Roy Stein:

Often when people have reached that level of addiction, their use is driven more just to avoid being "sick", as they will put it, rather than that they're even enjoying the drug use anymore. They started out using it to get high, and that may or may not continue, but at a certain point, it really becomes just that they rely on it to function, they have to have it. So that's opioids, so they do carry a very real risk of overdose death, and a lot of the sustained use is driven by physical addiction and avoidance of withdrawal.

Dr. Roy Stein:

The other problem with a lot of opioid use is people often progress to injecting it. People can take opioids by mouth or they can smoke it or they can sniff it through their nose, but probably the most dangerous form of abuse is intravenous injection with a needle. Once you get into that, that behavior carries a tremendous number of risks of infection, acquiring hepatitis C, acquiring HIV, bacterial infections. At that point, it's the route of administration, it's the injection behavior as opposed to the drug itself that causes a lot of very, very serious problems. That's opioid use disorder.

Dr. Roy Stein:

Stimulants refers to medications that stimulate the nervous system, and the ones we typically think of here are amphetamine and methamphetamine. So they tend to make people more alert, they also induce euphoria. Of course, another stimulant that's widely used is cocaine, so cocaine, amphetamine, methamphetamine are the stimulants that we worry about. So they have kind of the opposite effect in terms of making people more activated, not needing sleep, but they do also induce euphoria.

Dr. Roy Stein:

They don't have as much of the physical withdrawal after a person becomes addicted, like heroin, let's say, but what they do have is when a person has really gotten involved in it, they have really, really intense drug craving. They can be exposed to reminders of previous use that will induce really intense craving. We call it cue induced craving, so for

example, a person who's become addicted to cocaine or methamphetamine, if they have a bunch of cash, if you were to hand them a 100 dollar bill, and there's very good evidence, scientific evidence for this, that could trigger really, really intense, almost irresistible desire to use because for them, cash has been converted to drug, and then the drug affecting their brain.

Dr. Roy Stein:

Another problem with stimulants is often people wind up using cocaine or methamphetamine to enhance sexual pleasure and sexual activity, so those two activities of sex and the drug use become very intertwined, so then that's another big trigger. It's very hard for them to go back and have a normal sex life without enhancing it with the drug. So they're both very addictive in somewhat different ways, the opiates and the stimulants.

Glenn Hinds:

They're really quite complex situations that you find yourself in as a health practitioner involved with supporting people who have discovered a drug, either to make them feel a real sense of painlessness, or an absence of pain and existence of euphoria, or a drug that makes them feel activated and energized and is related to things that they enjoy. Then to come along and meet someone like you who says, "you know what? Maybe you should be stopping doing this". At the same time, it sounds like on occasions that, by the time they come into your company, they've gone beyond the pure joy, and it's now just the avoidance of the pure pain and the opioid... So now it's about how do you overcome these cravings, these cue induced cravings that they're experiencing? I imagine that they can be very disabling for an individual who's just going about their everyday life, and just somebody hands them a hundred-dollar bill, and all of a sudden, they're in an intense craving state or they meet somebody new for a first time, and immediately they think of drugs.

Glenn Hinds:

So, what is it you are then doing as a psychiatrist in those scenarios, and where are you blending in what you've learned in Motivational Interviewing to help those patients?

Dr. Roy Stein:

Okay, let me just step back and add one other element to the picture, then I'll try to answer that question. Unfortunately, at least in the United States, the stimulant and opioids have really become very mixed together, literally, meaning that a lot of the methamphetamine and cocaine that people buy on the street now in the United States is contaminated with a drug called fentanyl, which is a synthetic that is a laboratory produced opioid, that is extremely powerful.

Dr. Roy Stein:

Nowadays, it is not unusual for someone who buys cocaine or methamphetamine, that's all they want to use, but then they have an opioid overdose because they didn't realize that fentanyl was in the same product, or they test positive, a urine drug screen shows,

"did you know that you were using fentanyl?" "No, I mean, Dr, I was getting high on meth, that's what I wanted, I didn't intend to use this other drug, but it's there". So literally the drugs are mixed together now in what people are buying, and so, many of the people that we see now do have both addictions simultaneously, which just makes life that much more complicated.

