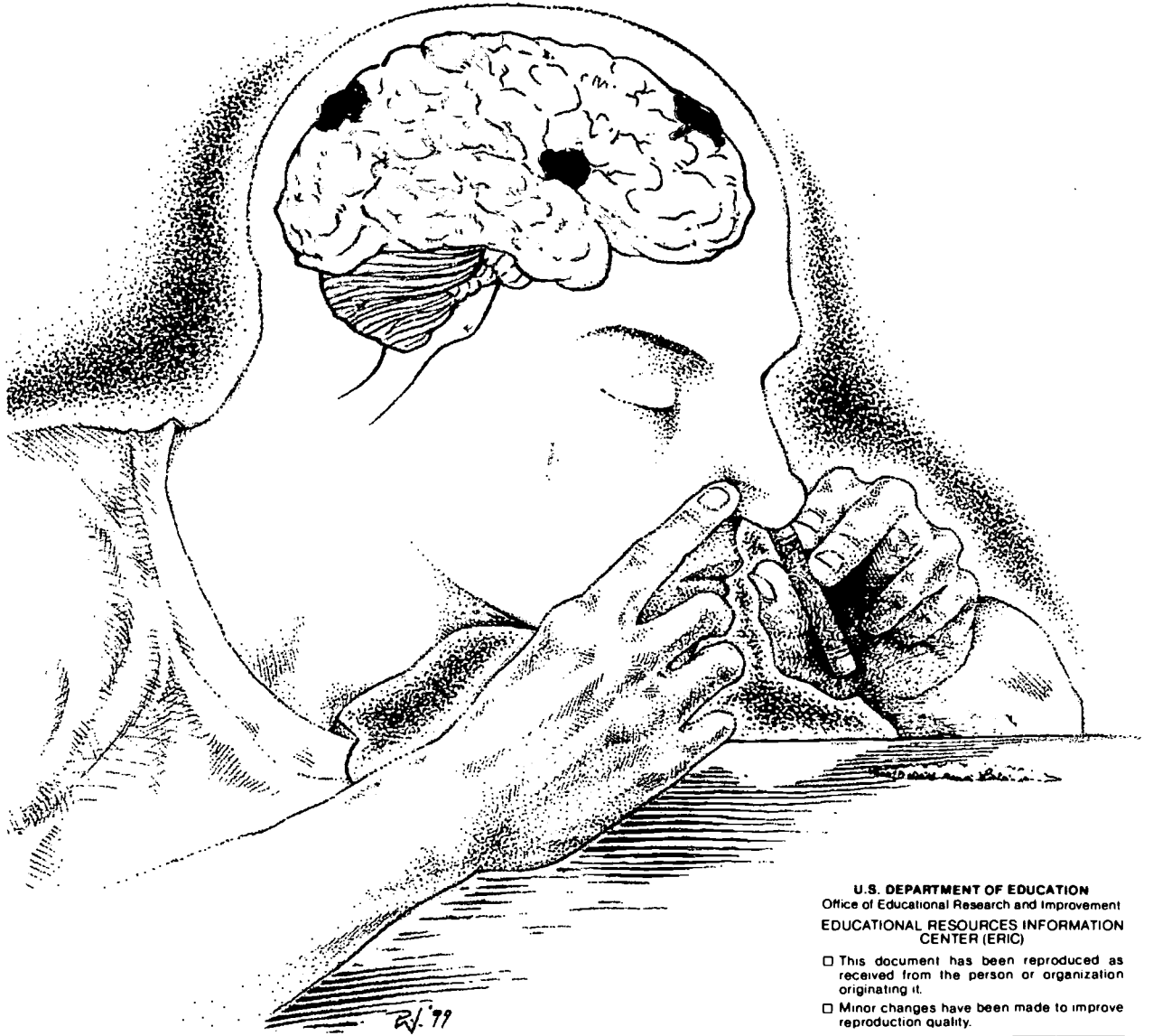




# Addictive and Compulsive Disorders



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**Katherine Lauderdale, BA, Jerry L. Roberson, BA, & Carlos A. Bonilla, PhD.**  
An ICA Publication in Behavioral Psychology

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**Addictive and Compulsive Disorders  
A View From the Trenches**

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# **Learn about Addictive and Compulsive Disorders**

**Self-mutilation**

**Heroin Addiction**

**Risk-Taking Behavior**

**Doctors Who Abuse Drugs**

**Sexual Addiction**

**Trichotillomania**

**Addiction to Shopping**

**Munchausen's Disorder**

**Internet Addiction**

**Steroid Abuse**

**Addiction to Gambling**

## Meet The Editors

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**Katherine Lynn Lauderdale** is in pursuit of a doctorate in Clinical Psychology. Self-employed as a consultant for accounting and computer software, Kathie also tutors college students on a variety of classes, and speaks on issues such as: assertive training, domestic violence and sexual harassment. Kathie has co-edited six titles and co-authored in three, the latest one "*A Skeptics Guide to Alternative Medicine: A Holistic Approach to Well-Being.*" (ICA Publishing, 1998).

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## And Our Illustrators:

**Eric Affleck** is a cartoonist whose work appears weekly in IMPACT, the official newspaper of San Joaquin Delta College in Stockton, California. Eric, 21 years old, is pursuing a degree in fine arts under the guidance of Mario Moreno. His work has also appeared in newspapers and several books. Eric's drawings appear on pages 7, 11, 13, 17, 31, 74, 79, and 100.

**Peter Weese** is a 17-year-old junior in high school. His passion is drawing and art. He plans to attend art school and pursue a career as an illustrator and/or cartoonist. Peter's work has appeared in many publications, the latest one "*A Skeptics Guide to Alternative Medicine: A Holistic Approach to Well-Being*" (ICA Publishing, 1998). Peter created our cover.

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**The**

**Biochemical and Physiologic**

**Basis of**

**Addiction**

**Carlos A. Bonilla**



A detailed analysis of the biological basis of addictive and compulsive disorders is beyond the scope of this book. Suffice it to say recent advances in the neuro-sciences, using high resolution imaging scanning technology (NMR, PET) scans have demonstrated the superb ability of the brain to grasp, retain and process the information with which it is challenged. A simple description of scanning technics is presented in figure 1 (FNMR) and figure 2 (PET).

No one questions this concept: the brain, when exposed to prolonged drug use, changes in fundamental and, usually, permanent ways. Just how this happens is not yet well understood but the quest for answers continues in a relentless manner, worldwide, by investigators in the neuro-sciences, developmental psychology, behavioral psychology, psychiatry, pharmacology and medicine. The quest for answers is important, for the numbers are frightfully large; consider: over 4 million Americans are drug addicts which include 2-3 million hooked on COKE (cocaine and crack) and over  $\frac{3}{4}$  of a million addicted to the opiates, mainly heroin.

Alcoholics, of course, comprise the largest category of addicts, numbering well over 14 million. Many more, though probably not yet addicted, use illegal drugs and, as for the smokers, the highly addictive properties of nicotine (1 million users) make it the largest legal and most insidious problem for our society. Cigarette smoking is the leading preventable cause of morbidity and mortality in this country: more than 400,000 deaths per year are attributed to it.

As of this writing (February, 1999) no drug treatment is available to treat those addicted to cocaine and, while methadone helps some who are hooked on heroin, the number helped is small. As for alcoholism, only two drugs are available, but useful in a small number of those afflicted.

## **Funtional Magnetic Resonance Imaging(FMRI)**

FMRI is an increasingly popular innovation in brain scanning. It shows mental activity over a shorter intervals than PET, with better anatomical detail, and does not require injection of radioactive tracers.

MRI makes structural pictures based on magnetic field changes throughout the brain. These changes are initiated by radio pulses that affect spinning hydrogen protons. Functional MRI makes images so quickly that changes in blood flow can be detected, indicating areas of activity. Water shows up particularly well, so organs like the brain, with a high water content, show up in great detail.

Figure 1

## **Positron Emission Tomography (PET)**

PET uses radioactive tracers to track the brain's use of energy. Mental activity is revealed as the tracers decay into gamma rays, which can be detected by a scanner.

The tracers are attached to sugar or water molecules, which are introduced into the bloodstream. As the tracers enter the brain, the subject performs a mental exercise or task. The PET scanner's ring of detectors picks up the radioactive decay of the tracers.

As each positron decays, two gamma rays are emitted at 180 degree angles to each other. A powerful computer counts these gamma pairs and converts them into images of the brain's energy use, showing the areas associated with the mental activity.

A PET scanner makes a series of slice-like images of the brain, which can be combined later to provide three-dimensional images from any angle.

Figure 2

What happens to the brains of addicts when indulging in their favorite pastime, satisfying their specific craving? A complete picture has not yet been elucidated but these facts stand out:

- The powerful brain chemical, DOPAMINE, is now known to play a key role in a wide range of addictions, including those to alcohol, heroin, cocaine, nicotine and methamphetamine.
- Dopamine is, likewise, involved in the pleasurable reactions elicited by sex, gambling and chocolate consumption.
- Dopamine is one of the major substances utilized by nerve cells to communicate with one another.
- Dopamine is the major chemical associated with the, so-called, “pleasure center” of the brain.

The rise and fall of dopamine levels in brain tissue alter brain cell function and contributes to the craving reaction. Some changes in the brains of addicts resemble those which occur in healthy people when certain types of memories are formed. The above has caused a shift in the neurological research emphasis, from simply looking at addiction as a function of the reward/pleasure center, to a complex reaction involving the engraving of emotional memories in an area of the brain known as the amygdala.

Obviously, drug addiction is an unbelievably complex phenomenon but, because we now know that a simple sight or smell can trigger brain circuits altered by drug abuse and spur a relapse, the move to study the addiction -dopamine-emotional memory axis is well warranted.

# WHAT IS THE HARDEST HABIT TO BREAK? THE MEMORY OF THE HIGH!

A pictorial summary of the brain's activity during the rush (figure 3) and the ensuing craving reaction (fig 4) in a subject given cocaine helps to understand the complexity of the reactions involved, as viewed in functional MRI scans. In this work it is our intent to acquaint the reader with some of the more interesting aspects of addictive and compulsive disorders. While we know this is but a drop in the bucket, we hope it becomes the proverbial bucket which helps fill the ocean of knowledge regarding the scourge of addiction on society.

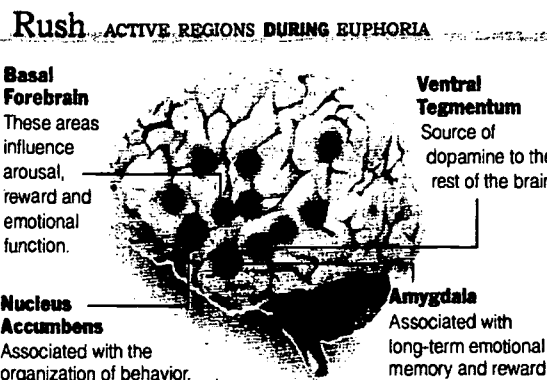


Figure 3

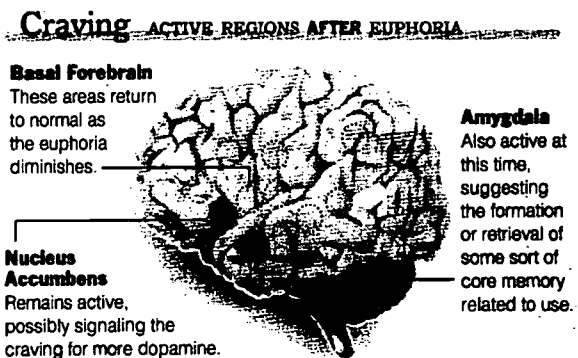


Figure 4

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## DICTIONARY OF TERMS

**Neuron or nerve cell:** the brain's computer chips which receive, coordinate, analyze and transmit information. Each brain contains billions of these cells.

**Synapse:** the junctions by which nerve cells link to one another; there are trillions of these structures, which form when tiny tentacles from neighboring neurons connect.

**Neurotransmitter:** chemicals found in the midbrain which enable cells to talk to each other by carrying messages between them.

**Functional Imaging:** the technology which utilizes high resolution scans of living tissue. It allows scientists to literally watch the brain work.

**PET (Positron Emission Tomography):** a type of functional imaging which uses a scanner to make a series of slice-like images of the brain; when combined later, they provide three-dimensional images from any angle.

**FMRI (Functional Magnetic Resonance Imaging):** the most popular and innovative technique in brain scanning. It allows visualization of mental activity -as it occurs- over shorter intervals than PET, with sharper anatomical detail.

## The Many Faces of Addiction

Our nation is facing an addiction crisis. An epidemic! Images race across T.V. screens, newspaper headings and magazine covers regarding it. Addictions have captured our nation's attention, and rightfully so. But, what is addiction? How does it affect us? Is it simply a character flaw or the extreme enjoyment derived from a chemical substance? Or, is it an act that has become an obsession?

Ultimately, addiction is characterized as a weakness, a lack of willpower, a sickness, an inability to face reality. Altered moods or "highs" attract addicts to various substances. The need to escape reality, and the instant gratification received, propels them to continue seeking a "high!" These behaviors become, for the addict, a way of life.

In the early stages of substance abuse addicts' are not consciously aware of their problem. For instance:

- Stan comes home from working hard all day, craving a beer. He goes directly to the refrigerator, takes one out and drinks it. It tastes good and it satisfies his craving.
- Cheryl and her husband have spent a great day together on the beach enjoying the sunshine. She cannot wait to get home, go directly to her favorite room and make love for hours. It is good and she feels satisfied.
- Bob awakens each morning ready for a morning jog. He gets up, changes into the right gear and jogs three miles. When done, he feels wonderful and is satisfied.

Obviously, it feels great to satisfy our cravings, desires or needs for, after all, we want our needs fulfilled. The question is: when do our "wants" become an addiction? By simple definition a "want" becomes an addiction when, if not satisfied, it causes a person to suffer mentally and/or physically.

Throughout this book, results of interviews and research revealed many social, personal and biological reasons for addiction and their relevance to behavior. Addicts are in denial when they rationalize:

- I do not need anyone
- I do not have to tell anyone the truth
- I do not owe anyone anything, they owe me
- I cannot face life
- I cannot face my problems
- The pleasure derived from the addiction is more important than anyone or anything
- I can do anything I want

These patterns of thought support the addict's belief: I am all right.

Working with addicts requires patience, and yielding to frustration leads to failure.

**RELAPSE IS THE RULE, CURE THE EXCEPTION!**

Controlling addiction is an enormous endeavor made more difficult by the fear of withdrawal, unwillingness to face exposure, and society's stigma when a person is labeled "drug addict." Often it takes hitting "rock bottom" before the journey to recovery can begin and, many times, "rock bottom" is tainted with enormous tragedy; consider:

- A loving mom and dad beat their 3-year-old daughter to death; they were on a crack binge.
- A drunk driver kills a husband and his two-year-old daughter in an auto accident.
- Ben cannot stop eating; he is addicted to food.
- John, a 15-year-old, dies after prolonged sniffing of airplane model glue.
- Sheila "maxes out" her husband's credit cards in two days; her addiction is shopping.

- A 20-year-old marriage ends in divorce; Pam is a sex addict and cannot seem to stop having affairs.
- Charlie loses his job after twenty years; he was caught snorting cocaine.
- Kathy loves jumping out of planes and doing stunts; She is a thrill seeker.
- Sheila easily becomes angry on the road and yells at cars next to her; she constantly exhibits road rage.
- Each night, when Angie comes home from work, she wants to relax and drinks excessively; she becomes an alcoholic.
- Casey spends hours on her computer using the Internet. Her house is a mess, she does not show for work on time and allows her children to run wild; Casey has an addiction to her computer.
- Mike will not allow his 16 and 18-year-old children to do anything without him; he needs to be in control at all times. He is a control freak.
- John spends every pay check gambling, has lost his home and his family; gambling has become his compulsion.
- Peter, a very successful businessman, is forced to quit his job; he cannot control his need for heroin.

Now, think a minute, then tell us: among your relatives, friends and acquaintances have you met anyone who exhibits any of the above?

**We invite you to journey with us into the  
labyrinthine world of addictive and  
compulsive disorders.**

Teresa Butler

Lynn Hawkins

Susan Hawkins

Xiomara Jalilie

Jamie Weidman



## BIOs

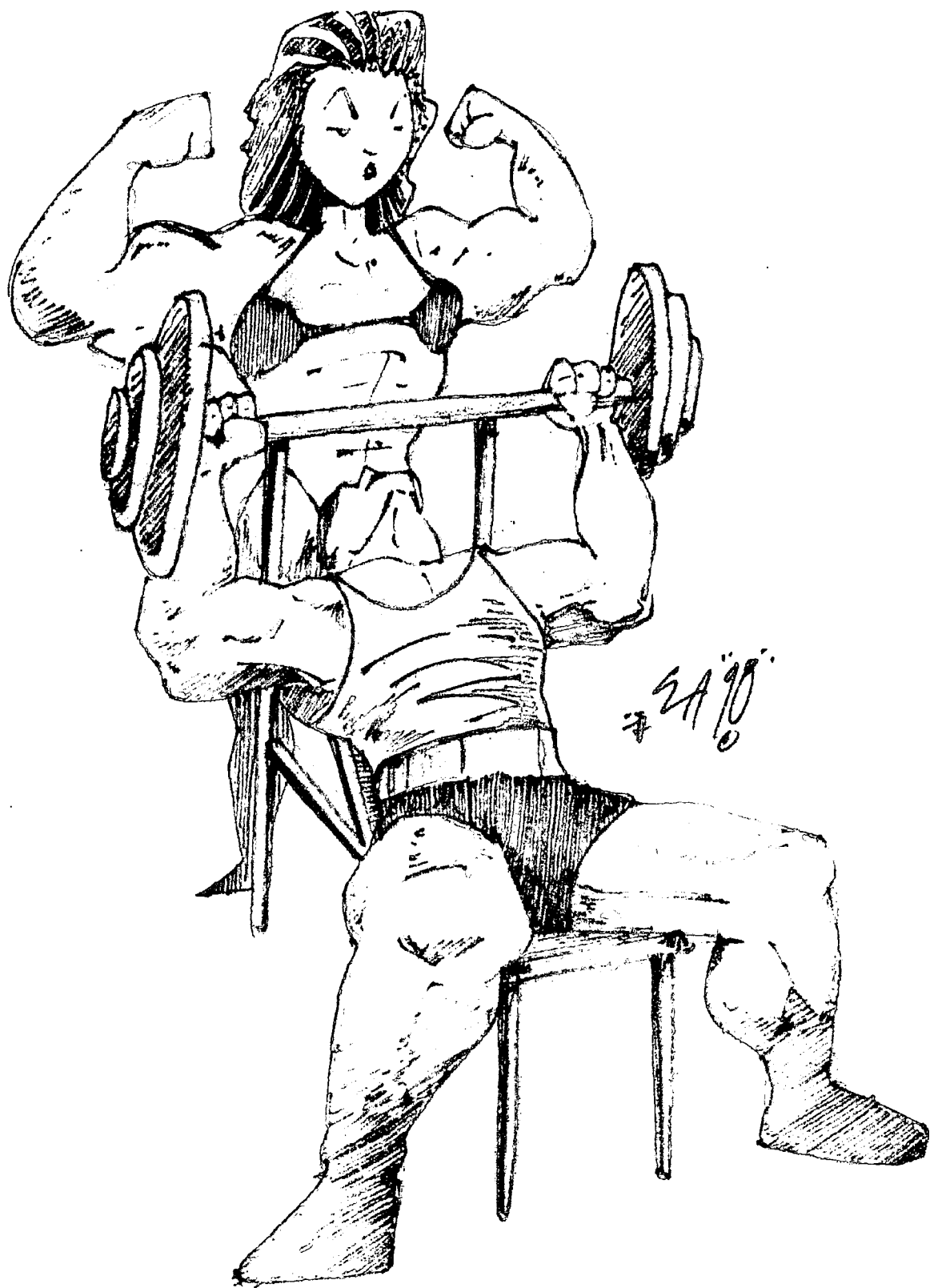
**Teresa Butler** is a Student Accounts Officer at National University's, Stockton Campus. She is also a student working on a BA in Behavioral Science. A wife and mother of two, she enjoys being with her family and singing in the church choir. Christian counseling is Teresa's goal for the future.