Dr. Roy Stein:

So as a doctor in a clinic where we're providing treatment, a lot of the people who we see in our particular setting, have been referred because they already have very serious medical complications from their injection drug use. So this is maybe a narrow angle, but many of these people are young individuals who have gotten infections on their heart valves from injection drug use, and in many cases, they've had to have heart surgery to replace and put in an artificial heart valve, and in many cases, they've even continued to use after that. So they've already experienced an incredible degree of medical illness and surgery due to their drug use. At that point, because things have gotten so bad medically, they are open to some kind of help. I mean, they're often ready for something.

Dr. Roy Stein:

What we find is that a lot of the times, people really do want to get off the opioids because, as I said, at a certain point with the opioids, it becomes more, almost a job. They're really not enjoying it that much, it's more, "I have to use, I have to get up in the morning and figure out every day, how am I going to get my drug?" Then you use it, let it wear off, get some more, it becomes a full time job. They're not getting much pleasure out of it. Plus, when they do go into withdrawal, it's so unpleasant. So if we can offer medication that will help them deal with that, and not have to go use illegal drugs, they are really appreciative, and that, this is something to stress, is that we do have really effective medications for opioid use disorder.

Dr. Roy Stein:

Methadone has been around for many years, and then in more recent years, we have buprenorphine which, in the United States at least, is sold as suboxone. These are medications for opioid use disorder that really allow people to feel normal, not have the drug craving, not have the withdrawal, and allow them to resume functioning quite normally. They work really well, and a lot of patients really want to be on them, so that's a good thing, that brings them to us, we have something to offer that really helps.

Dr. Roy Stein:

A lot of the patients we see are continuing to use the methamphetamine and they're not as interested in stopping that. They mostly, "that makes me feel good", and they're not viewing that in the same way. So, one thing is the fact that we do have medication to offer, brings them into treatment, it keeps them engaged with helping professionals, where we can at least be working on developing that relationship, and hopefully helping them make additional changes for their overall wellbeing. There's a difference in how they view the two drugs, but fortunately we have something that they want, that brings them to us.

Dr. Roy Stein:

As far as using Motivational Interviewing, MI is generally regarded as, it's always listed as one of the effective interventions for substance use disorder. Certainly, in the realm of alcohol, and to some degree, tobacco, there's good evidence for efficacy, especially for people at the milder end of alcohol use disorder, even fairly brief MI interventions can be quite effective. I would have to say that for people with advanced or severe stimulant use disorder, cocaine and methamphetamine, there's not a lot of evidence that MI, as a brief standalone treatment, is particularly effective, because of the magnitude, the enormity of the problem, takes more than that.

Dr. Roy Stein:

Having said that, I think almost everyone who works in this field, and I agree, would say that MI and an MI approach is important to incorporate in a more comprehensive approach to treatment. So, it's not to abandon MI by any means, but we shouldn't overestimate its impact. So if somebody was coming relatively new into this type of work, it would be unwise to think that, oh, I can do three or four sessions of MI and the person who has methamphetamine use disorder is going to stop. They would be sorely disappointed and frustrated. So having realistic expectations of the impact, I think is very important.

Dr. Roy Stein:

I think the essential features of the spirit of MI, basic use of OARS and looking for change talk, is the same... OARS mean open ended questions, affirmations, reflections and summaries, the basic skills of communicating and then looking for people's speech that favors change and reinforcing it. These core elements of MI are the same in this population, as with anybody else.

Dr. Roy Stein:

Let me come back to MI spirit. When you think about stigma, and you think about shame and how people are viewed in society, if you think about somebody who is a "heroin addict", in our profession, and I would strongly advocate that we don't use the word "addict", for most people the word "addict" has a pejorative connotation. I would recommend, and I think everyone in this field would say, that "a person who uses heroin" or "a person with opioid use disorder", is a proper way to refer an individual, or "a person with methamphetamine use disorder", not a "heroin addict". That conjures up a very negative picture, at least for a lot of people.

Dr. Roy Stein:

If a person in society is thought of as a heroin addict, a crack head, a meth user, an injection drug user, those conjure up very negative images in society and for people about themselves. So society looks at them very negatively and they don't feel so good about themselves for being in that state. Add to that the fact that many people who have these addictions are engaged in criminal activity to support their drug use, it's not that they were criminals to start with, but they have no other way to afford the drug. In many of the young

women we see, and it's true for young men as well, but especially in the young women, prostitution or sex work is a very common way for them to try to survive.

Dr. Roy Stein:

So, when you think about that constellation of an injection heroin and meth user who's a prostitute or engaged in, let's say, selling drugs to support their own habit, I mean, just think about the amount of shame and stigma that person faces. Often these people have had very negative experiences with healthcare professionals. We saw a patient yesterday, she was hospitalized with heart valve infection, a lovely young woman, she was there with her mother, very concerned in the hospital, and she told us that at the other, at a community farther away, they basically told her when she went for help in the emergency department, "we don't have anything to offer you, you brought this on yourself, you're a drug addict. Basically, go away".

Dr. Roy Stein:

So, these are real experiences in 2021 that people have. So imagine their concern about coming in to see a doctor or winding up in the hospital, and we're going to talk to you about your addiction. All this to say that the engagement, the first of the processes that we emphasize in Motivational Interviewing, of engagement, of forming a therapeutic alliance based on trust and respect for the other person, an I-You relationship with this individual. You're a person with struggles, and despite the fact that I regret that you're engaging in a number of these behaviors which are harmful, you are a real person and that we care about you. That is so critical, to a degree that's much stronger than somebody talking about weight loss or "I want to exercise more". I mean, those are very important health behaviors, but here's a person who is really fearful of being judged, based on their experiences, fearful of being rejected.

Dr. Roy Stein:

The other thing is, if you don't have a genuine sense of, "I'm really here to be your ally and understand your plight and see if we can work together", they're not going to be honest. Honesty is another challenge. People who have serious drug use disorders, kind of by necessity, learn how to be dishonest, they learn how to lie or manipulate to get out of trouble, to get what they need, and they bring out those behaviors sometimes into the consulting room. This issue of forming the relationship is not only important for them to feel safe, it also means they have to feel safe to tell you what's really going on, otherwise, we can't be very helpful.

Dr. Roy Stein:

So, I really stress the MI spirit is not just a throwaway that we mention that in some slides, and "oh, yes, yes, that MI spirit and be compassionate". Again, MI spirit, the notion of acceptance and the notion of the absolute value of the human being, that no matter how kind of degraded or debased the person's current lifestyle is, forgive me for saying that, but they're living in a horrible situation and engaging in very undesirable behaviors, you're still a human being. That's who we're here to connect with, and we hope that maybe we can help you with some of the behaviors. So I think I just want to stress that, a challenge...

Sebastian Kaplan:

Thank you. If I could just jump in Roy...

Dr. Roy Stein:

Yes, yes, please.

Sebastian Kaplan:

It really is a very helpful reminder of just some of the real basic principles of what we're talking about, basic principles of viewing another person as a person, as a human being, even if their life circumstances are really challenging or they're engaging in some of these behaviors, that we shouldn't have their conditions or their diagnoses or their behaviors be the defining features of them, that they are human beings, first and foremost. If you approach them in that way, and from our standpoint, very much influenced by the MI spirit, where stigma isn't really, it doesn't fit with the MI spirit, or shame inducing conversations isn't part of the MI spirit, that is really central to what you do, and central to helping conversations go in helpful directions.

Sebastian Kaplan:

Also, just maybe a helpful reminder for us, who are doing this kind of work every day, that an example like you shared there, that in 2021, in a hospital setting, someone would go to seek medical care and be rejected in that way, and in essence, blaming the person for their condition. It's a reminder that there's no shortage of the work that we do left for people to take part in or be helped with. I wonder if you could also talk a bit about, and maybe you were getting to this with acceptance, in particular, maybe autonomy supportive principles, we talked before we started the recording about the urgency that practitioners might feel when working with people who are engaged in life threatening behavior in an objective sense, in a non-judgmental way, that the behaviors that they're engaging in are imminently life threatening, so therefore, it might lead to a sense of urgency on the part of the practitioner, be it a psychiatrist or a non-medical provider.

Sebastian Kaplan:

If you could speak a bit to that and how you think MI can help maybe reorient or refocus the practitioner in ways in the face of that urgency, and in ways that can continue to be helpful in the conversation.

Dr. Roy Stein:

Glad you brought that up. So the lethality, the immediate lethality of these conditions is striking. Literally, yesterday, the US Center for Disease Control released new figures that, for the 12 months ending in August of 2020, there were 88,000 overdose deaths in the United States, which was a dramatic increase from the previous 12 month period. There's a lot of reason to think that the pandemic has really fueled a huge increase in various forms of substance use, but including overdose deaths. Most of the patients that we see are young, they're in their 20s and 30s, and so to be working with young individuals who have very complicated medical complications, and to know that it's a very real possibility that between this week and next week, this person could die of an overdose, is very

disturbing, especially if you're approaching them with a sense of compassion and connecting to them as a human being.