**Lynn Hawkins** is employed by Tracy High School, Tracy, California as a Student Security, Varsity Football Coach and Track Coach. Lynn has two children, Nichole and Lynn Dell II and an adopted son, Jerry. Lynn is also the proud grandfather to Courtney, Jr. A dedicated individual who finds great pleasure in helping kids, he is pursuing a teaching credential and will continue toward a Masters in Educational Administration. Lynn hopes to coach a college football team.

**Susan Hawkins** is employed by Providian Financial as a Manager. She enjoys spending time with her two children (Nichole and Lynn Dell II), her adopted son (Jerry), and grandson (Courtney, Jr.). Susan dedicates time to Tracy High athletes, is the Volunteer Coordinator for the Tracy Bean Festival and volunteers time to children in need. She hopes to graduate from National University with a BA in Psychology and will continue towards a Masters in Psychology.

**Xiomara Jalile** is employed at National University as a Admissions Advisor. She is working on a BA in Behavioral Science (also at National University) and hopes to become a counselor. The Masters in Social Work will be her next educational achievement.

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# ROID RAGE

# THE DANGERS OF STEROIDS

BETSY MONTALVO and LINDA LUNDGREN



***Roger Maris single-season home-run record was just beaten by Mark McGuire. McGuire uses androstenedione, andros. a steroid the body converts to testosterone. Andros is legal in Major League Baseball, Pro Basketball, and Hockey but banned in the National Football League, Olympics, and NCAA. Andros is unsafe. Even so, its sales have more than doubled since McGuire announced he uses it.***

## **History of Steroid use and Abuse**

Since ancient history, many athletes resorted to performance-enhancing aids to gain an edge over their opponents. Greek Olympians used strychnine and hallucinogenic mushrooms to “psyche up” for an event. It has been reported that in 1886 a French cyclist was the first athlete to die from using speed balls, a mixture of cocaine and heroin. In the 1930s Adolf Hitler allegedly administered the hormone testosterone to himself and his troops to increase aggressiveness. Athletes’ use of testosterone to boost performance became common by the 1940s. The first synthetic anabolic steroid was developed in 1953, having a strength-building effect five times stronger than testosterone. Controversy surrounding steroids began in the 1950s during the Olympic Games, when it was discovered athletes from Russia and other Eastern nations that dominated the games had used large doses of steroids.

Side effects from this usage was dramatic. Many male athletes developed enlarged prostate glands and required insertion of a tube to urinate. Some female athletes developed severe masculine characteristics and needed chromosome tests to prove they were, in fact, female. Since the beginning, anabolic steroids have been very effective and desired by athletes and, today, black market sales of these drugs top \$400 million per year. One million Americans use black market steroids, sadly, half of them adolescents.

### **CHARACTERISTICS OF STEROID USE**

What are the signs of steroid use among teenagers? Empty syringes or pill bottles on teens or in their personal belongings are dead giveaways. Steroids can be taken orally, or injected directly into the muscle, so puncture marks, bruises, scar tissue, or calluses on the upper thighs or buttocks resulting from injections are tale-telling signs.

#### **Warning signs**

- ◆ Rapid weight gain
- ◆ Combative behavior
- ◆ Increased facial acne
- ◆ Hair loss
- ◆ Swelling of face, hands and feet
- ◆ Enlarged breasts in boys

#### **Why Do Teens Take Steroids?**

- ◆ The pressure to win
  - ◆ To be the best
  - ◆ To have a competitive edge

Steroid molecules which mimic testosterone can rapidly build muscle mass and strength, to improve athletic performance. Some teens who use steroids are masking insecurity about their body, a common complaint for adolescents. Some use steroids to look leaner, others use them to build muscle. Nearly a dozen studies done between 1988 and 1994 show that 4 to 12% of adolescent boys and 0.5 to 2.9 % of adolescent girls have taken steroids (Garfield).

Some of the pressure teens feel comes from coaches or their staff. Coaches feel they must win or their job is in jeopardy, the pressure to win leads some to encourage players to use steroids. Gregory Gas, outreach coordinator at the Great Plains Sport Medicine and Rehabilitation Center in Peoria, Illinois, interviewed high school students and was shocked to learn 19% of admitted steroid users reported the suggestion had come from their coaches. Another 14% said a coach was their primary supplier (Granfield, 1995).

Parents can create situations where the teen feels a need to turn to steroids. "When a father tells his son he is proud of him for being bigger, stronger and faster," he sees the comment as an approval of how his body looks (Granfield).

## **BIOLOGICAL AND PSYCHOLOGICAL EFFECT**

People who use steroids are aware of the possible side effects, or adverse reactions, but rationalize "it won't happen to me." Sexual problems, rashes, and the infamous and uncontrollable "roid rages" are some of the immediate consequences.

Women produce very little testosterone and the use of androgenic steroids may lead to a masculinity syndrome, the development of masculine characteristics. Some of these effects are irreversible (Connecticut Clearing House, 1998).

Women suffer from shrinkage of breasts, hirsutism (male hair growth), deepening of the voice and menstrual problems (Associated Press, 1998). Long term effects are numerous.

The longer the usage, the greater the damage and risk. Steroids affect thinking and may produce extreme personality changes, increased aggressiveness and overt self-confidence; anger thresholds decrease producing what is known as "roid rage". With heavy usage, individuals may experience psychotic symptoms. Withdrawal symptoms include diminished self-confidence, irritability, anxiety, and deep depression sometimes producing suicidal tendencies (MDX Health, 1998).

A study, conducted by Harvard researchers, concluded 1/8 of steroid users suffer from "bodybuilders' psychosis," with psychotic symptoms including delusions and paranoia (Mayo, 1998).

**Established side effects and adverse reactions (Connecticut):**

*Acne*

*Cancer*

*Clitoris enlargement*

*Death*

*Edema* (water retention in tissues, swelling of feet or lower legs)

*Fetal damage*

*HDL* ("good Cholesterol") decreases

*Heart disease* (Increased coronary artery disease, heart attacks, stroke)

*Hirsutism* (hairiness in a woman--irreversible)

*Jaundice* (Yellowing of the eyes or skin)

*Liver tumors*

*Liver disease* (Peliosis hepatitis)

*Male pattern baldness* (in a woman--irreversible)

*Oily skin* (females only)

*Penis enlargement*

*Priapism* (painful prolonged or frequent erections, mature males and boys)

*Prostate enlargement*

*Shrunken testicles*

*Sterility* (reversible)

*Stunted growth*

## WHERE TO GO FOR HELP

If you feel your children have interests in, or are experimenting with, steroids you should talk openly and honestly with them; show your concern but do not accuse. If your teens show concern about how their body looks, taking a trip to the doctor may be warranted; clinicians are a fine source of information.

Communication is most important in parenting. Tell your child: yes the drugs may produce big muscles and improve performance, but they are likely to have many long-term negative health side effects. Encourage your children to tone their bodies with diet and exercise; not drugs.



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## **Sources for help regarding Steroid Prevention**

The Adolescents Training and Learning to Avoid Steroids (ATLAS) prevention program offers two publications: "Steroid Prevention" a handbook for parents, coaches and educators, and The Nutrition and Exercise Guide, for teens who want to improve their physiques. Call 503-494-7900 for more information.

ATLAS Program  
Division of Health Promotion & Sports Medicine  
Oregon Health Sciences University  
3181 SW Sam Jackson Park Road  
Portland, OR. 97201-3098  
(503) 494-8051 Phone  
(503) 494-1310 Fax  
: <http://www.ohsu.edu/som-hpsm/atlas.htm>  
E-Mail: [hpsm@ohsu.edu](mailto:hpsm@ohsu.edu)

MATT Brzycki  
A Practical Approach to Strength Training -third edition  
NCAA sports sciences' staff via telephone: 770/399-3060  
<http://www.ncaa.org/news/19980302/active/3509n09.html>

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1999.

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**Betsy Montalvo** has been a Special Assistant for 15 years. She is in pursuit of a BA at National University, Stockton Campus, and plans to continue work toward a Teaching Credential. She loves kids and animals.

# WHAT MAKES A GOOD DOCTOR BAD?



DOCTOR AND DOLL - 1929  
NORMAN ROCKWELL

## *PRACTICING SUBSTANCE ABUSE THE PROFESSIONAL WAY*

Sheri Hoerth  
James Langston

Theng Khien  
Jill Martin Previtali

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## THE GOOD AND THE BAD

Images, like Norman Rockwell's 1929 illustration, "Doctor and Doll," remind us of the simple but yet defining characteristics of a good doctor. Compassion, dedication, and kindness emanate from this picture. A real life example of the same is illustrated in the June, 1998 edition of LIFE. The front cover of the magazine includes a photo of David Loxterkamp, M.D. with the question, "What Makes a Good Doctor?" His exemplary life appears to answer it. In an inside story, entitled "Country Doctor," photographer Lynn Johnson and writer Claudia Glenn Dowling, portray Loxterkamp as the type of physician who is at both "childbed and deathbed." He exhibits admirable characteristics, cares about his community, and strives to be a "good doctor."

Loxterkamp was mesmerized by a 1948 LIFE photo-essay also called "Country Doctor" by W. Eugene Smith. The article detailed Dr. Ernest Ceriani's daily rounds in Kremmling, Colorado, that characterized a good doctor's attributes. Inspired by the story, Loxterkamp entered family practice in Belfast, Maine, and set out to emulate Dr. Ceriani. His life undoubtedly portrays the fulfillment of a dream.

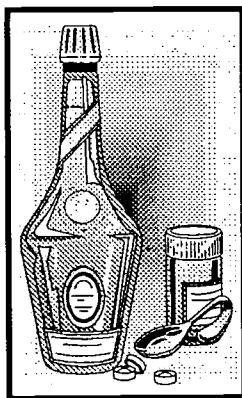
**...substance abuse, addiction, and compulsive behavior can shatter even a good doctor's most idealistic dream.**

Substance abuse, addiction, and compulsive behavior, however, can shatter even a good doctor's most idealistic dream. David Smith, a former aspiring medical student provides a good example. Dr. Abraham Verghese (1998), a teacher at Texas Tech School of Medicine describes, in a memoir entitled "The Tennis Partner," how he crossed paths with Smith, a medical student who came to America on a tennis scholarship. Verghese was his teacher and mentor while Smith, the student, helped Verghese sharpen his tennis game. Smith was a recovering intravenous cocaine addict who struggled to hold on to his girlfriend, career, and sobriety, but spiraled out of control and ultimately was consumed by the dark beast of addiction. As a result, he died at the age of 29. Dr. Verghese shows us, in his matchless memoir, doctors are not superhuman and that they are susceptible to substance abuse as well as anyone. Maybe more so.

**We have a tendency to associate invulnerability with professional and distinguished individuals.**

We have a tendency to associate invulnerability with professional and distinguished individuals. It is hard to accept that a president could have a sexual problem, a famous athlete be a murderer, a minister be involved in adultery, a parent could be an abuser and, in this case, a physician be an addict. In fact, because of the elevated status given to professional and distinguished individuals, they may feel themselves exempt from such vulnerabilities. Many times it is a rude awakening when disclosure is made and professional substance abusers are required to acknowledge the truth. They have not lived up to society's expectations and failed to behave in the manner of idealistic role models. They have discovered a simple truth: **THEY ARE HUMAN**. Substance abuse among financially-successful professional persons may well be one of the largest, and certainly one of the most seriously neglected, groups in society.

A study by Dr. Patrick Dixon, author of "The Truth About Drugs," that coincides with a recent survey by the British Medical Association, indicates one in ten doctors have addictions (Dignan, 1998). The October 18, 1998, London Sunday Times article that gave this report also quotes Dixon: "*A patient undergoing surgery stands a 50% chance of having an addicted doctor on the team treating him.*" A September 6, 1998, Rocky Mountain News (Colorado) report describes many young British doctors who drink too much, and use cannabis and other illegal drugs (1998). This article



includes an excerpt from a letter in The Lancet (Medical Journal) by Dr. Farhad Kamali, of the University of Newcastle: "*The current drinking habits, illicit drug use, and stress in some junior doctors is of concern, not only for their own well-being, but also how they affect patients' care.*" In addition, a fourth-year medical student at the Mount Sinai School of Medicine, writes in a September 27, 1998, edition of the Los Angeles Times that appreciating a drug's pharmacological benefits is often a tempting inducement for some of

his fellow medical students to give it a try (Gohlieb, 1998). The same article sites a 1986 study published in the New England Journal of Medicine which found a quarter of American doctors and medical students surveyed had self-prescribed mood-altering drugs, most often tranquilizers and opiates. Physician substance abuse is prevalent. We are only vaguely aware of it. A case in point: the Hazleton St. Joseph Medical Center in Pennsylvania.

**“A patient undergoing surgery stands a 50% chance of having an addicted doctor on the team treating him.”  
Dixon**

Screams of patients caused officials to investigate anesthesiologist Frank Ruhl Peterson regarding substance abuse (Olson). Disclosure revealed he stole narcotics from surgical intravenous bags to allay his compulsive behavior, thus shortchanging anesthesia prescribed for procedures that included cesarean sections, biopsies, and spinal surgery. How can this be? Somewhere he crossed the line from experimentation with drugs to become driven and out of control. The result was his own self-destruction and endangering the lives of others.

What drives an individual to compulsive substance abuse despite negative consequences? Volpicelli and Szalavitz (1998) indicate that substance dependence is bio psychosocial. Causes and consequences of substance abuse leading to dependence are not only related to the brain and body, but to a person’s psychological state and social interactions.

### **BIOLOGICAL FACTORS**

Drugs such as alcohol, nicotine, and heroin cause long-lived alterations in biochemical and functional properties of neurons in the brain (Hyman). Available levels of certain neurotransmitters associated with feelings of pleasure are affected, particularly Dopamine, a major neurotransmitter believed to be instrumental in experiencing these feelings. Anything that creates the feeling of pleasure may be related to a rise in dopamine levels in the brain. Besides altering nerve pathways, drugs also help form emotional memories regarding the feeling of pleasure. These memories create the craving associated with substance abuse. Although dopamine is thought to play a critical role in motivation

and reward, Ingrid Wickelgren (1997) reports it may not directly produce feelings of pleasure or euphoria. Continued research suggest that dopamine release draws attention to rewarding events and events that predict rewards.

Roy Wise of Concordia University in Montreal, the primary architect of the pleasure theory says, "*I no longer believe that the amount of pleasure felt is proportional to the amount of dopamine floating around in the brain*" (Wickelgren, 1997). He agrees with other researchers that dopamine also facilitates learning. This may help explain why many addictive drugs can drive continued use without producing pleasure. As addiction develops, cravings increase and drug-induced pleasure decreases or remains the same. This seems to imply a difference between "liking" and "wanting" in regard to pleasure on receiving a reward and to the behavioral pursuit of a reward. This "wanting" motivates the persistent pursuit of drugs that no longer give pleasure and possibly explains the core paradox of addiction (Nesse and Berridge, 1997). The complexity between the state of the brain and the effects of substance abuse will no doubt promote continued research. PET scans and other imaging technologies that help visualize neurochemical activity may help identify those who are most vulnerable to addictive substance abuse. Simple awareness of biological vulnerabilities is one avenue that can help the physician avoid this potential trap.

### **PSYCHOLOGICAL FACTORS**

Depression and anxiety disorders may increase a physician's propensity to become involved in substance abuse. Virsup, Coombs, and Kohatsu (1993) suggest a special psychological vulnerability of the physician. The nature of the typical physician's personality seems to affect how they handle emotions to which they are subjected on a daily basis. Unfortunately, training in the therapeutic effectiveness of drugs often leads to self-medication. Although the loss of objectivity can accompany self-prescription, medical knowledge and access to prescription drugs increase the potential for physician self-treatment (Christie, J.D. *et al*, 1998). Self-prescription is reported to be common among physicians but is difficult to evaluate; they need to develop psychological skills that will



improve their ability to cope with their practices. This is a preferred alternative and important element in preventing substance abuse.

## SOCIOLOGICAL FACTORS

The way physicians think, feel, desire, and act in the environment associated with medical practice is another critical factor; the demands of medical training are only the beginning of a “way of life” associated with their profession. The physician’s day-to-day activity is demanding and frustration and burnout are only too common; many physicians show signs of serious stress and, as indicated, some turn to drugs and alcohol. When this happens, the surgical mask becomes more than a sanitary precaution. It becomes a mask behind which to hide a great deal of emotional difficulty.

An important question to consider is: what motivates a physician to become a professional? Is the motivation a realistic aspiration or an attempt to gain self-worth? While the former leads to success, the latter is a futile attempt to fill a vacuum or emotional-emptiness associated with an unfulfilled life. Instead of developing a sense of self, this individual attempts to satisfy the “emptiness” by becoming a professional. This secondary means of accomplishment to gain self-worth leads to a wide array of stressful activities that eventually leads to burnout. The professional then becomes vulnerable to escaping reality by resorting to substance abuse. Virshup, *et al* (1993) compares this to bailing water out of a leaking boat. Instead of fixing the leak, the professional soon tires and sinks with the boat into a sea of despair and substance abuse.

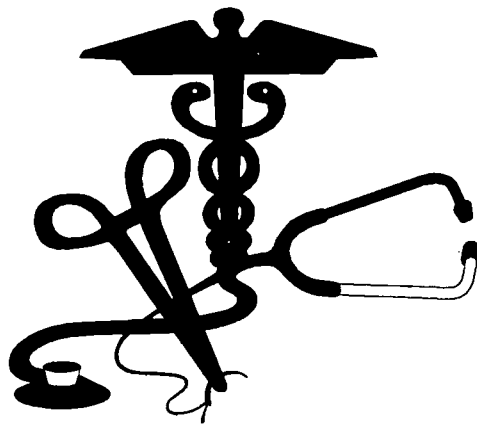
An anonymous story in the book, *Alcoholics Anonymous* (“Doctor, Alcoholic, Addict”), describes the distorted thinking of a physician responding to his stressful environment. His feeling was, “*If you had my problems, you’d drink, too.*” He describes his path of alcohol abuse during pharmacy school, graduate and medical school, internship, residency, specialty training, and finally practice. As his responsibilities increased, so did his drinking. His progression into substance abuse included pep pills, Benzedrine, Demerol, morphine, codeine, Percodan, tranquilizers, and Pentothal. He

rationalized his behavior by self-prescribing medication for his many ailments. Acceptance of himself, life, and others began to eliminate his problems and, consequently, his need for drugs. Fortunately he became liberated through Alcoholics Anonymous.

### **GOOD VERSUS BAD**

Substance abuse and addiction do not indicate the physician is a bad person. It simply means that a good and well-meaning individual has been caught in a downward spiral of producing bad results. A variety of bio psychosocial factors contributes to this behavior. A physician's awareness of these can help prevent ensuing problems and, those who are free from them can provide insights into alternative ways of handling the stress associated with the medical profession.

Norman Rockwell's illustration, "Doctor and Doll," shows a physician who has "lightened up" to the stressful way of life within his profession. Holding a stethoscope up to a little girl's doll, his relaxed demeanor, and a "country doctor's" dedication to his small client are all indicative of a "good doctor." David Loxtercamp is a similar but real life example of the same. Although he strives to be the ideal, his sense of identity is well-established. Instead of bailing water out of a sinking boat, he is skillfully sailing through the tumultuous and difficult sea of a demanding career. Awareness of himself and the traps of the medical profession is what keeps this doctor "good."