Dr. Roy Stein:

If your compassion is there, and your sense of forming a real relationship with someone that you care about, and knowing that they could die in the next week or month, is a real challenge to deal with, and certainly can drive that very understandable so-called righting reflex, that we talk about in Motivational Interviewing, the urge to, "I've got to get in there and do something, I've got to save this person, this is just unacceptable". The problem being that if we get too much into an, "I'm here to save you, this is what you've got to do", we, in many cases, just drive them away and they become less engaged, so that is a dilemma.

Dr. Roy Stein:

How does MI help us with that? One, is the notion of autonomy, which is another part of the MI spirit, that tragic though it may be, people really do have control of their own lives, of their own decisions, and just reminding ourselves that we cannot force change on somebody, and instead, if I can be present, if I can be their companion, so to speak, in addressing change, if I can be by their side and ready to engage, as they are ready to engage in change, that's what I can do realistically. I don't have the power to impose a change on them. I would say that challenge, which we deal with any kind of health behavior when doing Motivational Interviewing, is just that much more acute when we know that the person could die now, we're not talking about dying of lung cancer 30 years from now, we're talking about what happens tomorrow. So it does create an urgency that we have to be conscious of.

Dr. Roy Stein:

I also, I just want to make a side comment that because of this acute nature of these problems, I think it's really important to take care of ourselves as individual clinicians and the other members if we're in a team care setting, to be very attuned to how this is affecting oneself and one's colleagues, the staff, and helping them process that. They can sort of get into it, just as though they're working in a kind of crisis mode all the time, and I think that can have deleterious effects on the individual's health, of the staff, and on their effectiveness. I think there's a risk of so called burnout, or another way to look at it is compassion fatigue, that when you're really caring about people who are this much on the edge and are sometimes defeating your best efforts, so to speak, that can be hard. People can wind up becoming distanced as a result.

Dr. Roy Stein:

When there is a death, it's very important to be very present to one's colleagues, the members of one's team, because it does happen. It's happened in our team and it hits people hard. So empathy for each other and ourselves, I think is really important in this setting.

Glenn Hinds:

What's striking e about what you're saying was, so much about the potential opportunity to create success in the sense of stopping someone, make a positive change with their drug use. For an individual practitioner, it sounds like so much of what makes the outcome work is what happens at the front end, at the beginning stages of this process, particularly with stimulants. One of the things that struck me was, it's almost like an invitation is to help someone who's used to going fast, the practitioner has to be willing to go slow to recognize this is going to take a bit of time, this idea of a brief intervention, it would be wonderful, but a brief intervention with a stimulant use disorder, it's probably going to be quite a long brief intervention.

Dr. Roy Stein:

Yes, yes.

Glenn Hinds:

And to bring into that as well, the importance of what it was that brought you into Motivational Interviewing. Guess what? An awful lot of people who have been attracted to MI, is around the spirit and the music that that sings, and you referenced Kohut early on, around that willingness to experience the other person without losing your objectivity. As we listen to you talk about the drug users you're describing, they're living on the edge of society. They're modern day lepers. A bit like the lepers in biblical stories, nobody wanted to be around them, and took really brave individuals to be willing to go and support the lepers of our society.

Glenn Hinds:

The risk was that they would catch leprosy, and I guess what we're exploring is emotionally, that the practitioner, Rory talked about, Rory Allott talked about this before, working with psychiatric patients, being empathetic and going into the patient's world, we have to be careful that metaphorically we don't catch the leprosy, "the madness", the chaos, the fear, the apprehension, that is potentially informing the person's use of drugs, and then becoming that experience, and it overpowering them or them losing sight of themselves. I used to work in addictions, and my understanding of the disease model is that's how we practitioners or other people catch the disease. We may not end up using the drugs, but we've lost sight of ourselves, as we lose ourselves in the chaos of the drug use that we're trying to support.

Glenn Hinds:

I guess what I'm hearing you say is, for anybody who is considering going into the world of supporting drug users, particularly amphetamines or stimulants and opiates, so much is about your own self-care, about being open to recognizing the experience that you're going to have, and those moments are going to be full of fear because you're going to be with frightened people. To recognize some of the fear you're experiencing, the desire to make them well, is actually what the client is communicating to you. It's about how do you feel supported, and not... I guess one of the things I'd be curious about, given that you've been in this world for a long time now, Roy, what is that you have done to maintain your wellbeing that could help other people who are listening to this podcast today? Do you

think, okay, so here's someone who's been around this for a long time, still practicing, still on the straight and narrow, how do they do that?

Dr. Roy Stein:

Well, I guess I'd go back to how I was brought up, and I guess, somewhere around here I've mentioned that, I talked about Martin Buber and the I-You relationship. Somehow I got that, I think my mother sort of was somebody who was taken by that, or I think that's where that came from. My father was an internist, a medical doctor, and he clearly loved medicine. He loved being a good doctor, in many ways, it was sort of his hobby as well. I mean, he loved reading medical journals at night, underlining with a red pen, going through. I just remember him doing that, but he also really set limits as far as his work, he had his work but he also spent time at home with the family. He wasn't gone all the time, nights and weekends he was there. He loved music, he played piano very well. He set an example that I grew up with, which is that you can be a doctor to whom the profession of medicine is deeply meaningful, it's not just a job, but having the rest of your life, your family life, is equally important.

Dr. Roy Stein:

I think I've just always held that as a value, that was part of the value when I married my wife who is also a physician, that we said to each other, "if we're going to do this, we want to have our career, it's meaningful, it's a sense of purpose, but it is not going to just overrun the rest of our lives". So from the very beginning, family, family dinners now our kids are grown, but reserving time for the rest of life and for relationships outside is exceptionally important. I guess that's what I would say.

Sebastian Kaplan:

You're referencing really some basic fundamentals of living, and hearing what you say about self-care and the model that your father set for you, and even thinking about the way that you interact and have conversations with your patients, it just gets back to some of the fundamentals that we talk about so often. As far as self-care, the idea of balance, having a life outside your profession, and then as far as the work with patients, just approaching them with compassion and care and respect.

Sebastian Kaplan:

So often, like you've mentioned, the MI spirit isn't just something you put on a slide and kind of gloss over, it is truly fundamental to just about each and every moment that you have with someone. I wanted to ask, and maybe we've already touched on this... Two different questions. One is, do you feel like there are particular adaptations to MI that are relevant, or are even somewhat uniquely relevant, to working with people with opioid and/or stimulant use disorders, again, beyond the fundamentals of the spirit that we've talked about?

Sebastian Kaplan:

The second one has to do, particularly for people with opioid use disorders that are in specialized treatment programs, receiving medically assisted therapies like suboxone,

like you've mentioned, how you feel like MI fits in those kinds of models that are also kind of regulated, right, as far... I don't work in those systems, but I understand that there are rules that patients follow to be a part of those. The idea of setting rules and doing MI, for some might feel counterintuitive or sort of at odds with each other. So again, any unique adaptations, if at all, and also how it fits.

Dr. Roy Stein:

Well, let me first start on whether both, for opioids or stimulants, for both categories... We've talked quite a bit about engagement, MI spirit engagement relationship, but if we go through, MI talks about four processes: engaging, focusing, evoking, and planning, okay? So let's talk a little bit about focusing. It is not unusual, especially on the stimulants, that the person, let's say, is not as ready to stop using. They might say, "well, I'd like to cut down", or maybe they don't want to change it at all. So maybe the focus is not going to be on, certainly, on abstinence, at least initially. We might hope for that, we might aspire for that to ultimately be the outcome, and I do believe that, personally and as a doctor, that the best outcome for individuals that we're talking about would be abstinence from both opioids and stimulants, but that's not going to happen for everybody or maybe is not going to happen anytime soon.

Dr. Roy Stein:

So, there are a lot of other possible and highly relevant change goals, or target behaviors. So I'll just list off a few. So if abstinence might be the gold standard, reduction in use, so cutting down, if they want to work on that, meet them there on that. Simply engaging in treatment, simply being involved in counseling, beyond maybe just basic medication management, would be a goal. So going to sessions, even if your behavior's not changing.

Dr. Roy Stein:

I want to make a side comment on that, Richard Rawson, that's R-A-W-S-O-N, has been one of the national leaders in research on stimulant use disorder for decades now, and continues to be very active. They have a very effective body program at University of California, Los Angeles, UCLA. One of the points he makes is that simply attending treatment, the treatment retention is associated with reduced overdose deaths, even if people aren't really stopping their use or even measurably reducing their use, people who stay in treatment are less likely to die than people who just drop out entirely. So the focus can simply be keep coming, and that's, I guess that's what they say in AA is just keep coming. Something good happens, at least in terms of avoiding the worst outcomes, if people stay engaged in treatment, so that could be a focus.