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## **TREATMENT REFERRAL TELEPHONE NUMBERS**

- National Clearinghouse for Alcohol and Drug Information: 800/729-6686
- Alcohol Treatment Referral Hotline: 800/ALCOHOL
- Center for Substance Abuse Treatment National Drug and Alcohol Treatment Referral Service: 800/662-HELP
- Cocaine Hotline: 800/COCAINE
- NCADD Hopeline: 800/622-2255

## **SELF-HELP GROUPS AND OTHER SERVICES**

- Al-Anon/Alateen Family Group Headquarters, Inc.:  
800/344-2666 (U.S.)  
800/443-4525 (Canada)
- The CDC National AIDS Hotline:  
800/342-AIDS  
800/344-SIDA — Spanish  
800/AIDS-TTY— TDD
- Marijuana Anonymous World Services: 800/766-6779
- Narcotics Anonymous: 818/773-9999
- Secular Organizations for Sobriety (SOS): 310/821-8430
- SMART Recovery Self-Help Network: 216/292-0220
- Alcoholics Anonymous World Services Inc.: 212/870-3400
- Families Anonymous: 800/736-9805
- Nar-Anon Family Groups: 310/547-5800
- NAPARE Alcohol, Drug, and Pregnancy Hotline: 800/638-BABY
- Rational Recovery Systems: 800/303-CURE
- American Self-Help Group Clearinghouse:  
973/625-3037  
201-625-9053 — TDD
- CSAP Workplace Helpline: 1-800-WORKPLACE

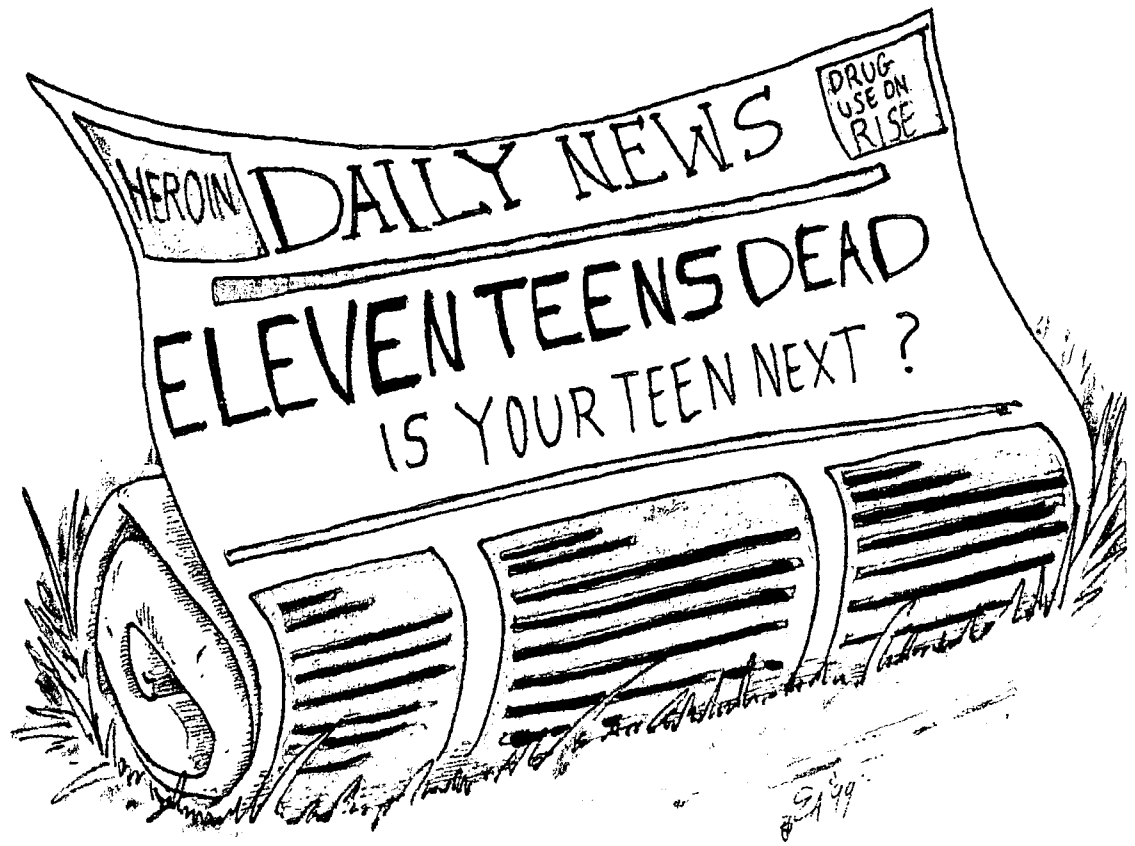
## **BIOs**

**Sheri Hoerth** is 30 years old. She lives in Ripon, California with her husband 12 ½ - year-old stepdaughter, and 6 ½ year-old daughter. She will receive a B.A. degree in Behavioral Science, followed by a Multiple Subject Teaching Credential from National University. Eventually, she would like to return to college to pursue a Masters Degree and possibly become a school counselor.

**Theng Khien** is 29 years old. He has attended National University since October 1997, majoring in Behavioral Science and will pursue a higher degree in Psychology. His future goal is to be a counselor, or behavioral specialist, and someday hopes to be a professor of Psychology in Cambodia. He enjoys playing football and fishing.

**James Langston** lives in Lodi, California with his wife Alice, daughters Anna and Cheri, and son James. He has a degree in Theology from Christian Life College and is working on a Behavioral Science degree at National University. His future goal is to attend law school and become an attorney.

**Jill Martin Previtali** is 26 years old. She is majoring in Behavioral Science and will receive a BA degree. Jill will continue in school for her Teaching Credential to become a teacher. She enjoys summer and summer fun.



**Aaron Bailey**

**Lisa Marie Carter**

**David Moore Gina Ruby**

**BEST COPY AVAILABLE**

## ELEVEN TEENS DEAD! WILL YOURS BE NEXT?

"Eleven teenagers died of heroin overdoses in the past twelve months. All from inhaling the drug, a practice youngsters are convinced is safer than using a needle" (Newton, 1997). In Fort Worth, Texas there have been four (heroin- related) deaths in the past year. The youngest victim was a 13-year-old boy (New View). According to USA Today, emergency room visits since 1992 rose 58 percent for heroin cases. These new, young heroin users are in their late teens and early twenties. The purity of the drug is up and the price is dropping, a strategy used to win new customers.

Heroin, a drug for many years dormant in our society, is making a strong comeback. While marijuana is still consistently the drug of choice among the young, heroin use is increasing in both the teenage and adult population. Heroin comes from four major sources: Southeast Asia, the Middle East, Mexico, and South America. "Heroin was readily available in the United States in 1995. Wholesale prices were stable, and purity is high, suggesting that international supplies had increased" (DEA, 1998). The increased purity and its availability makes it competitive with other drugs.

"The 1995 National Household Survey on Drug Abuse estimated that 1.4 million people have used heroin in their lifetimes." This figure was twice as large as the 1994 figure. The most significant increase was in the 35 and older group. "Other age groups were also higher in 1995, including youths 12-17. Heroin use is no longer limited to the older age groups and the rich. Teens are finding it easily

obtainable, affordable and prevalent within their peer groups. "Heroin is making a comeback and not just in the inner cities. It's in the suburbs as well" (Marla). Teens are at risk every day to drug abuse. It is obvious the various campaigns against drugs are not reaching today's youth. "The percentage of 12-17 year olds who recognized there are serious risks associated with illicit drugs has decreased since 1992 and is still declining" (Marla, 1996).

"The most dangerous and addictive narcotic is heroin" (Stop Drugs Organization). This fact is not a secret, we can assume most individuals in society have this knowledge. Despite all the known dangers of such highly addictive substances, "Heroin use is increasing in almost every part of the United States, among all age groups, including middle school and high school age teens" (Marla). Reaching young children by educating them on the dangers of drugs is the crucial factor on combating drug abuse. Some individuals believe children are already educated about drugs, and speaking to them earlier will have the reverse effect, pushing them to abuse drugs. Straight statistics prove this belief is incorrect. "A survey of teenagers conducted for the National Center on Addiction and Substance at Columbia (CASA, 1996) by the Luntz Research Cos. reveals the number of teens expecting to try illegal drugs in the future has doubled since 1995. The percentage of teens saying that they would never try illegal drugs dropped 40 percent from 86% to 51% in 1996" (CASA Survey).

**Parents, we ask you: just how much do you  
know, really know, about drugs?**



## Parents

### **Test Your Drug I.Q.!**

1. Which drug is the most addictive one, both physically and psychologically?  
a. heroin    b. cocaine  
c. alcohol    d. marijuana
  
2. Name the three drugs most commonly used by children.  
\_\_\_\_\_
  
3. Which drug is associated with the most teenage deaths?  
\_\_\_\_\_
  
4. Heroin is sold in what types of containers?  
a. glassine bags    b. capsules  
c. pills    d. balloons  
e. all of the above
  
5. Heroin is a particularly dangerous drug because it is?  
a. cheap    b. readily available  
c. highly addictive    d. all of the above
  
6. Fumes from which of the following can be inhaled to produce a high?  
a. spray paint    b. glue  
c. nail polish remover    d. whipped cream canisters  
e. all of the above

7. People who have not used alcohol and other drugs before their 20th birthday:
- a. have no risk of becoming chemically-dependent.
  - b. are less likely to develop a drinking problem or use illicit drugs.
  - c. have an increased risk of becoming chemically-dependent.
8. A speed ball is a combination of which two drugs?
- a. cocaine and heroin
  - b. PCP and LSD
  - c. valium and alcohol
  - d. amphetamines and barbiturates
9. Which of these are considered long term physical conditions that accompany heroin addiction?
- a. reduced energy level
  - b. reduced sex drive
  - c. lack of motivation
  - d. an overall lethargy
  - e. all of the above
10. How can heroin be taken into the body?
- a. smoked
  - b. snorted
  - c. skin popped (injected just under the skin)
  - d. mainlined (injected directly into the vein)
  - e. all of the above

## Parents

How well did you do?

### Test Answers

1. a
2. Alcohol, tobacco and marijuana
3. Alcohol
4. e
5. d
6. e
7. (Early use of alcohol and other drugs--often by age 15 or less--is strongly associated with drug-related problems such as addiction).
8. a
9. e
10. e

## **Parents: Beware!!**

### **Signs of potential drug use or abuse**

- Kid has conduct problems at school.
- Rarely participates in extracurricular activities.
- Does not believe drugs to be dangerous.
- Does not believe parents disapprove of drug use.
- Has easy access to drugs.
- Believe most of his friends are using drugs.

Only 7% of students reported had no conduct problems at school.

## **Parents: Helpful Hints!!**

### Tips on helping your children stay off the drug scene

- Encourage your child to participate in extracurricular activities.
- Show up at your child's school events; demonstrate your support.
- Encourage your child to have healthy relationships with friends.
- Talk to your child; strive for effective communication.
- Ensure your child knows you disapprove of drug use.
- Support substance abuse prevention programs at school.
- Encourage you child to work at getting good grades.

Heroin, a very powerful narcotic, is one of the most addictive substances on earth, both physically and psychologically (Teen Challenge). This is a drug habit that can't be conquered alone. If there is a problem for you, or your loved one, get help. Ongoing counseling and family support are crucial in the recovery process. Fortunately, help is not far away, go for it!

## **Resources**

### National Hotline numbers:

- ▶ Viewpoint 800-840-5704
- ▶ Drug and Alcohol Hotline 800-894-4357
- ▶ Drug Abuse and Addiction Assessment (24 Hr Hotline) 800-229-7708
- ▶ Drug Abuse Treatment Center 800-333-2294
- ▶ National Clearinghouse for Alcohol and Drug Information 800-729-6686

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## **BIOs**

**Aaron Bailey** is both a full time civil service employee and student at National University. Upon receipt of a BA in Behavioral Science he plans to obtain a Master's in Psychology. Future plans are to teach and counsel young people to make sound decisions in their lives and become more productive citizens in our communities. I believe, says Aaron, if you can help turn one persons' life around you have accomplished something valuable in life. I don't want to stop at one. I derive my strength and perseverance from God, my mother, my wife and my children.

### **Lisa Marie Carter:**

**Gina Ruby** is finishing her bachelor of science degree. She has one son and hopes to enter the master's program at a local university. Gina's work appeared in "*Chaotic Conversation: A Foray into the Complex World of Communication*," ICA Publishing, 1998.

### **David Moore**

# The Innocent Victims

## How Addictions Affect Infants and Children

**Jerry Roberson**

There has been much discussion of the basics of addiction in our society. Whether behaviors associated with various addictions and compulsions are environmental in nature or biological in origin, is at the center of this debate. There is, however, a person whose existence may depend upon both of these factors: we are speaking of THE UNBORN CHILD.

For centuries, in various cultures, newborn babies have been born “Tabla Rosa” or blank slates ready for the true business of learning and development beginning sometime after they take their first breath. What researchers are discovering now may alter that premise. New research into the brain activity of the fetus pinpoints patterns associated with hearing recognition, language development, sensor-motor stimulation and even emotional links to its mother. In effect the process of teaching a newborn is well underway at the time of birth (Reestak, 1988).

What then does the addicted, depressed, or obsessive mother contribute to the future of her child? Normal delivery will occur in about 40 weeks or so after conception. This gestational period is divided into 3 parts or trimesters, each having a specific purpose in fetal development. Conventional thought among researchers has been that trimester 1 was for the cells to multiply and migrate to their respective tissue and organ systems. This process, known as proliferation and migration, is indeed a vulnerable period for the prenat (Logan, 1992); at



some points as many as one million cells per second divide and migrate to their final positions within an organ. Obviously any drug or alcohol interaction at this point will cause cell death or deformation. We have all found many substances also harm cell growth in neurological centers by the inhibition of folic acid synthesis from its precursor molecules. This can occur long before the mother is aware of her pregnancy and is a leading cause of defects such as Hydrocephalus and Spina Bifida. These neurological deficits are preventable with the addition of folic acid to the diet.

Alcohol ingestion, even in moderation, can destroy the connection of brain cells leading to Fetal Alcohol syndrome and Fetal Alcohol Effects in children. The Other vital organs such as the heart and liver are especially at risk from maternal drug abuse, or from smoking, within the first and second trimesters. Prenatal medical care is crucial: the occurrence of serious brain abnormalities can be reduced to about one-third, even in women who are pregnant and undergoing drug rehabilitation. Smoking robs the oxygen available to the fetus and produces toxins in the blood that can be measured at birth. Drugs that are highly bound to fatty acids, such as marijuana and cocaine, are rapidly and disproportionately dangerous to the fetus because they are dissolved in amniotic fluid and re-ingested by the fetus, for weeks (Psychology Today, 1998).

## **Drug Abuse and The Language Acquisition Connection**

New research on fetal research in the United States and England has indicated that the pre-nate can learn language within the first eight weeks of gestation. Stories spoken, or sung in melodic tones, are remembered after the child is born and levels of stress hormone within the mother and fetus are drastically reduced when melodic music, songs or reading are shared during very early stages of pregnancy. What increases stress for the mother does the same for the fetus, and not surprisingly, relaxation also translates into more neuron connections and brain activity within the developing fetus. As many as 90 -95% of developing neurons are allowed to die shortly after birth simply because they were not stimulated or connected in the womb. Any drug taken in by the mother will affect the unborn baby at these late stages of development. Severe immaturity within the lungs, or Broca's area (involved with language) within the brain will cause lifelong deficits in language and development.

Children who may later be diagnosed with fetal alcohol syndrome, Attention Deficit Disorder or severely Emotionally Disturbed are born to parents who, if addicted, are most unable to appreciate the needs of their child. Drug addiction, Smoking and Obsessive Compulsive disorders all have the common effect of distorting a parent's ability to respond to the child's needs. Education and prenatal care are part of the solution. On the other hand, the possibilities are

endless for the infant given the right training in areas such as language and mathematics. Science now tells us that all children use limited mathematical formulas to interpret language structure and communicate with others (Goss, J., & Fisicaro, 1999)

Parents, Teachers and clinicians who realize this new direction in the care of the child at their most teachable phase can revolutionize our homes and schools. As teaching centers look for better ways to diagnose, understand and intervene in the societal problems within our schools, the parent will again be the gatekeeper of their child's future.

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# The Hidden Victim

## The Unborn Addict

Maria Espinoza

Nicole Nixon

Krista Petersen

Julie Sotelo

## **The Unborn Addict**

All women of childbearing age should know that abuse of any drugs pose a threat to their unborn child. Nationally the number of women admitted to hospitals for delivery of substance-exposed newborns is 375,000 annually or about 11%. These babies have defects that devastate their lives: what were these women thinking? They, the mothers, carry the unborn victim, the forgotten addict. We examine the effects of drug exposure on these innocent victims from conception, in utero and through childhood, and pose the question: Why do so many of these babies end up in foster care? What are the intervention strategies to avoid a crisis situation on our society?

These infants are in double jeopardy: being biologically vulnerable to substance exposure and being cared for by a mother who is likely to be facing a combination of social, psychological, emotional and financial problems. These factors, and the inherent difficulty with personal relationships, make it difficult for the infant to develop normally.

Most birth defects are caused during the first trimester(12 weeks) of pregnancy, harming new cells and causing a high risk of brain damage. During the second trimester, the size of the heart and lungs increases and drugs rob protein and vitamins these organs need for normal and steady development.

What are the legal and the illegal substances used- and abused- and how do they affect the fetus?

### **NICOTINE**

One legal drug that is extremely harmful to the fetus is nicotine. When a mother smokes, she not only inhales nicotine, but over 500 other harmful chemicals present in tobacco. The fetus is invariably exposed to many or all these chemicals. Nicotine causes vasoconstriction, which decreases flow through the

blood vessels, leading to problems during labor and is responsible, in part, for one-third of all premature or low birth weight newborns.

Smoking during pregnancy causes miscarriages and stillbirths. Nicotine has a direct effect on the fetal brain and may cause behavioral and learning disabilities including hyperactivity. The ability to process vitamins, minerals and antioxidants also decreases, affecting many body systems. The fetal lungs do not fully develop so children exposed to nicotine from smoking have 300% greater rate and risk for asthma than unexposed children. Passive tobacco smoke is known to significantly increase an infant's risk for Sudden Infant Death Syndrome (SIDS). Long-term effects on exposed children include: short stature, delayed reading ability, and delayed social adjustment.

Infants exposed to 10 or more cigarettes per day, in utero, have a 50% greater risk of cancer than unexposed children. To avoid these risks mothers should avoid all exposure whether active or passive, during pregnancy. Some experts now believe the use of prescribed nicotine patches and gum is safe to assist mothers in quitting smoking. A doctor's supervision is required to minimize risk to the unborn child.

## **ALCOHOL\***

Alcohol is another legal drug that has devastating effects on the fetus. When a mother drinks, the alcohol quickly passes through the placenta to the fetus. Alcohol is metabolized slowly in fetal tissues so exposure is prolonged and the blood alcohol levels become higher than those of the mother. As a result the baby may suffer lifelong damage. Every year 50,000 babies are born with alcohol related damage known as Fetal Alcohol Syndrome(FAS).

\*See Chapter 7 by Nelson-Wong *et al* (pgs 53-63) for greater detail on these disorders.

Children who have some of the effects associated with FAS may also suffer from a condition named Fetal Alcohol Effects (FAE) which may affect ten times as many children as those with Fetal Alcohol Syndrome. FAS is usually associated with mothers who drank four or more alcoholic beverages per day while FAE may occur when the mother drank even moderately, or lightly, during pregnancy. In 1995 a French study reported that four-year-old children whose mothers drank three drinks per day scored seven points lower on intelligence tests compared with those of mothers who drank less. FAE can have tremendous behavioral and mental consequences. Many children with FAS/FAE are not able to understand cause and effect relationships or be cognizant of the consequences of their actions.

Drinking alcohol during pregnancy increases the chance of miscarriage, low birth weight, stillbirth, and death in early infancy. Many women who drink also delve into other drugs such as Marijuana, Cocaine and Heroin.

## **MARIJUANA**

Marijuana has an active ingredient named Tetra-Hydro-Cannabinol (THC). This drug damages chromosomes during pregnancy, especially the male reproductive system, which may cause infertility or birth defects in future generations. THC reaches the fetus during pregnancy to the extent of 90% is passed through breast milk. Smoking marijuana affects gestation, development of organ systems and leads to low birth weight and premature births.

## **CRACK-COCAINE**

Every year, in the United States, 375,000-700,000 “crack” babies are born. Of these, 11% were exposed in utero to the drug. Urban areas pose an even higher risk. Babies are born addicted to crack and may have serious emotional problems, symptoms of anxiety, tremors, excessive crying, eating and sleeping Disorders.