Dr. Roy Stein:

The others become more specific around harm reduction. So if you have a person who elects to continue to inject drugs, well syringe services or syringe exchange programs, which are now widely available, so using clean needles and clean syringes, having them decide to inject, use safer skin cleaning practices to avoid bacterial infection. These are things that can make a difference about getting endocarditis, the heart valve infections.

Getting tested for, and being treated if necessary, for hepatitis C and HIV. There's now, in many communities, they have fentanyl test strips, so that people can test the drug that they're going to use to see if there's fentanyl in it, so they don't accidentally overdose on the fentanyl. That's harm reduction. It's acknowledging that the person is going to continue to use the drugs, they're going to continue to inject, but they'd like to avoid overdosing on a contaminant.

Dr. Roy Stein:

Reducing sexual, risky sexual behavior, because as I've mentioned, there's a big correlation, especially with the stimulants and risky sex. Getting into safer housing, especially alluded to the fact that many of these young people are exploited, they may be involved in interpersonal violence situations. So even if they're going to keep using drugs, if we can help them move into a safer housing or get themselves out of dangerous situations where they're being harmed. Believe it or not, there is some evidence, at least modest evidence, that exercise is beneficial in reducing stimulant use. So maybe the person is not ready to do anything else, but they want to start walking a mile or two a day. Any kind of positive behavior change that they can identify together with you, that they'd like to work on, helps them stay engaged in treatment, maybe helps them do something that's going to make them a little bit safer, and if they have a positive experience of change in one area, that could be a stepping stone to more comprehensive changes.

Dr. Roy Stein:

So, I would say, when it comes to the engaging process, keeping a very, very wide net, and not assuming that what we're here to work on is stopping drug use or even reducing drug use if they're not there yet. Any kind of change that's constructive, that they can come up with, or that you can offer, would be worthwhile. Again, there's a very strong push, I think, worldwide now, for so called harm reduction, that acknowledges that people may or may not stop using, but there're positive changes they can make.

Dr. Roy Stein:

Now, as far as, one of the things about some adaptations. Adaptations is, I think is, perhaps more of an issue on the stimulants because some of the complications of stimulants. So methamphetamine and cocaine have more deleterious effects on one's mental functioning. People who use, I'm in no way endorsing heroin use or opiate use, but the big risks with opiate use are that you overdose and die, or you get an infection from injecting it, but they don't cause nearly as much psychiatric or mental health deterioration, whereas chronic use of stimulants can cause cognitive impairment, difficulties in executive function, more impulsivity, problems with attention. It can affect cognition, and it can induce psychosis, paranoia, and aggression and violence.

Dr. Roy Stein:

So, there are a lot more behavioral problems associated with the stimulants than with opiates, so that's where perhaps some modifications might come into play. One is just, if the person has some cognitive impairment, this may be slowing things down more. I think we always encourage people when they do reflections, to keep them concise, don't do

lengthy, elaborate, more abstract reflections, which I don't think we should be doing anyway, but it's especially important to keep things a little more basic and a little more concrete, when we're reflecting with people who may have some cognitive impairment due to the drug use, just a general sense of things are going to move more slowly. That would be an adaptation.

Dr. Roy Stein:

One other, and this kind of comes from my psychiatric experiences, at least we're taught in psychiatry, that most people respond really well to empathic listening. Most people find that just to be very rewarding, to have somebody who really is listening and conveying genuine understanding. Someone who's paranoid may actually feel threatened by a listener who is getting too close to their own feelings, they may feel a little bit invaded. So, I guess I would be maybe a little bit cautious, and gently providing empathy with someone who is currently exhibiting any kind of paranoid features, giving them, they need a little more space because they can feel easily threatened, even by well-intended expressions of understanding and caring, so respecting the space of the more paranoid methamphetamine or cocaine user. In the same way, realizing that they do have, particularly when they're under the influence, they have the ability to be aggressive or even violent, not to be fearful of them, but again, just give them a little more space than you might do in the average situation. Those would be the only modifications I can think of there, in the way that you communicate and interact with the person.

Dr. Roy Stein:

Now, you mentioned about medication assisted treatment or medication for opioid use disorder, which again, I would stress is quite effective, whether it be methadone or buprenorphine, many, many patients do so much better and they're so grateful to have gotten on these treatments, so I think it's important that they be offered. If you are the prescriber, so, okay, I am a prescribing practitioner, I obviously do have authority over what I prescribe, so in that sense, there is a power imbalance, there is a hierarchy there. The patient wants the medication and I have to decide whether or not to prescribe it.