## **HEROIN**

Heroin use during pregnancy has been linked to birth defects and behavior problems. Newborns addicted to Heroin often experience withdrawal symptoms after birth: they have tremors, cry in high-pitched tones, are irritable and inconsolable, and may develop neuromuscular problems in later life. Seizure, vomiting and lung problems arising from pneumonia are common. The risk of sharing needles also places both the mother and infant at risk for HIV/AIDS and hepatitis.

### **CASE: BABY JANE DOE**

Baby Jane was born at 35 weeks gestation. She tested positive for Alcohol and Cocaine and was born to a 21 year-old mother. Her birth weight was 5 pounds and 14 ounces. The mother admitted smoking 1-2 packs of cigarettes per day during pregnancy and using Crack-Cocaine once a week and the night before delivery. Her sister confirmed the heavy use of alcohol. Pre-natal care was insufficient as she saw a Doctor only twice during pregnancy.

The toxicology report performed on the infant was positive and she displayed withdrawal symptoms at birth. She had trouble feeding and had irregular sleep patterns, was sweaty, had loose stools, and an intense air hunger (oxygen deprivation).

The central nervous system effects included a high-pitched cry, sneezing, hyperactive reflexes, and hiccoughs. She also had poor tolerance for stimulation, position changes, or being held.

A drug hold was placed on the infant under section 300c of the Welfare and Institutions Code. She was removed from her mother and placed in foster care through the San Joaquin Count Office of Child Protective Services. At the age of four years and ten months a psychological evaluation was performed. She was found to have dysmorphic features from exposure to alcohol in utero. She became



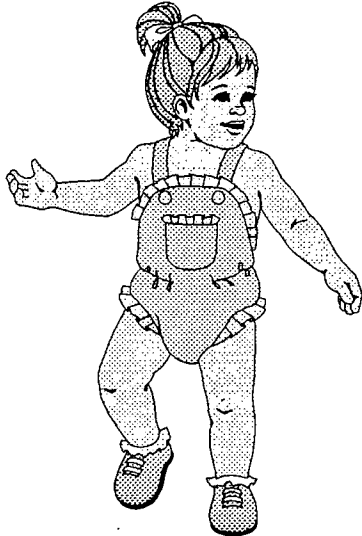
extremely emotional over minor issues, and would hit other children in anger. She also has a cardiac defect which may require surgery in the future. The Slossen Intelligence Test indicated an I.Q. of 90 and is somewhat delayed.

### **DIFFERENTIAL DIAGNOSIS.**

**Axis I:** Oppositional Defiant Disorder w/ Reactive Attachment Disorder.

**Axis II:** Deferred

**Axis III:** Probable Fetal Drug or Alcohol Syndrome.



Baby Jane Doe now displays, at six years-age, serious behavior problems. She is disruptive in school, exhibits inattentiveness, and compulsive hand-washing. She does not tolerate most types of touch but likes being hugged. She has a low weight for her age and will need special observation for her heart condition.

## **CONCLUSION**

What should we do about mothers who abuse drugs during pregnancy? That is a controversial issue. Criminal prosecution, and sterilization, have been seen in some cases. A South Carolina judge sentenced a mother to prison during her pregnancy. Another woman was ordered into a drug treatment program but failed it. This policy was challenged in court and has been discontinued. Programs such as C.R.A.C.K ( Children Requiring A Caring Kommunity) pay drug-using mothers \$200 to attend sterilization or long term contraception( Norplant™) clinics.

According to a 1996 National association Junior League study of 34 U.S. cities, lack of childcare was the number one barrier to women seeking help. Should taxpayers fund substance abuse programs, before, during, and after pregnancy?

What is to become of the so-called lost generation? The schools and their teachers are having difficulty dealing with drug-exposed children. Prevention, education of parents and school-age children is mandatory. Total abstinence from all harmful substances in pregnancy should be emphasized. Teacher and public education programs should be funded to increase their outreach to the larger, poorer sections of the community.

\* \* \* \* \*

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American Cancer Society: Tobacco Information: Smoking and Pregnancy. [HTTP://WWW.CANCER.ORG/TOBACCO/TRL13.HTML](http://WWW.CANCER.ORG/TOBACCO/TRL13.HTML)

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San Joaquin Co. Child Protective Services. 10/98

## **BIOs**

**Maria (Toni) Espinoza is pursuing a BA in Behavioral Science; her interest is in the field of Juvenile Probation. A single mother with four children, three of whom are teenagers, Maria has no time for hobbies. Instead, any “free time” is used to catch-up on her sleep.**

**Nicole Nixon is pursuing a BA in Behavioral Science and will, eventually, teach elementary school. She is a Junior Varsity Volley Ball Coach. Currently engaged to be married in May, her hobbies are sports (especially volleyball).**

**Krista Peterson wants to teach elementary school and to attain this goal is attending National University. Krista’s hobby is to spend time with her 18 month old son.**

**Julie Sotelo**

# Funny Looking Kids\*

Who pays the price?

What Teens Should Know About Drinking and Pregnancy



Leslie Nelson-Wong

Angela Robertson

Carol Waidner

Rex Rabine

\*Updated by Katherine Lauderdale

“Funny looking kids.” That’s the unofficial label often placed on the medical charts of children born with Fetal Alcohol Syndrome (FAS) or the less severe Fetal Alcohol Effects (FAE). Today’s teens are bombarded with public service messages regarding the dangers of unprotected sex, drinking and driving and cigarette smoking. Most teens are aware alcohol is a mood altering drug yet remain unaware of the consequences of drinking during pregnancy.

Thanks to public awareness, the teenage birth rate has decreased. But teenage pregnancy continues to be a problem. Few teens receive prenatal care. In fact, many do not realize they are pregnant until six or seven months after conception and as a result, not only do they fail to obtain prenatal care, but often continue to party using alcohol and/or drugs. More than 90% of all U.S. teenagers experiment with alcohol by their senior year (CDC, 1998).

FAS is a series of mental and physical birth defects caused by the consumption of alcohol during pregnancy. These defects include:

- ★ mental retardation
- ★ growth deficiencies
- ★ central nervous system dysfunction
- ★ cranio-facial abnormalities
- ★ behavior maladjustments

The medical costs associated with the disorder are increasing each year. It is now diagnosed in one out of every 750 births in the United States. This tragedy is further compounded by the fact that for each baby diagnosed with FAS there are ten more that show evidence of FAE. In 1980 the lifetime cost, to age 65,

associated with a typical FAS case was \$596,000. In 1996, care for these patients cost the United States \$9.7 billion dollars. The Centers for Disease Control and Prevention (CDC) reported a sixfold increase in the percentage of babies born with FAS over the past fifteen years.

Unfortunately, most teenagers fail to realize there is no safe level of alcohol consumption during pregnancy, since it varies according to the mother-fetus pair. Research studies have labeled *in utero* risk drinking as anything from 1-2 drinks per day (Mattson, 1995), to consuming as little as 0.5 ounces of absolute alcohol (a little less than one mixed drink) per day (Hankin, 1994). There is no cure for FAS. Once the damage is done, it cannot be reversed. It, however, is the only cause of birth defects that can be completely prevented.

One difficulty in trying to apply information from current research studies to teen pregnancies is most teens tend to “binge” drink, partying on the weekends. Although they may drink heavily on a Friday or Saturday Night, they may not drink at all during the week. One study dealing with binge drinkers estimated the fetuses of these mothers had been exposed to an average of more than one drink a day, with the median amount of alcohol equating to six drinks per occasion (Russell, 1994).

The CDC began tracking FAS in 1979 when number of the reported cases was 1 per 10,000 live births; by 1996 it reached 6.7 and in 1998, this figure jumped to 19.5 per 10,000 although the estimates run as high as 30 per 10,000 live births. The probability of having a child with FAS increases with the amount and frequency of alcohol consumed.

## Diagnosis

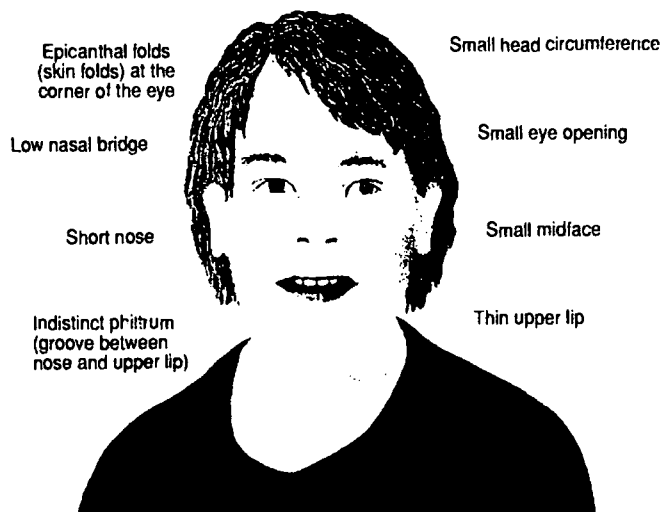
At this time, FAS is diagnosed when a health care provider recognizes a consistent pattern of minor, often subtle physical anomalies. Since FAS and FAE lie along a continuum of possible damage, with many of the resulting problems attributable to a wide range of other causes, it is often difficult (or even possible) to assess damage. FAS/FAE is a problem found in all races and socio-economic groups. It is widely misdiagnosed. Between 1/3rd (FAS-diagnosed) and 2/3rds (FAE-suspected) of all children in special education have been affected in some way.

One epidemiological study of babies born to mothers who drank heavily during pregnancy found that only 1/3 of the babies had classic FAS. In fact, almost 1/2 appeared completely normal (Aase, 1994), diagnosis is further complicated by the fact that many doctors are hesitant to label babies with these problems for fear of stigmatizing mother and child.

## Signs

The classic case of FAS is earmarked by a number of mental and physical birth defects. Many children born to alcoholic mothers may appear normal in early infancy, but the full impact of maternal drinking becomes

apparent as the child matures. Among the more well known FAS signs are shortened eye openings (leading to the appearance of widely spaced eyes), drooping of one or both eyelids and facial abnormalities.



In early childhood, FAS children grow at a rate 60 percent that of normal children, with a weight increase of approximately 3 percent. Mothers often have problems bonding with their infants due to feeding problems, irritability and unpredictable patterns of eating and sleeping.

A 1968 study found IQ ranges of 50 to 75 in 106 of the 127 FAS children studied (Dorozyaski). Difficulties in learning are multiplied by cognitive deficits in language, attention, verbal learning and memory. Adults suffering from it are often functionally illiterate, and have difficulty finding and holding jobs because of unreliability. It is also difficult for adults to establish and maintain lasting personal relationships (Aase, 1994).

#### **Behavioral Effects of Prenatal Alcohol Exposure**

- ★ **Hyperactivity**
- ★ **Attention deficits, distractibility**
- ★ **Lack of inhibition**
- ★ **Mental retardation, learning difficulties**
- ★ **Impaired ability to adjust to new stimuli or situations (impaired habituation)**
- ★ **Repetition of a mental activity with an inability to switch to another activity (perseveration)**
- ★ **Feeding difficulties**
- ★ **Gait abnormalities**
- ★ **Poor fine and gross motor skills**
- ★ **Development delay (motor, social and language development)**
- ★ **Hearing abnormalities**
- ★ **Poor state regulation (tremors, jitters, aberrant sleep patterns)**



## Current Research

At this time there is no known cure or remedy for either FAS or FAE children. However, by studying *how* alcohol damages the brain, researchers may be able to find ways to prevent and treat the disorder. Magnetic resonance imaging (MRI) and positron emission tomography (PET) are among the current tools being used. MRI uses a magnetic field to produce an image of a living brain, while PET uses radioactive isotopes to monitor brain metabolism.

Animals are also helping researchers probe further into the mysteries of FAS, by controlling such factors as genetic background, amount of alcohol intake, and pattern of alcohol consumption. Studies show the *pattern* of consumption is critical. Rapid consumption leads to a higher blood alcohol level than sipping the same amount of alcohol over a longer period of time. For example, researchers have found binge drinking in the third or fourth week of pregnancy (when many teens are not yet aware they are pregnant) will affect the structure of facial features, but not the kidney, which develops around the sixth week (Becker, 1994). Unfortunately, alcohol has been discovered to have a great affinity for rapidly growing fetal tissue; for the brain, one of the first organs to begin developing and one of the last to reach completion, there is no “safe period” for maternal drinking.

## What can we do?

The best way to prevent FAS/FAE is education. Research has indicated warning labels on alcoholic beverages are ineffective and, many of those who needed the warning most, did not change the amount of alcohol consumed after the warning label program was implemented (Hankin, 1994).

Health care professionals may have some impact on teens, since questions about drinking can turn a general public service message into a personal one. However, many teens are not aware they are pregnant until the second or third trimester, when damage may already have occurred. Current laboratory tests are frequently negative for risk in heavy drinkers who are otherwise in good health (Russell, 1994).

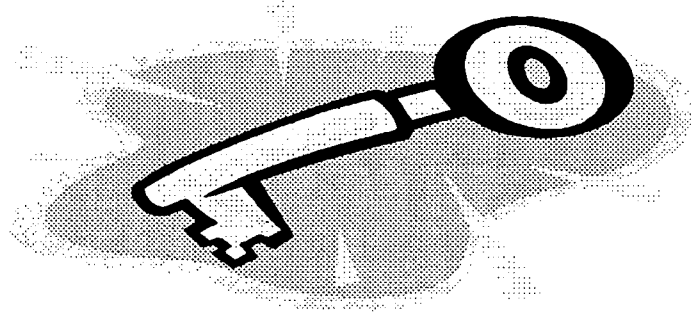
It seems the best answer is education before teens become pregnant. In California, teachers can discuss the effects of alcohol on the liver, the brain and other organs; but because pregnancy is related to sexual reproduction, teachers can not legally discuss the effects of alcohol on unborn children unless parents have been notified first and agree to the content.

Realizing education is vital, Washington State does not consider FAS educational programs to be a part of sex education and the Family Resource Institute goes to local high schools to educate students on the dangers of drinking during pregnancy. According to Cindy Kuhn, founder of the Las Vegas branch of the FAS Family Resource Institute, the number of births has dropped substantially as a result of these efforts.

Until all states create programs like Washington's, teens need to hear the message: *IT IS NEVER TOO LATE TO QUIT DRINKING*. Abstention, even as late as the third trimester of pregnancy, not only improves the birth weight of infants, but it may have other beneficial effects. Teenage mothers need to be taught alcohol enters the breast milk, and as little as one drink a day can negatively influence the motor coordination of their babies. Finally, teens need to

be warned combining smoking with drinking increases the risk four fold *in utero* growth will be stunted.

America must begin educating its teens about the dangers of alcohol as it relates to sex and unplanned pregnancy. The cost of keeping silent is too high. It is our teens, and future generations, who are paying the price.



**Education is the key!**

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## National Resources

### **CSAP National Clearinghouse for Alcohol and Drug Abuse Information**

Provides referrals, information packets according to need or topics of interest, literature search service or select from their 1,000 publications

800-792-6686

### **Office of Minority Health Resource Center:**

Conducts customized database searches, accessing information on health programs and organizations, as well as funding sources and articles. A printout will be mailed to you at no charge.

800-444-6472

**“Women of Substance”** a new one hour documentary on the barriers pregnant and child caring women addicts encounter in their struggle towards sobriety,  
Call Video Action Fund for ordering information

202-338-1094

**Hazelden Hotline:** A service of the Hazelden treatment program, helps people overcome fears about talking to friends and relatives with addiction problems.

800-I- Do-CARE

**“Men Have Babies Too”** Brochure developed by the March of Dimes examines the male’s influence on the unborn baby  
March of Dimes National Office

914-428-7100

### **“Alcohol, Health, and Research World, Special Focus: Alcohol Related Birth Defects**

Alcohol, Health and Research World: Vol 18, No. 1, 1994:

To order this special edition call

800-553-6847

For information on subscribing contact the US Government  
Printing Office at

205-783-3238

**Working With FAS Children: A Handbook for Caregivers of FAS/FAE Children:**  
Minnesota Services Association

Contact: Jean Cornish

612-645-0688

### **FAS/FAE Newsletter**

C/O Mailbag, P.O. 74612

Fairbanks, AK 99707

Support Group

Contact: Gail Hales

907-456-2866

### **SUPER Group:**

Fairbanks, AK

Contact: Jennifer Smith

907-452-6396

**National Resource: continued**

**Training of Trainers Manual of FAS American Indian Family Healing Center:**

1815 39<sup>th</sup> Avenue

Oakland CA 94601 (\$20.00)

510-534-2737

**"...and down will come baby"** A new seventeen-minute video for teenagers, which examines the specific health risks to the unborn child exposed to cocaine, heroin, alcohol and tobacco.

Scott Newman Center

6255 Sunset Blvd. Suite 1906

Los Angeles, CA 90028

800-786-6396

**Messenger Newsletter**

America Belongs to Our Children

6255 Sunset Blvd #1906

Los Angeles, CA 90028

800-783-6396

**The Clearing House for Drug Exposed Children Newsletter**

Division of Behavioral and Developmental Pediatrics

University of California, San Francisco, CA.,

415-476-9691

**Fantastic Antone Succeeds: Experiences in Educating Children with FAS.**

(\$23.50 soft cover & \$33.50 hard cover S/H Included)

NOFAS

1819 H Street NW, Suite 750, Washington, DC 20006

202-785-4585

**"Fetal Alcohol Syndrome: The Impact on Children's Ability to Learn: National Health/Education Consortium Occasional Paper #10**

Institute for Educational Leadership

1001 Connecticut Ave. NW, # 310

Washington, DC 20036

202-872-8450

**Training Tapes for Living with FAS and FAE:** "The Early Years, Birth through Age 12" and "Independence, Ages 12 to Adult" seek to assist those living with FAS/FAE and their families through a variety of challenges, from soothing a fussy baby to adaptive living skills. Each tape is 32 minutes long and costs \$295. To order, write:

Altschul Group Corporation

1560 Sherman Avenue

Suite 100

Evanston, Il 60201-9971

**National Resource: continued**

- “Alcohol, Pregnancy, and the Fetal Alcohol Syndrome”** This new Slide-Lecture Unit from Project Cork of the Dartmouth Medical School contains seventy-nine full color slides, with accompanying text, covering the effects of maternal drinking on fetal development. The slide unit is available from  
Milner-Fenwich, Inc.  
2125 Greenspring Drive  
Timonium, MD 21093 914-428-7100
- Minnesota Consortium on Fetal Alcohol Exposure**  
Contact: Kathy Gilmore 612-378-1777
- Children with Fetal Alcohol Syndrome/ A Handbook for Caregivers**  
HSA Publication  
336 N. Robert Street #1520  
Saint Paul, MN 5510 800-736-8967
- Support Groups for Adoptive and Foster Parents**  
Paramus, NJ. Contact: Ronnie Jacobs 201-261-1450
- “The Clinical Diagnosis of Fetal Alcohol Syndrome”** A new video by Jon M. Aase, MD., shows complete and never before seen information on the clinical diagnosis of FAS. The video can be purchased for the price of \$150.00 + \$9.00 for S/H from Flora & Company  
P.O. Box 8263  
Albuquerque, NM 87198-8263 (Or call, 24 hrs per day) 505-255-9988
- A Manual on Adolescents and Adults with FAS with Special Reference to American Indians (free of charge)**  
Indian Health Service FAS Project  
5300 Homestead, Ave NE  
Albuquerque, NM 87109 505-837-4228
- When the Bough Breaks: Pregnancy and the Legacy of Addiction**  
New Sage Press  
825 NE 20<sup>th</sup> Avenue #150  
Portland, OR 97232 503-232-6794
- Growing with FAS/FAE Newsletter**  
7802 SE Taylor  
Portland, OR 97215 503-254-8129

**National Resource: continued**

**FANN-Fetal Alcohol Network Newsletter**

158 Rosemont Ave

Coatsville, PA 19320

Listing of National Support Groups

610-384-1133

**FAS Information Packet South Dakota UAP Interdisciplinary Center for Disabilities, Early Childhood Research Program (\$3.00 for out of state)**