Dr. Roy Stein:

So, we do have certain expectations, you need to keep your appointments, so is it okay that you skip your appointments and just text me and say, "send in my medication", we get this. We do have expectations for periodic urine drug testing, and just at least to monitor and see what's happening, maybe the person doesn't adhere to that. Of course, as a physician, whether you're in the US or UK or anywhere else, we're under regulatory obligations about our own medical licenses, our ability to prescribe these medications, that we have to be mindful of. So there is a hierarchical situation built in, if you are the prescriber. That does alter it a bit, but in another way, you can still use Motivational Interviewing and just set certain boundaries. Well, there're certain things I can do and there're certain things I can't do, there are decisions you can make or not make, and just be clear about what the expectations and boundaries are, and then within those, I think you can still use Motivational Interviewing.

Dr. Roy Stein:

I don't think of it myself as similar to a correctional setting, but I know that in many countries, including in Scandinavia, there's been a big push to use Motivational Interviewing within the corrections system. Well, people don't have complete autonomy, they can't tell their correctional counselor, "well, I think I want to be released and be done", there're boundaries in life that are beyond our choice, but within those constraints, we do have choices and we do have a degree of autonomy. So I would say that be clear about what the rules are, clear about the expectations, be willing to be a little bit flexible when you can if you're a prescriber, but basically, define and clarify what the boundaries are, and then within that, the person still has a lot of autonomy of choices that they can make and where do they want to go with those.

Glenn Hinds:

So relationship sounds to be such an important message, and what you're saying is, the relationship, first of all, between the, almost like the treatment organization and the practitioner, to create the space for them to know that there's a wide horizon of potential treatment outcomes, rather than just getting off drugs. That's going to be promoted by the culture that the organization manifests for everybody to live towards, but also that what you're describing just now, but that, the relationship that we have with each other where there are things that we can ask to our clients or patients, and equally, that we are willing to give to them. So there is this give and take, but it's about maintaining our own wellbeing, maintaining our integrity as an individual and as a practitioner.

Glenn Hinds:

That's a very important message to the patient as well which is, look, I respect myself and in doing that, implicitly what we're endeavoring to do is try and teach other people how to respect themselves, by experiencing someone who wants to be helpful, yet maintains their own boundaries. Then what you were describing earlier on, with just recognizing, this person has an impairment because of their drug use. So think about these things when you're talking to them, in your relationship with them. Take these things into account, and continue to be caring, so make adaptations to what you've been taught in general in relation to Motivational Interviewing. Shorten your reflections, make them a wee bit more concrete, recognize this person's processing is inhibited because of their brain function. That's the reality of who this human being is and continue to see them as a ‘The-Thou’ and to treat them with that.

Glenn Hinds:

So again, just that reinforcing of, it's in the relationship, that most of what it is we're trying to achieve is going to take place, and these relationships are within the organizations, within our treatment relationships, but also relationships with ourselves as well, as practitioners. If we're paying attention to maintaining good relationships at those three levels, then things are potentially going to move much more efficiently and effectively for everybody that we come into contact with. As is often the case, at this point in the conversation, Roy, we would say, again, we could keep going, but I'm conscious that we're already speaking for over an hour.

Glenn Hinds:

So what I would like to do, if it's okay, is begin to draw us towards a close, and at this point, normally what we ask our guests is, other than what you're doing in your day to day work, and your specialism with Motivational Interviewing, and your treatment in drugs and alcohol, or drugs, is there anything else that's going on for you that's catching your attention, or anything that you're enjoying doing? It may be work related, it may be life related, that you'd want to share with us so we can talk to you about it for a few minutes.

Dr. Roy Stein:

Well, sure, I think this would tie in, in terms of this work/life balance, here in North Carolina, it's just about 8.30 in the morning, and at 9:00, my son is going to bring over our granddaughter who today is 18 months old, so this is her one and a half birthday. So I'll be taking care of her for the next several hours, as I now do every Friday, so that is a source, anybody who, I think, has become a grandparent would agree, is a source of tremendous joy.

Dr. Roy Stein:

So, I retired from the Veterans Health Administration a little over, just over a year ago, after 30 something years there. I knew that I wanted to continue being involved in my profession because it matters to me. Both it's rewarding to practice, but also because of the severity of this problem out there, this addiction problem, I feel somewhat of an obligation to keep both practicing and also teaching, because there's a need and I have things I can offer.

Dr. Roy Stein:

So, what I figured would be good for me is to retire and take a different position and work half time. So I moved over to the University of North Carolina, as a half time faculty member, which this has really been sort of a wonderful adaptation. Part of that is I don't work on Fridays, except for doing cool things like this, and then on Fridays I take care of our granddaughter. So it's great, I really get a kick out of it.

Dr. Roy Stein:

This was even before COVID I started, so I wasn't just part of the COVID fad, I started baking bread, specifically challah, you may be familiar with. Every Friday, I bake challah, and so when I have our granddaughter, Emmy over, she sort of helps in whatever way she can. That's sort of becoming a mutual project. So this all gives me tremendous joy and is a great antidote to the stress of people and their overdoses and endocarditis and such.

Sebastian Kaplan:

Helpful reminders of the work/life balance in action. Happy year and a half birthday to your granddaughter. It's a nice model to set also, and to hear how somebody's evolving their career and creating opportunities to continue to pursue their interests, and also make sure they're attending to other parts of life. So we appreciate that.

Sebastian Kaplan:

Roy, if people had questions or wanted to follow up with you, whether it's about professional things, maybe someone wants this challah bread recipe, I don't know, that could be of interest to some, would you be open to people contacting you? If so, how can they reach you?

Dr. Roy Stein:

Yes, I'll give you my email, which is Roy, R-O-Y, underscore Stein, S-T-E-I-N at med, that's M-E-D, .unc.edu. Of course, I'm looking forward to next Thursday, I'll be co-leading a workshop with Seb. Now I can start calling you Seb. So you and I are going to be working together next week, and we need to get our final slides in.

Sebastian Kaplan:

That's right, yeah, we need to hash that out, and I appreciate you inviting me to do that with you now for several years, maybe three or four years now.

Dr. Roy Stein:

Yeah, it's great.

Sebastian Kaplan:

It's the Governors Institute who puts on conference through, is it the Society for Addiction Medicine in North Carolina, is that the group?

Dr. Roy Stein:

I guess so, yeah.

Sebastian Kaplan:

Yeah, yeah. Okay. Well, yeah, looking forward to that for sure.

Dr. Roy Stein:

Well, I appreciate, I just want to say I really appreciate the two of you and I feel like I've learned a lot, and Glenn you've kind of helped formulate back for me a lot of ways to look at what I've told you and what I'm doing, so I really, it's been very rewarding for me to reflect more on these processes.

Glenn Hinds:

Well, again, as Seb has already said, we really appreciate you giving up your time and the joy was very clear to see, when you just mentioned your granddaughter, and even now as you, there's just a shine that comes on your face, it looks like a, it's just the, the granddaughter just brings joy into your life. We wish you every happiness for the rest of the day, and acknowledge the time and effort and your contribution, not just to this conversation, but to the work that you've been doing throughout your career. Your willingness to maintain that gift that it sounds like you feel that you gained from your mother and your father, which was the I-Thou, and your willingness to just continue to

allow that vein to help you navigate the path of life, and in your relationships, with everyone you come into contact with.

Glenn Hinds:

It has been a joy for us to spend the last hour and a half or so with you, and we wish you all the very best. Thanks for coming and thanks for chatting with us.

Dr. Roy Stein:

Sure, well, it was my pleasure. Can I just make a separate comment? I find, in working with older people, I guess I'm one of the older people now, just not even about addiction, but in patience, and you're concerned about depression and how severely depressed is this person? If you ask them about, if they have grandkids, and then you ask them about their grandkids. If you get that, that glow, which I know I have, but I've seen it in others, to me it's a very encouraging sign that this person is not completely beyond the pale with their depression. Tapping into something that seems almost universal, there's situations where it isn't, but often, a person's complaining about how miserable life is and then you mention the grandchildren and it's like they just, they light up. It's a useful clinical finding as well, it's a wonderful experience to have oneself.

Glenn Hinds:

Find the flame and give it some more air. What is it? Fan the flame, find...

Sebastian Kaplan:

Find the flames.

Glenn Hinds:

Find the flame and flame it. No. Fan it. Find the flame and fan the flame.

Dr. Roy Stein:

And fan it, yes. All right, you guys, this was a pleasure.

Glenn Hinds:

Thank you, Roy.

Dr. Roy Stein:

Right, bye.

Sebastian Kaplan:

Thanks so much, Roy, we appreciate it.

Glenn Hinds:

Thanks then. Take care, man. Bye, everybody.