414 East Clark Street

Vermillion, SD 57069-2390

800-658-3080

Or 605-677-5311

**Preventing FAS and Other Alcohol-Related-Birth Defects: Teacher and Student**

**Manuals:** The Arc National Headquarters

500 East Border Suite 300

Arlington, TX 76010

817-261-6003

**CSAP National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs: For health professionals and educators interested**

in obtaining information

9302 Lee Highway

Fairfax, VA 22301

800-354-8824

**The FAS Family Resource Institute**

P.O. Box 2525

Lynwood, WA 98036

FAS Workshops: Adult and Teen Prevention Programs

206-778-4048

**Fetal Alcohol Task Force**

1016 East First Street

Port Angeles, WA. 98362

**Iceberg Newsletter**

P.O. Box 95597

Seattle, WA 98145

**Adoptive and Foster Moms Support (AM/FM)**

Beaver Dam, WI

Contact Sandy Yaroch

414-885-6903

**Family Empowerment Network: Support Group**

Madison, WI Contact: Georgiana Wilton

800-462-5254



## **BIOs**

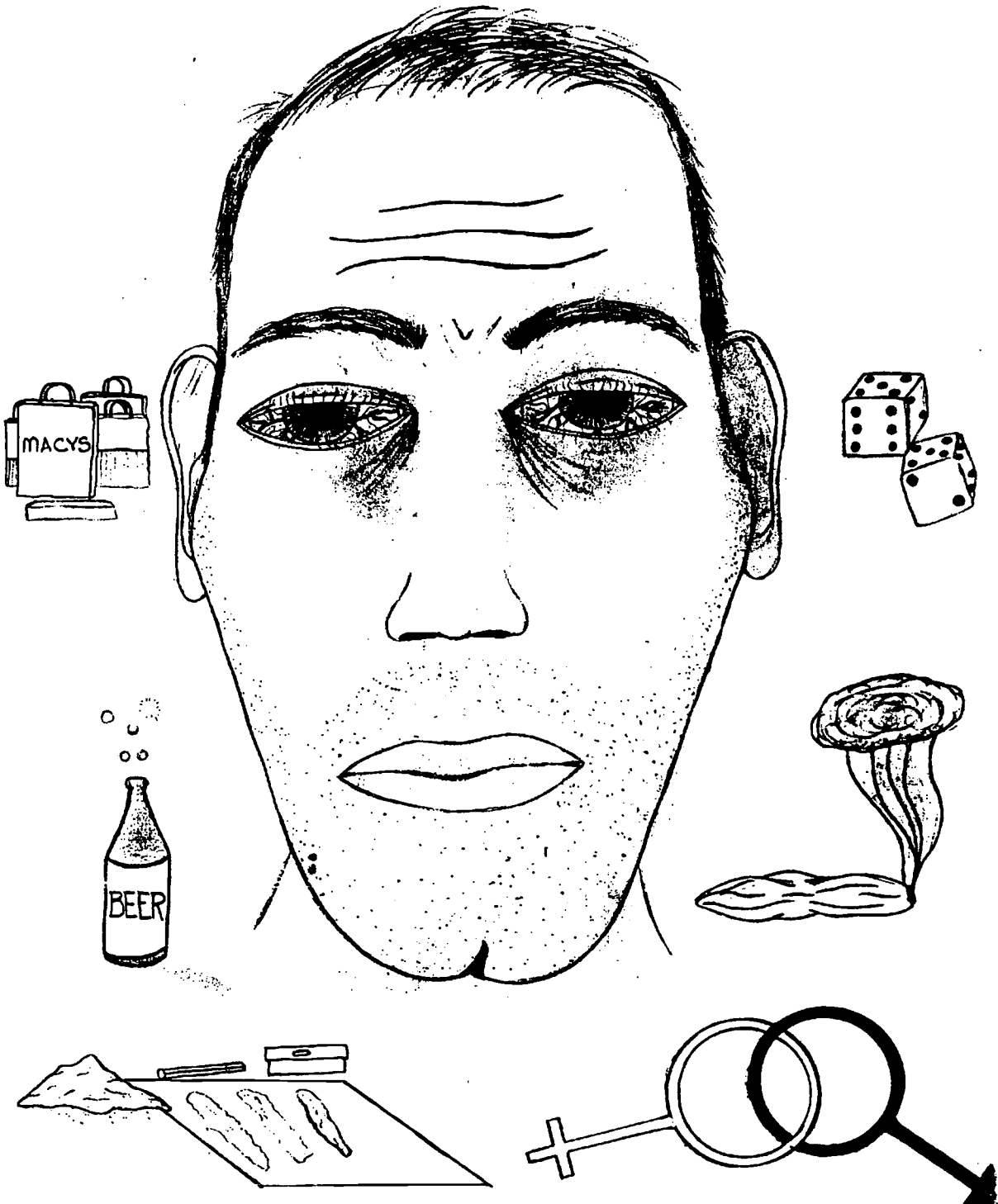
**Angela Robertson** lives in Lodi, California. She teaches Special Day Class and her hobbies are the piano and organ. She is the Sunday School Director and plays the organ for her church. Angela is an advocate for children who have special needs.

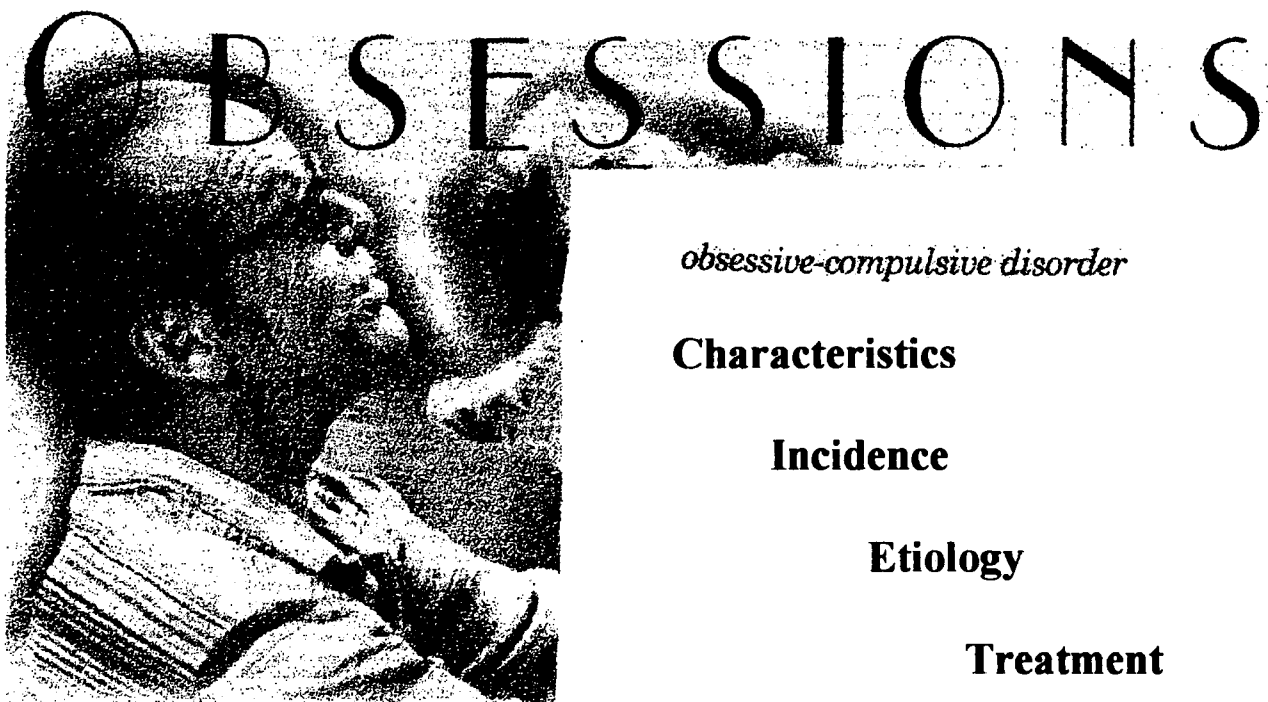
**Carol Waidner** currently works as an elementary school teacher in the Sierra Nevada foothills. She received a BA from California State University in a double major, English and Communications, with emphasis on public relations. Her hobbies are hiking and taking college classes for fun.

**Leslie Nelson-Wong** teaches chemistry and physical science at St. Mary's High School. Married with three children, her hobbies are reading and cross stitching.

**Katherine Lauderdale** see editors

**Rex Rabine**





Jack Nicholson  
portrays obsessive-  
compulsive Melvin Udall  
in 'As Good As It Gets.'

*obsessive-compulsive disorder*

**Characteristics**

**Incidence**

**Etiology**

**Treatment**

**Carlos A. Bonilla**

## Obsessions, Compulsions, Obsessive-Compulsive Disorders

What are they? Can they be treated? If so, how?

Obsession is defined as an idea from which the mind cannot be freed. The adjective, obsessive, relates to the characteristics of obsessions: “his obsessive interest in sex.” Compulsion, on the other hand, is the force or influence that makes a person do something, i.e.: “I will pay nothing under compulsion. It is a strong, usually unreasonable desire that is difficult to control: “Drinking is a compulsion with her.”

Obsessive thoughts fall into common categories. Some women who have given birth recently, for example, begin to think about stabbing their newborn baby and, of course, become terrified; in actuality they would never do it, so they find it impossible to understand the reasons for their thoughts.

Others, and I, myself, have been hit with this one in the past during a rare, and fortunately short, bout with depression, obsess that a burner left on in the stove will burn down the house. When, in order to relieve the anxiety caused by the obsessive thoughts, the sufferer turns to compulsive behaviors the problem becomes what is known as obsessive compulsive disorder or OCD.

Melvin Udall, the character played by Jack Nicholson in the movie “As Good As It Gets” is a prime example of a person with OCD; in the movie, Melvin will absolutely not step on any cracks on the floor or sidewalk; he washes his hands with scalding water and uses a new bar of soap, each time! Udall turns each lock in his apartment’s doors exactly five times.

Melvin, obviously, has an:

**OBSESSIVE-COMPULSIVE DISORDER!**

**Characteristics and Incidence**

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As mentioned earlier, OCD sufferers' lives are ruled by ritualistic behaviors; it is the lack of control over those "bizarre" behaviors which places this disorder among the category of mental illness. The number of those afflicted is substantial and estimated, by the National Institute of Mental Health, to be around 3.8 million.

Thus OCD makes up the third largest group of victims of mental illness; consider these figures:

<b><u>Disorder</u></b>	<b><u>Afflicted (%)</u></b>	<b><u>Afflicted (millions)</u></b>
Phobia	10.9	19.9
Depression	9.5	17.4
Obsession/Compulsion	2.1	3.8
Antisocial Personality	1.5	2.7
Panic	1.3	2.4
Schizophrenia	1.1	2.0
Somatization (Hypochondria)	0.2	0.4

In any one year, one-fifth (1/5) of the U.S. population suffers from a major mental illness. Obsessive-Compulsive disorder has its onset in childhood or adolescence in approximately half (50%) of the cases according to the American Psychiatric Association<sup>1</sup> individuals with OCD experience obsessions, defined as recurrent and persistent thoughts, images or impulses that are egodystonic (damage self-image), intrusive and, usually, senseless.

## **Symptoms of Obsessive-Compulsive Disorder**

- check objects repeatedly such as doors, locks, or stoves
- constantly counts, either in his mind or outwardly
- feels the need to “have” to do an activity, such as wash her foot exactly four times during each shower
- arranges items in a very orderly manner that makes sense to him but no one else
- experiences images “popping” into her head, usually of a disturbing nature endures nonsensical words or phrases repeating his mind
- hoards objects with no apparent value under a rationalization such as, “but what if I need small pieces of lint someday?”
- worries excessively about germs and have an overwhelming fear of contamination

These obsessions lead, generally speaking, to distressing negative affects (doubt, fear, disgust) or feelings of “incompleteness” which then manifest themselves in various forms:

- ▶ fear of harm to self or others
- ▶ urge to hoard things (hoarding)
- ▶ fear of contamination
- ▶ excessive scrupulosity
- ▶ urge to attain symmetry
- ▶ others

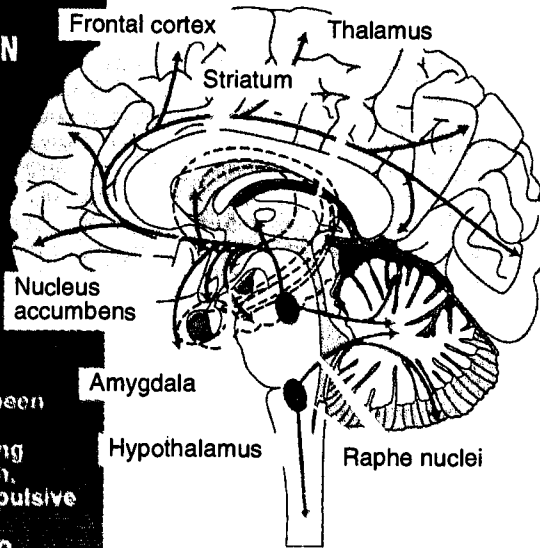
So, to suppress, neutralize or alleviate obsessions OCD sufferers resort to compulsive behaviors which can be observable (hand washing) or covert mental acts (counting). It is unfortunate but, according to James Broatch, executive director of the Obsessive-Compulsive Foundation in Millford, Connecticut, less than 20 percent of people with the disorder are receiving treatment at any given time.

## **Etiology and Treatment**

Current clinical agreement exists as to the causative factors for OCD consisting of a biochemical imbalance in the brain involving the neurotransmitter **SEROTONIN**. Just like dopamine and other known neurotransmitters, serotonin carries nerve impulses across brain synapses (see fig 1.). A person with OCD lacks enough serotonin to carry the impulses across the synapse so the impulse ricochets back. When this happens the individual’s brain is bombarded with activity he is unable to process normally, resulting in the development of odd, bizarre and frightening thoughts.

## SEROTONIN IN THE BRAIN

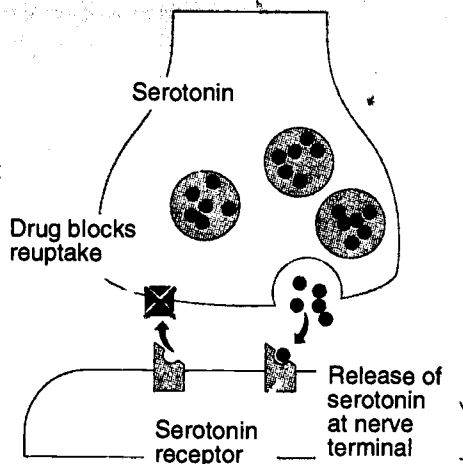
Serotonin is a messenger molecule involved in numerous brain and body functions, including mood, behavior, pain, appetite and sexual activity. Serotonin has been implicated in problems ranging from depression, obsessive-compulsive disorder and schizophrenia to migraine headaches and high blood pressure.



Nerve cells producing serotonin are found along the boundary between the brain's hemispheres in the midbrain and brain stem. Axons from cells such as the ones in the raphe nuclei extend to various brain regions, including those involved in thought and emotion.

## SEROTONIN SYNAPSES

More than a dozen different types of serotonin receptors have been identified, partly explaining serotonin's multifaceted effects. Some drugs used to treat depression block the action of chemicals that break down serotonin. Others, such as fluoxetine (Prozac), block the molecules that convey serotonin back into the releasing axon (a process known as reuptake).



6/10/96

Figure 1



Extensive literature has accumulated<sup>2</sup> which demonstrates that, just like in the case of chronic depression, potent serotonin reuptake inhibitors (SRIs) such as PROZAC are effective treatments for adults with OCD (please refer, again, to figure 1); in the case of Sertraline, a recently-developed SRI, treatment has been extended to children and adolescents also<sup>3</sup>.

As is normally the case, when treating OCD, just like treating other types of mental illness, most experts agree that normalization of behavior is enhanced by combining pharmacotherapy (ie. Serotonin re-uptake inhibitors) with specific cognitive-behavioral psychotherapy<sup>4</sup>.

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3. Maroch, J.S., Biederman, J., Wolkow, R., *et al. Sertraline in Children and Adolescents With Obsessive-Compulsive Disorder: A Multicenter Randomized Controlled Trial*. Journal of American Medical Association. 1998 (280): 1752-1756.
4. March, J.S., Mulle, K. *OCD in Children and Adolescents: A Cognitive-Behavioral Treatment Manual*. New York, New York: Guilford Press; 1998.

Note: Following the release of the movie "As Good as it Gets," Dru Sefton wrote a wonderful piece about obsession, which appeared in the Knight Ridder Newspapers, around the middle of March, 1998.

**S. E. X.**

***WHO***

***NEEDS***

***IT?***

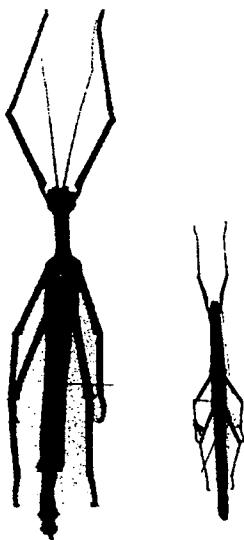
S.E.X. who needs it? Well, apparently many of us do. Some, in fact, don't seem to get enough of it. They are addicted to it! Recently I asked a very bright colleague of mine a simple question: Why do we need sex? To which he answered: well, to make babies, **STUPID!** By now you get the hint; "bright colleague" doesn't think much of my intellect.

At any rate, from his answer it can be surmised, in order to maintain the human race, we humans need to make babies. Fine and dandy; but, if such is the case, like one of my most admired American writers, James Thurber, I would like to pose this question: Why is it necessary? We could make babies more easily by parthenogenesis - virgin birth - the mode of procreation favored by sensible creatures such as the stick insects.

When it comes to sex, that is, sexual intercourse, I stand with the biologists who have always touted Lord Chesterfield's advice to his son:

*the pleasure is momentary,  
the position ridiculous and  
the expense damnable*

To which you, the reader, may say, fine and dandy but we are not stick insects, are we? Correct you are, to that one I have no further comment, so you may as well turn to the next page and begin to enjoy the discussion on compulsive disorders.



*A dirty picture of two stick insects  
discussing sexual addiction!*

Thank You,  
Carlos A. Bonilla

# Sexual Addictions

Myth or Reality?

Michael Brandt

Sandra Gail Kraus

Christine Sumner



Have you ever wondered, “is there such a thing as sex addiction?” If there is, what causes it? Is it a disorder brought on by emotional deprivation in childhood? Is it caused because of a lack of, or an excess of, dopamine or neuro receptors in the brain? How would a person know if they or someone close to them is a sex addict? How do sex offenders, prostitutes, homosexuals and people who frequent sex shops, public bathrooms or porno movie houses, fit into the picture? Persons who display sexually addictive tendencies can be doctors, lawyers, teachers, husbands, wife’s or even, as we all know, presidents of industrialized nations.

Addictive behavior can take on many different forms. Most behavior, which causes a person to be driven, or compulsive can be considered addictive. Those who are sexually addicted use sex as a means to cope with boredom, anxiety and as a way to feel important. It is a way to escape reality or pain, not unlike drug or alcohol addiction. In this instance the arousing sexual experience is an attempt to “fix” themselves, to remain emotionally stable. People with a sex addiction exhibit a combination of the following:

- constantly seeking a sexual partner, new romance or significant other
- an inability or difficulty in being alone
- consistently choosing partners who are abusive or emotionally unavailable
- using sex to tolerate difficult experiences or emotions
- missing important family, career or social experiences to maintain a sexual high or romantic relationship
- mistaking sexual experiences or romantic intensity for love

Unhealthy dependency, guilt and abuse characterize addictive relations over time. Not everyone who has engaged in one or two of the above has an addiction problem, but, when the situations become the norm, the assumption can be made a problem exists!

What causes sexual addiction? Sexuality is a natural instinct, so to accept this behavior as an addiction can be difficult and, only recently has the medical community begun to investigate its causes. Sanford Dietzen, PhD. who works for the Department of California Youth Authority, (CYA) does not believe it is really an addiction. He views it as an abnormality in the brain, caused by stimulation of specific neural receptors. He believes the person who acts out excessively in sex is responding to a lack of impulse control and the need to increase the activity of the brain in its pleasure center. When asked about the pleasure center, he described it as an area of the brain known as the nucleus accumbens (see pg.5 and 69) which connects the dopamine-releasing neurons to the prefrontal lobe which controls emotions. Both areas are activated during sex.

Oddette Howard who works with juvenile sex offenders does believe sex can be an addiction and an abnormal functioning of the brain. In juveniles, she believes, being exposed at a young age to sex, usually as victims of molestation themselves, may cause it. The recurrence of sexual activity creates the need for the person as they age to re-create those same feelings over and over again. Recovery is possible through a process of steps and challenging the person's thinking and behavior. A young man who has acted out addictively in sex, shared his beliefs: a victim of sexual molestation at a very young age he found sex was the one thing that allowed him to escape uncomfortable feelings. He also believes he was driven to obtain a "fix," similar to the needs of people who use drugs; when acting out his sexual feelings, the use of methamphetamine, in combination, became the norm.

An interview with an older gentleman (DS) revealed his addiction was on the phone, or the Internet, mostly masturbatory in nature, as the need to "fix" himself emotionally. This caused him to owe the telephone company enormous amounts of money from long distance calls and led to the cancellation of his phone

service. He admits he is still weak in this area but is trying to abstain from calling, is working on checking his motives before making any telephone calls or even getting on the Internet. Today, he is in recovery.

Dr. Carlos Bonilla, a professor at National University, says sex addiction is a two-fold phenomenon: it is not only the need for increased levels of dopamine in the brain, but also an emotional addiction. He believes it affects the brain somewhat like cocaine since both activate similar brain structures.

There is opportunity for recovery and available groups or centers can help. The Internet lists several centers that provide information and Mental Health Agencies have sex-anonymous groups meeting in most local areas

## **BIOs**

**Michael Brandt** is married and has two children. By trade he is a chrome plater, but his avocation is teaching, so Michael is attending college in pursuit of an elementary school teaching credential. His hobby is parenting and enjoying quality time with the children.

**Sandra Gail Kraus** is enrolled in the Behavioral Science program at National University. She is married and the proud parent of two children. Sandra teaches second grade in a private school. Her hobbies include reading and sports.

**Christine Sumner** is a student at National University working on a bachelor's degree in Behavioral Science. After graduation, she will go into the Master's Program in Counseling Psychology. Her long term goal is to get a Ph.D. in psychology. Currently, she is working for the Department of Youth Authority in the capacity of a Hall Secretary.



# Thrill Seeking

## Environmental, Genetic or Plain Stupidity?

Sheri Hillstrom

Patricia Scott

Dorothy Stanley

Sorin Ven

**A child who even at  
two weeks reacts  
strongly to stimuli  
. . . doesn't get  
scared, doesn't freeze  
in the crib – that  
same person at 20  
years old is willing to  
go mountain  
climbing or drinking  
and driving his car too fast.**

- Richard Ebstein  
Molecular Geneticist  
Sarah Herzog Memorial Hospital  
Jerusalem, Israel



## Research on Risk-Taking Behavior

When an individual is rewarded for a particular behavior, that behavior becomes more frequent. Thrill seeking is no different. To maintain a high or rush, the action is repeated over, and over, yet the initial high can never be duplicated. As a result, the individual winds up chasing the unattainable. This cycle paves the way for normal behavior leading to compulsion and becoming an addiction.

In the cycle of addiction, the neuro-transmitter *dopamine* is involved. Dr. Richard P. Ebstein, of Herzog Memorial Hospital in Jerusalem, has been tracking two dopamine-related genes: the “novelty-seeking” and “neuroticism” genes, in association with early behavior in newborns. His investigation has found marked differences in the manner in which babies respond to their environment and certain stimuli. In one group the babies, at two weeks of age, were alert and more apt to explore their surroundings while those in another group were not. By the time they reached their early twenties those alert babies were more likely to have become the “Novelty Seeker” type of individual. The “neuroticism” gene, which is believed to influence anxiety and avoidance to injurious behavior, may be lacking in those who constantly seek the rewards inherent in dangerous activities. Theoretically it is the balance between the novelty-seeking and neuroticism genes in us, which dictates our approach to perceived danger.

## Thrill Seeking

### **Environmental, Genetic or Plain Stupidity?**

*Bob, twenty-four-years old, having just set a new motorcycle speed record, removes his helmet. Not much excitement ! Having a new record is not thrilling compared to the anticipation, the craving to attempt to set, yet, another one. Bob finds fulfillment and excitement in the need for speed. He covets his victories and is driven by sensations that promote dangerous behavior. Rational thinking is overridden by an internal force yearning for more excitement and the pleasurable sensations associated with risk-taking. He cannot help it: you see, Bob is addicted to thrill-seeking.*

Why do some individuals seek thrills while others are content to avoid them? Is thrill seeking genetic or environmental? Despite recent research findings, many experts are skeptical and unwilling to give genes the responsibility for thrill seeking behaviors. We define those seeking adrenaline rush sensations as compulsive thrill seekers. According to Dr. Ebstein thrill-seeking behaviors can be tracked to two genes in direct correlation with an individual's temperament and personality.

Both genes and environment influence the actions of individuals and experts agree the contributions are equally dispersed. Dr. Ebstein's research is an attempt to emphasize the significance of genetics on overt behavior; the question remains: how much is genetic and how much is environmental?

Risk taking can be a productive part of growing up, but often adolescents are prone to undertake dangerous, even life-threatening risks. Recognizing thrill seeking behavior early and channeling an individual's excitement and energy into

productive tasks may be difficult, but necessary, to control strong genetic influences. When the following tendencies begin to invade daily life, there is just cause for intervention to save an at-risk individual.

<b>A</b>	<b>Attention Seeking</b>
<b>T</b>	<b>Tires easily of routine tasks</b>
<b>R</b>	<b>Resistant to authority</b>
<b>I</b>	<b>Impatient, seeks immediate gratification</b>
<b>S</b>	<b>Socially disruptive and self-destructive</b>
<b>K</b>	<b>Knowing but ignoring values/norms</b>

We conducted our own, non-scientific study, of this phenomenon. Recognizing the need to involve more than average risk, our study was narrowed to just one: skydiving!

## **Adventurous Thrill Seeking**

### **Dorothy's Account**

When, to test one of various hypotheses, Sherri said, "let's get a group together and go skydiving." "not me, count me out. If the gene is inherited, I am sure I was born without it" was my response. Over the next few months, while toying with the idea, I received much discouraging feedback, including my husband's threat to "break my legs" should I proceed with this foolish notion. Just be glad I am not researching sex addiction I told him!.

Stubborn as a mule - now, is that genetic or environmental? - each obstacle placed in my way made me all the more determined to jump. Additional research into thrill-seeking behavior, while perplexing, enhanced my curiosity; "attack it from the human side" prompted our, to-be, skydiving instructor, Chris. Finally, to Sheri's "let's go jump out of a plane" I said: O.K.!! How could I have agreed to

such a stupid stunt? How could a level-headed person do this? After three sleepless nights, the decision to jump, on my next birthday, early in October, was made.

### Jump Day

After viewing a video on the dangers of skydiving and signing the required “injury or death” responsibility-release forms, the dreaded moment had arrived. “Who is going first?” asked Chris, and I yelled “me”, petrified! On the other hand, my research partner, Sherri, could barely contain her excitement while waiting to jump. Now, wearing a black jump suit and harness and listening to a few, quickly forgotten, instructions I boarded the small piper cub plane joining the pilot, co-pilot, photographer and of course, the instructor.

In fifteen minutes the plane reached an altitude of 13,000 feet, the height from which I was to jump. The plane’s door opens, the photographer steps out onto the wing, instructor and student strapped to one another follow and quickly roll off into space.

Cold air rushes into me, takes my breath away. Am I about to pass out? “Oh, God, Oh God, Oh God” I screamed, terrified and unable to open my eyes. The photographer, right alongside, taps my hand, signaling for me to open my eyes. After one minute, which seemed like an eternity, the parachute opens and we float downward for another five. A wonderful five minutes: the silence, the view - I could see forever- the feeling of peace and solitude, floating in space. No room for fear now! while descending, I was able to direct my own landing. A feeling of accomplishment, the victory over my own fears, the pleasure derived from the strong adrenaline rush.

Will I skydive again? Watching the video of my jump, reliving the fear and the excitement, the answer is obvious: of course! And, next time, I will **KEEP MY EYES OPEN!**

## Adventurous Thrill Seeking

### Sheri's Account

In contrast to Dorothy's perception of the jump, I enjoyed every bit of it. That is not to say I did not experience some fear and nervousness. Because I chose not to tell anyone I was planning to skydive, negative feedback was not a problem. My safety net was in not discussing it, a *priori*, , which decreased the possibility of becoming over anxious.

At the skydiving school, I sensed a nervous calm about me, an unspoken trepidation. Ironically, my greatest fear arose while watching Bob, the man with whom I tandem-jumped, begin to show signs of tension during the flight. It was contagious. My mouth became dry, I began to fidget, and trying to focus on the directions I had been given was impossible. I was in a fog, "no pun intended." At 13,000 the door opened, the photographer walked out onto the wing and we followed immediately with a "thumbs up" to the camera.

Instinctively, I held my breath and closed my eyes for a brief moment then opened them to experience the most remarkable sensation I have ever encountered. Not falling, but floating, a feeling of being suspended in mid air. Is this what they call suspended animation? I wondered. The force of the wind, as we free-fell, filled my lungs with the coldest air I have ever breathed and was extremely invigorating.

The jump gave me an extraordinary sensation, the likes of which I have never experienced. Watching the resulting video, from time to time, I find myself getting motivated and energized. The positive feedback I received from the actual jump escalates my excitement and enhances my desire to attempt another thrill seeking maneuver. If this becomes an addiction, so be it!!!



## **Seeking thrills while seeking employment.**

The sound of gunfire echoes across their heads, the smoke from the grenades fills the air. People in a situation like this are risk-takers. Those who serve in our Armed Forces prepare for combat situations on a daily basis, training which includes live-fire demonstrations. Can these men and women retain their knowledge of tactics and procedures in an adrenaline-filled atmosphere when their lives are in danger? **YES!** Most remember their training in the heat of the moment; when they do not, accidents happen.

Many jobs in the world require the employee to learn and utilize skills for dangerous or life-threatening situations. Police officers, for instance, face danger daily; their training prepares them for situations that may occur in the field. Why would a man or woman choose a dangerous or risky job? Many people feel empowered by authority or stature over other people. They love the rush of adrenaline which accompanies risky situations. It is addictive and exhilarating. The power trip is like no other sensation.

Many questions have been asked about the suitability of people for these types of jobs. Men do well as gun-toting, tobacco-spitting Army sergeants and women do well in other, less risky jobs. Society teaches us that men and women are different and perform in certain high-risk jobs in different ways. A police officer answered questions involving the risks and thrills of his job:

*I chose my job because of the excitement of danger and the power of authority. My first experience with this sensation was when I was in the military, in a live-fire exercise, with bullets whizzing past my head. It was a unique addicting experience. I couldn't wait until the next time. I really don't fear death because I am confident in the skills I have and in the backup from my partners. My coworkers and I face danger daily. We have to trust each other. I was born believing I could do anything. My father set the example. So I believe both genes and environment made me what I am. The more I experience, the greater my desire is to do more.*

## **When the thrill factor is the risk involved.**

People can overcome lifelong fears and experience a sense of achievement by risk taking. For example: people who are afraid of flying report once they take their first flight, the fear disappears. They also gain confidence in other areas life. In these cases, risk taking is a positive occurrence. But, more often, risk taking is dangerous and sometimes devastating. That is how it was for Pat.

Unfortunately, Pat had no one in her life to teach her about good and bad risks. She grew up in a neighborhood plagued with poverty, drugs and poor role models who often took bad risks. She learned early that she liked the thrill of taking unacceptable risks, and enjoyed taking those which she knew her parents would not approve.

*At 12, Pat was challenged by her friends to take drugs. She did, not to disappoint them. Her friends were at risk themselves because they were the kids whose company her mom had forbidden. She continued to take one risk after another. First, sneaking out of her house and staying out all night with friends, then having sex too young, eventually marrying a man that was everything her mother and father hated. The marriage was a bad risk. Pat's life was riddled with bad choices.*

*After years of this lifestyle, she was living in hell. Her days were filled with desperate attempts to acquire more drugs and she fell into a deep depression. When did the risk taking stop being such a thrill and become a habit? She does remember the excitement of defying her parents, the exhilaration of another drug score. Drugs were now a necessary part of her life. She didn't know when to stop, didn't realize the thrill seeking would take on an addictive nature of its own and destroy years of her life.*

*Pat experienced a spiritual breakthrough at the age of thirty-four and her life changed for the better. Because of her interest in helping others who have fallen prey to addictive behavior, she has examined her past so that it can be a tool in reaching others, the many young people taking the very same risks she took.*

*Looking back, Pat realizes how lucky she is not to have acquired a terrible disease from all of the unprotected sex she had; how lucky she is to have overcome the drug addiction that ruled her life, how lucky she is to have all three of her children love her, and still be able to be a mom to them. How lucky she is to have had a second chance.*

Maybe you have a son, daughter or an acquaintance experiencing the same types of choices Pat faced. The best thing you can do in these situations is to talk to and guide them into healthy, productive choices rather than getting such a thrill out of bad ones. A friend, a counselor, a pastor can help. There are many organizations, clubs, help-lines, sports programs, school counselors, mentoring hot-lines, and volunteer organizations available to help. All it takes is a simple phone call. Let the youngster know that the thrill from being deviant will only last a little while, but the effects of their choices are likely to last a lifetime.



### **Reference:**

Allen, Jane E; "*Gene Linked to Infant Alertness, Exploration*. Associated Press, May 26, 1998.

Note: Dr. Richard P. Ebstein's original work appeared in THE JOURNAL OF MOLECULAR PSYCHIATRY, May 1998; we deemed it too technical for our purposes so instead made references to Jane E. Allen's synopsis released by the Associated Press, May 26, 1998.

## BIOs

**Sheri Hillstrom** attends National University, seeking a BA in Behavioral Science. Presently working as a substitute teacher, Sheri plans to complete her Master's Degree in Education Administration.

**Patricia Scott** is a single mother of three children, working towards her Bachelor's Degree in Behavioral Science. She is an assistant in Special Education and plans to complete her Master's Degree and work with emotionally disturbed children.

**Dorothy Stanley** is a Behavioral Science major at National University. A mother of two and a grandmother of three, she has been a teacher's assistant in special education for 28 years and will enter the credentialing program for teachers next year. Her plans are to remain in the special education field.

**Sorin Ven** attends National University. A Behavioral Science major he plans to work in the correctional system as a probation officer. Sorin is married and has one child.

# Trichotillomania

**Kay Neely      Randy Branscum**

**Sunni Grant   and   Barre Stadtner**

# Trichotillomania

Susie is twelve years old and in the sixth grade. She is having a rough time in school, as the other children tease her about the bald spots on her head. She is becoming more and more isolated from her peers and is beginning to show signs of depression. Susie does not know why she pulls hair out and, in fact, does not even realize she is doing this to herself most of the time. If she could, she would stop.

What is it that compels her to pull out her hair? She suffers from a disorder of impulse control called Trichotillomania. The Diagnostic and Statistical Manual of Mental Disorders (DSM IV) lists it along the lines of pyromania, kleptomania, and pathological gambling. An impulse control disorder is, by definition, the inability to control or to resist the temptation to do something harmful to oneself or someone else. This individual experiences the urge to act compulsively which, in turn, reduces tension.

Judy is a forty-eight-year-old woman who cosmetically eye-pencils her eyebrows on and applies false eyelashes each morning. In doing this, she attempts to conceal the fact she no longer has eyebrows or eyelashes. Judy started this ritual of uprooting the hairs when she was very young. She continued to do so through her early twenties until the hair would no longer grow back. She then began to pull the hair out of her head and continued to do so to this day. Now she has bald patches on her head.. Although this is upsetting to her own sense of pride, she is unable to stop.

According to the current psychiatric diagnostic manual (DSM-IV) Trichotillomania is defined as:

- ◆ Recurrent pulling out of one's own hair resulting in noticeable hair loss.
- ◆ An increasing sense of tension immediately before pulling out hair when attempting to resist behavior.
- ◆ Pleasure, gratification, or relief when pulling out the hair.
- ◆ The disturbance is not better accounted for by another mental disorder and is not due to a general medical condition (e.g., a dermatological condition).
- ◆ The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Trichotillomania is not a new entity. It can be traced back to the 1800s when it was described as an oddity which was unlikely to be encountered in practice. New treatments and increased publicity have given hope to people who are stricken with it.

The result of uncontrolled trichotillomania is a rare type of patchy non-scarring hair loss. The patients, mainly children and female, develop the nervous habit of plucking or twisting off their own hair. This produces a ragged patch of incomplete baldness usually found in easily accessible areas such as the scalp, eyelashes, or eyebrows. Interestingly, the scalp is free of inflammation, crusting, and infection.

Hair pulling is found in .5% of patients in children's mental health services. Recent surveys show 2% to 4% of the general population suffer from chronic hair pulling, an overwhelming eight million people in the United States. Although the compulsion to pluck the hair is a neurotic habit, it is not necessarily a sign of deep psychotic disturbance. The habit serves the person's emotional needs by relieving tension or frustration. In some individuals, the underlying psychological mechanism may be no more than a bad habit, similar to nail biting or thumb-sucking.

In patients with Trichotillomania, the hair loss is limited to one or more patches of baldness, typically located

- ◆ at the temples
- ◆ behind the ears
- ◆ above the forehead
- ◆ other accessible areas

Men are often seen pulling upon their mustaches, or beards.

The scalp is the number one target (75%), eyelashes (53%), eyebrows (42%), and arms (10%).

Hair loss within the affected area is never complete; short broken hairs are found mixed with a few long, normal hairs. There are growing hairs of various lengths but still young enough to escape the client's habitual plucking. This



combination gives the bald patch its distinctively ragged appearance. The pattern of bald patches is characteristic of Trichotillomania. The patched area has no exact borders as the margins appear to merge into the normal surrounding hair and take on an artificial look. They have a linear pattern, too regular in shape to suggest mechanical trauma, and are too irregular in outline lacking any definite pattern at all.

Usually, the surface of the scalp is noted for its perfectly normal appearance; the affected skin has no inflammation, scaling or atrophy, unless the client has scratched the area causing superficial scratches and crusts. Follicles are intact and are often visible as black points because the accumulated cells and pigment are pushed to the surface by the next hair developing in the follicle. New hairs growing in the area seem normal and show resistance to further plucking.

Most patients show no associated signs or symptoms. When appearance of the scalp suggests Trichotillomania, other hairy areas should be checked, particularly the eyebrows and beard, for similar ragged ill-defined patches. Some individuals complain of itching, and even claim they started this habit because of itchy skin in the affected areas. If itching is associated, the scalp may be red and excoriated from the patient's scratching.

The hair loss associated with Trichotillomania remains limited in most cases to one or two areas but the damage may be extensive. The compulsion may last for years, leading to severe hair loss. They have not destroyed the follicles but the outlook for a permanent hair regrowth in this case is less hopeful, even if the habit can be broken.

The cause of Trichotillomania is unknown. Several factors, such as a genetic predisposition or a self-punitive activity, could be the cause. Currently, the most popular way of looking at Trichotillomania is as a medical illness. One theory is a disruption in the system that involves a chemical messenger between

nerve cells in portions of the brain. Researchers are just beginning to investigate the causative factors. It has been found that depression frequently occurs in individuals with this disorder suggesting a direct neuro-biochemical relationship. It is secondary to the low self-esteem hair pulling induces. Most of those with Trichotillomania have had problems in their lives such as sexual or physical abuse, or a profound loss of a family member. Individuals may suffer other symptoms such as:

- ◆ substance abuse
  - ◆ self-mutilation
    - ◆ volatile moods
      - ◆ suicide attempts.

Two current methods of treatment found to be effective are behavioral therapy and pharmacologic intervention. In behavioral therapy, the patients need to learn a structured method of keeping track of symptoms and associated behaviors. Individuals with Trichotillomania are encouraged to substitute acceptable behaviors in place of unacceptable ones. Medications prescribed most commonly, but not always, for the treatment of trichotillomania belong to the anti-depressant category:

**PROZAC    LUVOX    ZOLOFT  
PAXIL    ANAFRANIL    DEPAKOTE  
LITHOBID    ESKALITH**

Hypnosis has been successful in some cases but in the absence of well-controlled studies, how well it works for any individual remains unknown. A combination of dietary factors and homeopathic treatment has yielded positive results. Some authorities recommend local measures to make it difficult or

impossible for the client to pull out his own hair. These measures include cutting the hair very short or shaving the head. While these measures interrupt the rhythm of the compulsion, their effect is temporary. If underlying frustrations or compulsions persist, the habit reappears.

The important thing for those who suffer from Trichotillomania is to remember they are not alone. Any knowledge the individual can gain about the disorder reduces feelings of isolation and self-blame. It is equally important for family members to be supportive and understanding of the compulsive nature of this illness.

Groups can be an especially helpful method of relieving the shame and isolation which accompanies this type of compulsion. Twelve-step meetings can be found around the country that many find helpful.

Judy, the forty-eight-year-old mentioned previously, did not have a supportive family. Her relatives' constant reprehension fueled her own sense of insecurity and self-doubt. Judy now sadly claims she avoids any chance of an intimate relationship for fear of having her shameful secret exposed. Seeking professional treatment, Judy now has a positive outlook for her future.

Susie, in our case study, is now currently receiving professional treatment also. Her parents are very loving and supportive so, hopefully, she can avoid the pain Judy experiences and will ultimately lead a normal, productive life!

**The important thing to remember is:  
"You are not alone!"**

## References

Christopher Wainwright, Canberra Australia, poie@ozemail.com.au

Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth  
Edition, American Psychiatric Association, 1994

Novak, MD. E., M.D. Copyright 1997 Pioneer Clinic, St. Paul, Minnesota

## Resources

### Where To Obtain Help and Information

Trichotillomania Learning Center  
1215 Mission Street Suite 2  
Santa Cruz CA 95060  
408-457-1004

[Http://www.sledge.net](http://www.sledge.net)

Pioneer Clinic  
Director: Carol Novak, M.D.  
2550 University Ave.W. Suite 229N  
St. Paul Minnesota 55114,  
(612)649-1105

<http://www.pressenter.com?~cnovakmd>

Stanford Medical Center Dept. Of Psychiatry  
Obsessive Compulsive Disorders  
Clinic Director: Lorrin Koran, M.D.  
Room 2301A,  
Stanford, CA 94305  
650-723-2423

Obsessive Compulsive Foundation, Inc.

P.O. Box 70

Milford, Connecticut 06460

203-878-5669 Fax: 203-874-2826

<http://pages.prodigy.com/alwillen/ocf.html>

Association for the Advancement of Behavior Therapy

305 Seventh Ave.

New York, NY 1001-6008

212-647-1890 Fax: 212-647-1865

<http://adaa.org>

Information Centers--Madison Institute of Medicine

7617 Mineral Point Rd.

Madison, WI 53717

608-827-2470 Fax: 608-827-2479

<http://www.INFOCTRS@Healthtechsys.com>

## BIOs

**Kay Neely** was born and raised in Butler, PA and has resided in Stockton, CA for the past ten years. She works as a teacher for the San Joaquin County Office of Education in the Alternative Program. She is completing her Bachelor's Degree in Behavioral Science and will enter the Master's Program in Interdisciplinary Studies. Kay and her husband of twenty-five years, Rex, are the proud parents of Lucy, their eight-week old poodle.

**Randy Branscum** resides in Manteca. He is a junior at National University in Stockton, CA. Randy is working on his Bachelor's Degree in Behavior Science and then will pursue his degree in teaching. Married to Jayne, his wife of fifteen years, Randy has three daughters, Jayde, Chyna, and Rayna. *"Chaotic Conversation: a Foray into the Complex World of Communication"* ICA Publishing, 1998, contains Randy's first published work.

**Sunni Grant** is a twenty-eight year old licensed Psychiatric Technician. She has worked in mental health for ten years. Currently working on a BA in Behavioral Science she will continue her schooling to become a School Psychologist. Sunni resides in Lathrop, CA with her daughter Jessica.

**Barre Stadtner** is working on a counseling license at National University. He is already facilitating anti-depression workshops, using the cognitive method.

***MUNCHAUSEN  
SYNDROME  
BY PROXY***

*Deb Clemens  
Dana LeNoir  
Marie Moore  
Debra Stiles  
Stacey Tokeim*

I don't know Doctor. Whenever I see her, she says she feels worse.



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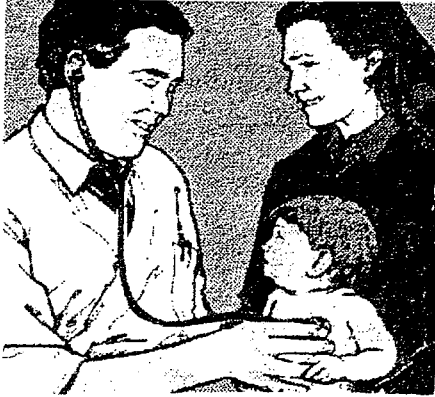
*Eight-month old Joseph Martinez lay quietly in a hospital baby bed, a cluster of tubes and other devices attached to his tiny body. Beside him sat his seemingly devoted, worried mother. Alone with her son, Cynthia Martinez did something peculiar. After glancing around the room she carefully disconnected Joseph's feeding bag and blew into a tube inserted in her son's stomach. The baby writhed about, his mouth opening and his head moving from side to side (Shannon).*

What was this mother thinking? How could anyone hurt their own child, especially when that child was already in the hospital? The answer is Munchausen Syndrome by Proxy (MSBP). MSBP is considered an "impulse control" disorder. It is a psychiatric disorder identified as an intentional production of physical symptoms (Karlin).

**In 98% of the cases the mothers are the perpetrators!**

## ***WHERE DID THIS NAME COME FROM?***

In 18th century Germany, Hieronymous Karl Fredrick Von Munchausen gained notoriety entertaining friends and family with stories about his adventures in the Russo-Turkish wars. Each time he told a story the tales grew more and more fantastic (Jones). In 1951 British Psychiatrist Richard Asher, coined the term Munchausen Syndrome to describe patients who falsified illnesses and reported sensational histories of varying types of sicknesses. In 1977 English pediatrician, R. Meadow, came up with an extension of the term Munchausen Syndrome. He discovered that many of his epileptic patient's mothers made up their children's



symptoms; he used the name "Munchausen Syndrome by Proxy (Karlin).

### **SYMPTOMS**

- A prolonged and abnormal multi-system illness.
  - When signs and symptoms disappear in the absence of the parent.
  - When one of the parents, in most cases the father, appears non-existent during hospital stays.
  - Health of the patient contradicts the results of lab tests.
- There is a history of SIDS (Sudden Infant Death Syndrome) in siblings.

## ***WHY DO THEY DO THIS?***

### **THERE ARE THREE MAJOR CLASSES OF MSBP PERPETRATORS:**

#### **DOCTOR ADDICTS**

Parents with an obsession to receiving medical treatment for non-existent illnesses in their children by falsely reporting medical histories and symptoms. They refuse to accept that their children are not sick and tend to be distrustful and angry in nature. Children of doctor addicts are usually older than six years of age.

#### **HELP SEEKERS**

Parents who look for medical attention for their children so that they may express their own needs, such as anxiety, depression, or the inability to take care of the child. Commonly, help seekers come from homes where domestic violence, marital problems, or an unwanted child exist.

#### **ACTIVE INDUCERS**

Typically, these parents are anxious and depressed and also in denial. Their goal is to attain control over the treating physician and to gain acknowledgment from the medical staff as being wonderful and loving parents.

## MOTIVATION

Most theorists believe parents with this disorder feign sickness in their children due to trauma earlier in the MSBP patient's life, such as death or loss of a parent's love. The help seekers are said to be acting out and making a cry for help at the same time. Active inducers and doctor addicts use their connection with doctors and medical staff to try and fix an earlier traumatic loss. They express their anger by deceit and create what they lack, which is protection, recognition, and security. This sort of relationship nurtures and protects them from their desperation.

### **CAUSE FOR SUSPICION**

1. PUZZLING MEDICAL PROBLEMS
2. PARENT NEEDY OR SEEKING ATTENTION
3. SYMPTOMS IN THE CHILD OCCUR ONLY WITH PARENT
4. UNUSUAL FAMILY HEALTH HISTORY AND LAB FINDINGS
5. SUSPICIOUS SIBLING DEATH OR ILLNESS
6. HISTORY OF OTHER DRAMATIC EVENTS (FIRES, HEROIC RESCUES, ETC.).

The following is an excerpt from an interview with Deborah Scheffiel, a detective with the Sheriff's Department:

**Interviewer:** *What would make you suspect MSBP?*

**Detective:** *A chronically-abused child brought to the attention of medical authorities time and time again. A report from the doctor or a Child Protective Services worker on a child that's received more than, I'm gonna say, about three illnesses or injuries.*

**Interviewer:** *What would you do in a case like that?*

**Detective:** *A scene investigation, starting at the home, talking to parents, neighbors, medical records, look at the home, living environment, interview the family, friends.*

**Interviewer:** *Do you then consult a psychiatrist?*

**Detective:** *Yes, there is a team response before I even contact the District Attorney. I consult a medical doctor, a psychiatrist, not a therapist; there is a difference.*

## ***IS THERE TREATMENT FOR THE PATIENT?***

Sadly, successful treatment for those with MSBP is extremely rare. Patients are very often in denial and continue their behavior even when faced with convincing evidence. Patients often refuse treatment. When pressured, they move on to another hospital or even to another city to continue their previous behavior.

After diagnosis, social services and state authorities must be informed. It is very important for the child to be removed from the home to avoid a permanent handicap or death.

**“9% to 31% of all MSBP victims die  
at the hands of their perpetrators”**

**-Artingstall**



MSBP patients act on their feelings on impulse instead of verbalizing them. It is difficult to gain access to their emotional life and for the therapeutic relationship to work patients must be committed to truth and reality. This is very hard for a number of reasons:

- often pathological liars
- the boundary between truth and non-truth is greatly blurred
- denial and defense mechanisms are in place

"While treatment should be offered in as an acceptable way as possible, compulsory treatment for the mother will rarely be appropriate" (Bools).

### ***WHAT HAPPENS WHEN THE CHILD GROWS UP?***

There is limited data about the long-term impact of Munchausen Syndrome by Proxy. Victims are hardly ever identified and most do not follow-up after termination of protective services supervision.

In one study ten victims of MSBP volunteered to fill out a 33-item questionnaire (Libow). Three subjects were single, four married, two divorced, and one was a widow. All of the subjects were from middle class families and seven were parents themselves. Out of their children, one was on Ritalin, two had birth defects, and the rest were all reported with good health.

Researchers agree the consequences of MSBP are serious and long lasting. The range of therapy for these victims is one week to 14 years. The subjects have difficulty maintaining relationships, dealing with memories from their childhood, feelings of insecurity and are constantly searching for a mother's love. They also

had trouble deciding what is real and what is not, especially for their illnesses or medical treatment. The victims also sought therapy for the birth of their first child, to ensure they did not follow the same path as their parents.

Most of the victims have understandably totally cut-off relationship with their parents, some even have obtained restraining orders. Some of the parents continue to involve their child by placing false police reports and, anonymous, bizarre phone calls. Most victims still fear their parents. Sadly, some of the parents have fabricated illness when children leave home.

### ***WHAT IF YOU ARE FALSELY ACCUSED OF MSBP?***

In one case a mother was accused in the death of her infant son. However, the woman's second child was born with a rare illness, and upon further investigation it was proved that her first child had died from the same disorder (Artingstall).

***“THE IMPORTANCE OF MEDICAL  
EVALUATION CANNOT  
BE OVERSTATED”***

***-Artingstall***

MSBP is a complicated and often misdiagnosed disorder. For this reason any accuser, including police, doctors, and investigators needs to explore all avenues when suspicion of it arises.

Mothers Against Munchausen Syndrome by Proxy Allegations (MAMA) is an organization started to protect people from being wrongly accused of it. When a mother takes her child to the doctor who finds nothing wrong, he may choose to report a "troublesome" mom because she is insisting there is something wrong with her child.

Parents need education on how easily a MSBP diagnosis or profile can be formatted to fit any mom who is a serious advocate for her child. Laws must be changed to protect children and families from this problem. It is too simple for a doctor to make an accusation of this magnitude with basically little or no evidence.

MSBP is a serious disorder needing early diagnosis. Family members and doctors must recognize the symptoms so that the mother can get help and the child can be protected. Early recognition and treatment increases the chance of saving the mother and early intervention is the best chance for the child. This does not mean diagnosis of MSBP should be hastened. It means, if suspected, further investigation is necessary to confirm the disorder and protect parents from being falsely accused, or to remove the child from a dangerous situation. If wrongly accused it is important that the parent and family know there is support for them to overcome this ordeal.

### ***HELP IS OUT THERE***

Mental Health Services of San Joaquin County	(209) 468-8686
Heritage Oaks Sierra Vista Hospital	(916) 423-2000 or (916) 489-2066
Sutter Center for Psychiatry	(800) 801-3077

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## **Addendum**

A recent report described the case of “a 30-year-old patient, a nurse’s aide who suffered from recurrent episodes of infections arthritis of the right ankle. She had been hospitalized for 168 days over a period of 3 years, and had undergone 15 surgical interventions. This turned out to be a case of self-induced infection brought about by the patient’s now rinsing of surgical wounds with soiled water from the toilet.

When confronted by the hospital staff the patient strongly denied it but over the course of a three-year period no further infections occurred. The case was labeled “**MUNCHAUSEN’S SYNDROME BY MICROBE.**” Unfortunately, it is not the first case; several other have been reported in the medical literature.

Carlos A. Bonilla

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## **BIOs**

**Deb Clemens** is very busy with her husband and twins (boy and girl). While enrolled in the behavioral science degree program at National University, she volunteers at her children's preschool. Her educational goal is a doctorate in clinical psychology. Her hobbies: "Who has time for hobbies?"

**Dana Lé Noir** is majoring in Behavioral Science at National University. Her goal is to become an inmate counselor in a correction facility. Her hobbies include jazz music and biking. Dana currently works at the sheriff's office. Dana says "although my mother is no longer with me, I know she is very proud of my work and is beaming with pride."

**Marie Moore** is single. She loves to travel and teach. Her educational goal is a bachelor's degree in behavioral science. Eventually her goal is to teach elementary school.

**Stacey Tokeim** is pursuing a degree at National University. She lives at home with her parents and three brothers, in the country. Stacey works as a secretary in a physical therapy office. Her hobbies are piano and tap dancing.

**Debra Stiles**

# A Silent Cry For Help!

## Self-Mutilation

Jennifer Abraham

Cecilia Cabello

Stephanie Olvera

Sara Sellers

Melody Wright-Murphy

Throughout the years people have found effective ways to deal with stress, anger and mixed emotions. Some use meditation, others take weekend getaways as positive ways to cope with life's bumpy roads. Many people, however, involve themselves in destructive behavior by using drugs or alcohol, starvation, bingeing and purging as a way to cope with the many challenges in life. Now attention is being given to another form of destructive behavior: self-mutilation.

According to Winchel and Stanley (1991), self-mutilation (also known as self-injury or self-harm) is defined as the commission of deliberate harm to one's body. The injury is self-induced, without the aid of others, and it is severe enough for tissue damage to result, but usually not lethal. Dangerous and strange to many, this act is performed in reaction to psychological crises in which the self-injurer does not know how to cope. Obviously, this behavior is not socially acceptable!

Self-mutilation involves mild to moderate injuries which include cutting the skin, burning, head banging, trichotillomania\* (plucking the hair), and scraping the scabs off of old wounds. The injurious tools are as diverse as the injuries they cause: knives, razors, broken glass, or sharp object; cigarettes, hot bulbs and irons; needles and safety pins, abrasive and caustic agents: oven or drain cleaner (Ritter). The more serious cases include amputation of limbs, breast, digits, and genitals. Breaking bones, facial skinning and scarring, eye enucleation (removal of the eye) and ingesting sharp or toxic objects. About 75 percent of self-injurers use more than one method.(Conterio).

\*A detailed discussion of this disorder can be found in the previous chapter.

Self-mutilation is also a characteristic of Borderline Personality Disorder (BPD) as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The term “borderline personality disorder” suggests the image of a person who is on the edge of the thin line between normal and neurotic behaviors. It is a very complex disorder.

According to Joseph Santoro, Ph.D. in “The Angry Heart,” in order to be classified as BPD, five or more of the following signs must be present:

- ◆ Frantic efforts to avoid real or imagined abandonment.
- ◆ A pattern of unstable and intense interpersonal relationships.
- ◆ Unstable sense of self and identity.
- ◆ Impulsive actions that are ultimately self-damaging such as drug abuse, excessive spending, reckless driving, or unsafe sex.
- ◆ Recurrent suicidal actions, threats, thoughts, or self-injury behaviors.
- ◆ Unstable, intense moods or emotions that can be triggered by events and may last hours or days.
- ◆ Chronic feeling of emptiness, boredom or loneliness.
- ◆ Inappropriate or intense anger that is difficult to control.
- ◆ Temporary, stress-triggered paranoid ideas or severe dissociative symptoms.

Not all of these symptoms need be present. Symptoms may not occur all the time, and may change depending on the environment and the level of stress present at a given time.

In the United States, there are an estimated two to three million self-mutilators. Dr. Armando Davazza, Professor of Psychiatry at the University of Missouri, Columbia Medical School, estimates the number of self-injurers at 750

per 100,000. Experts believe there may be many more, but largely hidden due to their ability to work and function normally in society (Egan).

The self-injurer is usually a fairly healthy person who may have been raised in unsafe or unsatisfying family conditions. For the most part, they grew up in dysfunctional families and had little or no parental guidance or emotional support. Typically, it is white, middle-class women with above-average intelligence whose problems may date back to adolescence. There is a lack of adaptive coping skills that make for uncomfortable, and seemingly uncontrollable, feelings which then find relief through injury (Conterio).

Many self-mutilators are teenagers and there is an increasing number who are males having suffered sexual and physical abuse. Eating disorders such as bulimia and anorexia are common as are compulsive gambling and shoplifting. Some suffer from depression and many use drugs or alcohol. A large number of self-injurers have trouble regulating their emotions, rapid mood swings, difficulty maintaining friendships, excessive emotional sensibility and impulsivity.

Self-mutilation can best be understood as a morbid self-help effort providing fast relief from feelings of depersonalization, guilt, rejection, and boredom, as well as hallucination, sexual preoccupations, and chaotic thoughts. Those with sexual guilt feelings are likely to mutilate themselves more severely than others: in some cases of this type, men have been known to amputate their external genitalia. Self-mutilators have low self-esteem so they focus on making other people happy, but their failure leads to self-punishment in order to feel a sense of release.

By employing the psychological defense of self-mutilation, the idea is to cause physical pain to ward off emotional pain: a substitute for anger toward someone else or ourselves. Endorphins, the brain's own hormones produced to fight anxiety, agitation, and depression may be released during or after self-injury;

thus, it is not unlikely addiction to these endogenous “drugs” may occur and suggests “self-medication” of one’s mood disorders (Levenkron).

The sight of blood causes a change in the mood and a sense of relief; when there is insufficient bleeding, the patient continues to cut or injure until enough is released. There is an addictive quality of the release, the “wanting to see the blood” bad things inside flow out, and there is a general feeling of “cleansing.” When people self-injure, they are in control for, after all, it is an experience nobody can take away. Each physical scar usually has a time, a history, a reason which a self-injurer can describe.

These patients may go undetected for quite some time because their injuries in places not easily observed: cuts in the arms or legs are covered by long sleeve shirts and long pants but, as their illness worsens, are likely to become more noticeable. As a cover-up some self-injurers make up stories about the origins of their cuts or scars: cuts are caused by a cyclone fence, scratches by a cat.

Finally, how do therapists treat self-mutilators? Strategies involve a combination of behavioral and chemical treatment tailored to individual patients. Behavioral therapy is based on the assumption these patients are vying for attention, or escaping from a demand, and need to learn alternative ways of communicating.

In order for therapy to succeed an understanding of why an individual causes self-harms as a primary coping mechanism must be acquired. According to Dr. Tracy Alderman, author of “The Scarred Soul: Understanding and Ending Self-Inflicted Violence”, one of the first steps necessary to treat self-mutilation is identifying and changing feelings, thoughts and behaviors.\* They must look at

\*This, in fact, is the essence of effective cognitive therapy (for a synopsis see Jane Brody’s article, cited in the references).

self-injury as a larger problem and learn to deal with its origins; this is half the battle. As in all forms of psychotherapy the patients need to want to stop, and must commit themselves to being uncomfortable while attempting to achieve a cure. They must realize this is a long and arduous process. Drug therapy consists of benzodiazepines (valium-like compounds) and antipsychotics.

Adjunct to treatment is provided by Dialectical Behavioral Therapy classes which use different coping strategies and techniques. Change is possible only when there is a desire to accept reality and patients must be willing to let go of emotional suffering. In class they learn ways to observe and describe their emotions, distance themselves from them and then let go. Distraction techniques are also helpful.

Treatment of self injurers with hypnotic relaxation techniques has been attempted. During hypnosis the patient is put in a trance, told to count and become aware of breathing patterns and to visualize a calm, pleasant, and relaxing scene, then encouraged to discuss things they may not be able to talk about under normal conditions. Hypnosis offers the most immediate relief when strong communication and close "here-and-now" contact is used.

+ + + + +



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## BIOs

**Jennifer Abraham** is a correctional worker, who works with youth in California. She is a proud mother of a nine-year-old son, Kevin and is presently attending National University to obtain a BA in Behavioral Science.

**Cecilia Cabello** is married and the mother of two children. She is attending National University working toward a Bi-lingual Credential of Language Arts Degree (BCLAD).

**Sara Sellers** is a full-time student and mother who is presently working with children. She hopes to continue her education to be put to use in educating others.

**Melody Wright Murphy** is the mother of an eight-year-old girl, Briana. She is presently working towards her teaching credential to teach elementary school and has been working as a domestic flight attendant with a major airline for the past 14 years.

**Stephanie Olvera** is working towards her BA in Behavioral Science. She works for Stockton Unified School District as a child assistant and is the proud mom of two sons.

# The Other Addictions Internet, Shopping and Gambling

**Rudy Jimenez, Jr.**

**and**

**Mary Pearson**

## Internet Addiction

Amy cannot wait for the clock to strike five; she is an addict! Her eight hour workdays seem to last sixteen. Due to lack of sleep she has dark circles around her eyes and her appearance is deteriorating at an alarming rate. As the clock reaches five, Amy gathers her belongings quickly and races for the elevator which is jam-packed. No matter, She forces her way in, anyway. When the elevator reaches the first floor she is out and running to her car. Although it is a beautiful day outside it does nothing to calm her nerves or to relax her. At this moment she is like any other addict looking for a fix. The anxiety is so rampant Amy will do whatever it takes to get hers. A fifteen minute commute seems like an hour, but when arriving home she cannot wait to download her drug of choice. This addiction, increasingly visible in American society, and becoming more prevalent is **THE INTERNET.**

**Internet addicts tend to form an emotional attachment to their on-line friends and activities they create inside their computer screens... These virtual communities create a vehicle to escape from reality and seek out a means to fulfill an unmet emotional and psychological need.**

Internet addicts openly admit to having an “addictive personality” and many have a history of abusing prescription medication, alcohol, cigarettes, or food. Individuals suffering from a sex addiction may seek the Internet as a safe, “disease free” way to fulfill sexual desires. While drug and Internet addiction have similar characteristics, there are physical differences. Drug addiction is a chemical dependence where the body and mind need a substance to survive or make it through the day. Internet addiction has been labeled a behavioral addiction. Individuals are addicted to the activity not to a drug.

**Those most vulnerable to this obsession include women and men who already suffer from depression, bipolar disorder, anxiety, low self-esteem, or the struggles while recovering from prior addiction.**

## **Are you, or someone you know, addicted to the Internet?**

### **Typical Warning Signs:**

1. Do you feel preoccupied with the Internet (think about previous on-line activity or anticipate next on-line session)?
2. Do you feel the need to use the Internet with increasing amounts of time in order to achieve satisfaction?
3. Have you repeatedly made unsuccessful efforts to control, cut back, or stop Internet use?
4. Do you feel restless, moody, depressed, or irritable when attempting to cut down or stop Internet use?
5. Do you stay on-line longer than originally intended?
6. Have you jeopardized or risked the loss of significant relationships, job, educational or career opportunity because of the Internet?
7. Have you lied to family members, therapists, or others to conceal the extent of involvement with the Internet?
8. Do you use the Internet as a way of escaping from problems or of relieving a dysphoric mood (e.g. feelings of helplessness, guilt, anxiety, and depression)?

As society becomes more aware of life-threatening addictions (i.e. alcohol, and drugs), there are others we do not easily recognize. It is time we educate ourselves and realize a person susceptible to addictive behaviors may not only turn to the obvious ones but can be easily attracted to more subtle activities. Just as with the Internet there are

others which attract an individual vulnerable enough to fall into trap: gambling and shopping are two examples which serve to illustrate.

### **Gambling Addiction**

A gambling addiction is defined as “a progressive behavior disorder characterized by a psychologically uncontrolled urge to gamble” (Michigan). It has been identified as a disorder of impulse control and associated with various kinds of addictions such as alcohol and drug dependency. Researchers believe about 5 percent or 10 million people are compulsive gamblers (O’Brien). In 1997, Americans bet \$638.60 billion legally and lost about \$51 billion of that amount (IBID).

The criteria according to the Diagnostic Manual of Mental Disorders (DSM-IV) include the following:

- preoccupation with gambling behavior
- The need to increase the amount of the bet
- The inability to cut back
- Restlessness or irritability while cutting back
- Using gambling as an escape mechanism
- “Chasing” losses
- Lying to family members or therapists to conceal behavior
- Committing illegal acts to cover losses
- Jeopardizing relationships or opportunities because of gambling
- Having to rely on others to cover financial losses

A pathologic gambler does not rely on winning every bet but on sporadic wins as the reward system which encourages additional gambling behavior. Games such as blackjack, slot machines, and instant game lottery tickets tend to be more addictive than sports-book wagering or the weekly lottery (Pasternak). The pattern begins with a winning streak. This encourages more gambling and soon the winnings are replaced with losses, so many that the person becomes desperate to regain the lost money. The individual feels hopeless and may contemplate suicide. It is at this critical moment the gambler may come to terms with the addiction and seek help.

The discovered population for pathologic gambling is two-thirds minority males, unmarried individuals and people with a history of other disorders: depression, alcohol

abuse, tobacco and illicit drug use. Some individuals also have a family history of pathological gambling and/or alcohol abuse (Pasternak). Hawaii and Utah have escaped the pressure of legalizing gambling so far, but every other State has some form of legalized gambling. This addiction has infiltrated the children of our society. "We call it the silent addiction. You can't smell it on their breath, you can't see in their eyes" (Reuters). On August 15, 1998, the American Psychological Association told of 5-8 percent of young Americans and Canadians involved in "serious" gambling (IBID). The target population among teenagers is boys, who are three to four times more likely to gamble than girls.

**"Compulsive gambling disorders may be for  
Generation X what cocaine and crack were for  
their parents' generation" (O'Brien).**

## **The Compulsive Shopper**

Shopaholics seek shopping as a way to "deal with other, more basic psychological problems" (Pirisi). It creates a cycle of behaviors that leads to enormous debt. "Negative or undesirable mood states have also been shown to precede compulsive buying episodes, and short-term improvements in mood are reported to follow these experiences" (Christenson, et. al.). In Canada, there are about 58 million credit cards an increase of 600 percent in 15 years (Pirisi).

Compulsive shopping affects around one percent of the North American population, or about 4 million people. The target population for Shopaholics is usually men in their 20s and women in their 30s, although there has been no demographic or psychological profile provided. Therapists have discussed the connection between depression and unresolved trauma to compulsive shopping as being "a method of coping and a form of relief from anxiety caused by boredom" (Pirisi). Individuals most susceptible are those who seek shopping as a way of nurturing themselves, making up for an absence of self-esteem, love, and attention.





### **Common traits found in Shopaholics and compulsive people:**

- May be rigid in their thinking--even obsessional
- May be consumed with meeting deadlines
- May be consumed with cleanliness
- May be consumed with minute details

Now, those of you who are addicted to asking questions and obsessed with causing questions and obsessed with causing troubles to those of us who discuss addictive behavior may ask: **SO WHAT? IS THAT IT? GAMBLING AND SHOPPING, WHO CARES?** No, that is not all! Come, we invite you to visit the P & J mini-gallery of weird addictions, so hang in there!

### **Resources**

**Center for On-Line Addiction:** <http://netaddiction.com>

**National Council on Problem Gambling:** 1-800-522-4700

**Michigan Council on Problem Gambling:** 1-800-270-7117

**Debtor's Anonymous:** 1-781-453-2743

**Debtors Anonymous General Service Office**

P.O. Box 888

Needham, MA 02492-0009

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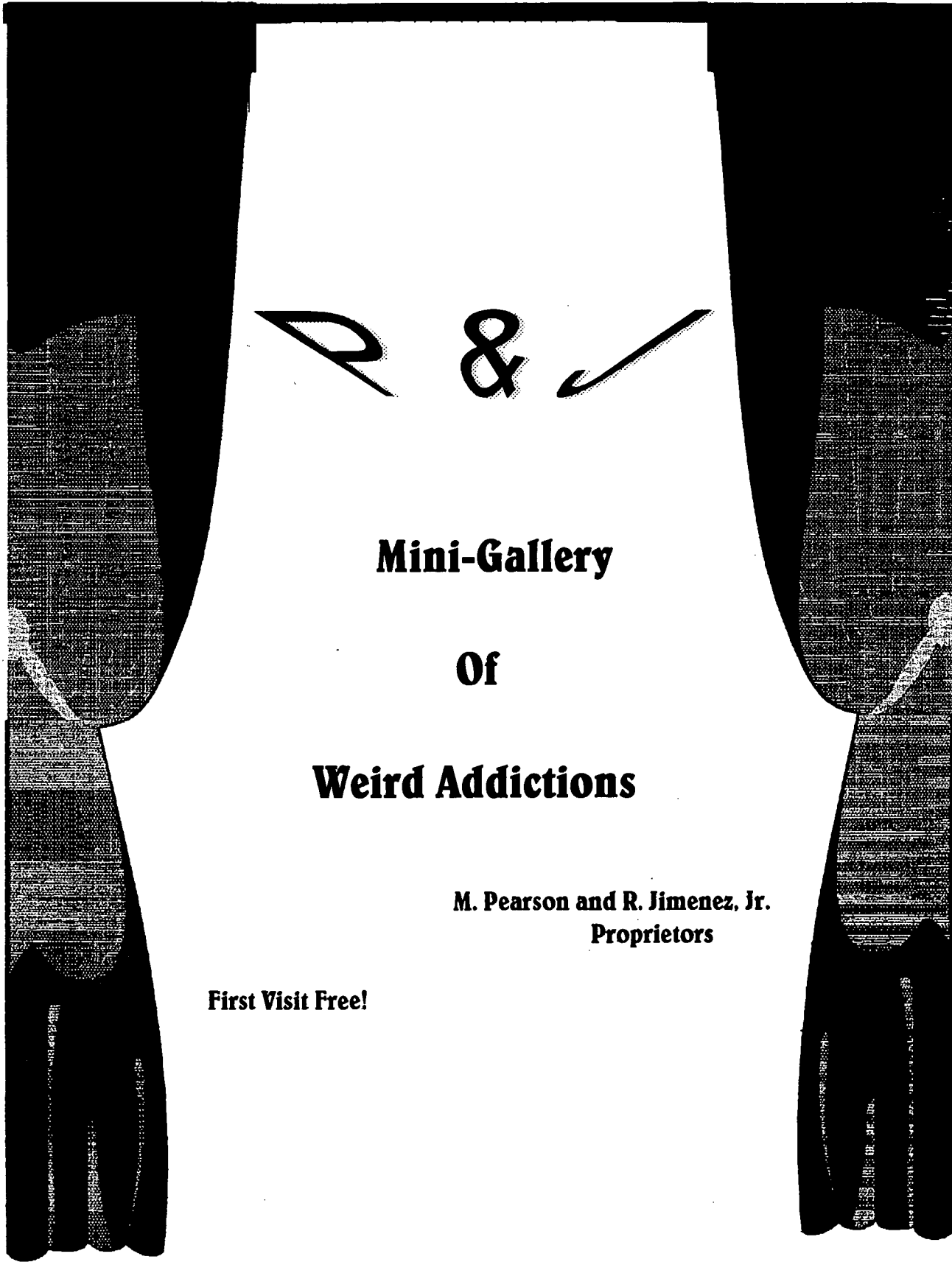
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## **BIOs**

**Rudy Jimenez, Jr.** is majoring in Business Administration and will graduate in June, 1999. He is employed at Lawrence Livermore Laboratory as a technical coordinator. Rudy is the father of three children.

**Mary Pearson** is an undergraduate student at National University. She has worked with children in various settings for seven years and is currently working with Autistic children. Her goal is to receive a BA and a multi subject teaching credential. Mary's work has appeared in "*Minefields in the Way: Growing Up In America,*" ICA Publishing, 1998.

A stylized graphic of a window with curtains. The window is white and framed by black curtains. Inside the window, there is a sign with the letters 'R & J' in a decorative font. Below the sign, the text 'Mini-Gallery Of Weird Addictions' is written in a bold, sans-serif font. Below that, the names 'M. Pearson and R. Jimenez, Jr.' and 'Proprietors' are listed. At the bottom of the window, the text 'First Visit Free!' is written. The entire graphic is set against a white background.

**R & J**

**Mini-Gallery**  
**Of**  
**Weird Addictions**

**M. Pearson and R. Jimenez, Jr.**  
**Proprietors**

**First Visit Free!**

## Addiction To Beanie Babies

A California woman was sentenced to six months in jail and five years' probation on the condition that she doesn't touch her drug of choice: **BEANIE BABIES!**

The woman, Tamara Dee Maldonado, 25, became obsessed with the beanbag toys while working at a McDonald's where she had to stuff Beanie Babies into Happy Meals.

Obsessed, she began to buy them, via the telephone, using her own credit cards and continued, when that wasn't enough, to order them using stolen credit card numbers.

Said Maldonado: "It was like a drug; once I started, I couldn't stop. It was like being addicted." As part of her sentence, she agreed to allow authorities to search her home, without warrants, to make sure she doesn't have any of the contraband toys.

Reported in The Sacramento Bee, 11/21/98



## **Addiction To Loud Music**

Have compassion, brethren! The next-door neighbors' loud music, which you hate so much, may not necessarily be attributable to the fact they are inconsiderate. They may be addicted!

In a study, just reported in the December 15, 1998 issue of *The Journal of the American Auditory Society*, a number of people were identified as having "Maladaptive Music Listening" syndrome.

In their case, music, like alcohol, heroin and nicotine, has the capacity to induce rapid and potent changes in mood and level of arousal, the ability to reduce negative states, and the tendency to elicit the experience by craving.

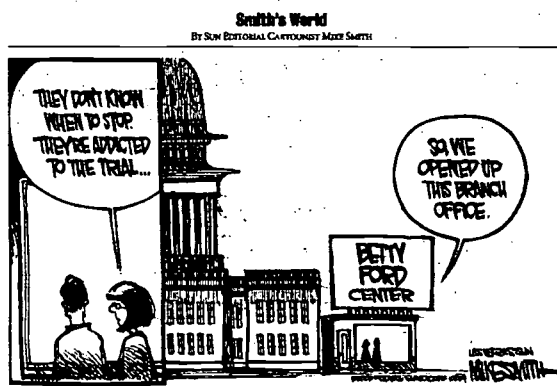
One of the prime characteristics of addiction is continued use (exposure), despite the threat of overt physical or emotional harm. So, Maladaptive Loud Music listeners certainly fit into the category of addicts.

-Reported in *The Los Angeles Times*,  
January 10, 1999

## Addiction to Monicagate

The American populace is becoming addicted to the investigation of President Clinton's sexual exploits and the ensuing impeachment trial.

Mike Smith, one of the finest Nationally Syndicated cartoonists, has depicted the problem in exquisite form.



Las Vegas Review Journal, January 31, 1999

## **Addiction To Good Grades**

According to Professor Bonilla many students become addicted to good grades and will do anything to get an A, or A+, if available. They will cheat, if necessary, and may even resort -sometimes- to study, in order to get a good grade.

*Yes, you read it right, study, in order to get a good grade! Can you believe it?*

Lack of cooperation from teachers, professors and the like, however, simply fuels these individuals' craving for an A or A+; but, as is the case with other addictions, when a good grade is not received, anxiety and depression may result. "Who knows?" even suicidal tendencies may show up.

*Said Dr. Bonilla:*

*"It is a sad thing, really."*

Bonilla, C.A. "Observations and Musings About Students Behavior in My Classes." unpublished.





# **Recovery**

**Compassion, Understanding and Love**

**The Essential Ingredients**

# Spirits in The Trenches

By Jennifer Abraham

For many years gone and for many years to come,  
The spirits dance in the trenches of our souls.  
For some, aimlessly as it did with Frank Duvall, and  
others with care and concern as with his wife, Nancy.

I watched Frank work hard in the coal mines,  
Feeling he could never make ends meet.  
A bull of a man, tall with broad shoulders,  
he attempted every trick of the trade to get ahead.  
Always needing more— new boots, an overcoat, a car,  
for himself, and a dress, jewelry, appliances, for his wife.  
Needing so much, he began to lose to the aimless spirits  
that danced constantly in his head.

Nancy, a loving soul, did everything to keep Frank happy.  
A house well kept, good hot food on the table, and  
a cheerful smile to ease the pain. Each day her man  
trampled through the door from the mines, cold and angry.  
As she cheered him on, the spirits about her kept her full of hope.

Frank began losing his battle for sanity.  
He began to fight with a bottle - spirits in the bottle  
against the spirits of his soul. Frank would laugh.  
He became happy with his spirits and sought them every  
evening after work. The aimless spirits moved in and  
he became friends with his bottle of joy. Friends so much  
that he began to talk to the spirits. "I'm tired of this shit. I don't have  
to work. I can make it without that stinking job.  
I don't need her either. I don't need nobody. To hell with Nancy,  
I say, to hell with her and her so-called love."

Nancy noted the change, but would never leave Frank.

She tried to do more to be his comforter.

She'd have a hot tub of bubble bath with a nice bottle of Chardonnay waiting. She massaged his back and shoulders to soothe him. She was learning that for Frank, only the bottle seemed to ease the pain.

Frank felt empty inside until he guzzled on his spirits.

His life was becoming more miserable, with every drink.

After a night's binge, many times he failed to show up for work. He was argumentative with Nancy; she couldn't do anything right.

Because of his stupid outbursts and drunken stupors, his friends no longer felt welcome and visits became few.

Nancy tried to talk to Frank about his behavior.

She told him he was playing a losing game with her and with his job.

He needed outside help before they lose everything.

Frank would look at himself in the mirror and have, yet, another drink.

He knew, however, he needed to make a change.

He needed to fight a better fight against the aimless spirits.

Why couldn't he be in control like Nancy? Her spirits, were always good. She didn't need a bottle for joy.

At the brink of losing his job, Frank sought help.

He sought help from the local Alcoholic's Dependency Program.

He couldn't fight those spirits that were overtaking his soul.

Nancy encouraged him and stood by his side, through thick and thin. Now he began to win his battle.

He no longer fought spirits against spirits. He fought man against immortality. Thanks to the spirits of care and concern, Frank won his battle.

His battle against the bottle.

Now, after a hard day at work, he would have his bath, and drink hot apple cider. And Nancy, good spirited, would massage his back for further encouragement. Encouragement was truly needed, because the spirits will always dance in the trenches of our souls.

# Addictive and Compulsive Disorders



Katherine Lauderdale, BA, Jerry L. Roberson, BA, & Carlos A. Bonilla, PhD.  
An ICA Publication in Behavioral Psychology  
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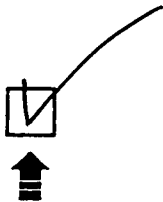
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