Illinois Institute for Addiction Recovery
at Proctor Hospital

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Winter 2002

Vol. 7 No. 1

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Spotlight

Coleen M. Moore

Coleen Moore is an energetic counselor who always strives to offer the best clinical care. She challenges herself to meet clients wherever they are at any given moment. She implements new strategies to draw her clients into the group process. Coleen received her bachelor's degree in 1996 from Augustana College in Rock Island, Illinois and her master's degree in 1998 from the Illinois School of Professional Psychology in Rolling Meadows, Illinois. Ms. Moore is licensed by the state of Illinois as a licensed clinical professional counselor, and she is certified as an alcohol and other drug counselor (CADC) and as a compulsive gambling counselor (CCGC). She is also registered as a mentally ill substance abuse counselor (MISA II).

Previously living and working in the Chicago area, Coleen and her husband desired to be closer to their families — both are Peoria natives — so they began looking for jobs closer to home. Coleen began working at the Illinois Institute for Addiction Recovery in June of 1999. She has had a desire to work with addictions ever since several of her clients appeared to be struggling with the disease. Although Coleen enjoys working with this population, it is her goal to some day work with individuals and their families who are struggling with chronic or terminal illnesses.

Ms. Moore is dedicated to improving the quality of care at the Illinois Institute for Addiction Recovery. She has been proactive in implementing and co-founding some of the programs at the Institute, including Early Intervention for Young Adults.

On a personal note, she recently celebrated her three-year anniversary with her husband, Charlie. They have no children but enjoy the company of their talkative cat, Max. Coleen and Charlie both enjoy traveling — not only to get a break from the regular routines of life, but also to immerse themselves in the history of an area. In her free time, Coleen enjoys volunteering and is an active participant in helping her community with special events. She has a great appreciation for music and enjoys attending musicals and orchestra productions. Coleen plays the piano for enjoyment and relaxation, and she even plays the clarinet in a summer municipal band.

As Coleen walks through the Addiction Recovery Center, the first thing you'll see is her smile. She is full of laughter, and people are always commenting on her radiant smile and jovial laugh.▼

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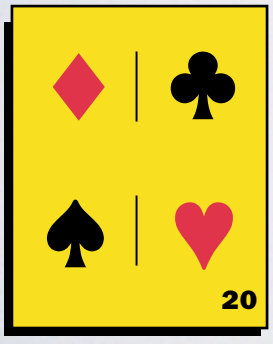
Contents Winter 2002



Cover Art Courtesy of NARSAD
Titled "Crown of Grandeur"
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Also Courtesy of NARSAD
Art on page 8 Untitled by Aranda Michaels and page 19 Untitled by Annick Hollister

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PARADIGM magazine is published quarterly by the Illinois Institute for Addiction Recovery at Proctor Hospital with general offices at 5409 N. Knoxville Ave., Peoria, Ill. 61614. Bulk Rate postage is paid at Moline, Ill. and additional offices. PARADIGM is a registered trademark of Targeted Publications Group, Inc. *and is licensed to the above publisher. No article in this issue and no part of this publication may be reproduced without the expressed written permission of the Publisher and* Targeted Publications Group, Inc. *SUBSCRIPTIONS: Subscriptions in the United States are $18.00 for one year and $36.00 elsewhere outside the United States. Back issue rate is $9.00. Send subscriptions to Eric Zehr, Proctor Hospital, 5409 N. Knoxville Ave., Peoria, Ill. 61614. Allow 6-8 weeks for new subscriptions. Allow 6-8 weeks for change of address. For more information, phone Eric Zehr at 1 (800) 522-3784.*

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In Detail: Rosalynn Carter's Advocacy in Mental Health

Rosalynn Carter has been a visible, active leader in the mental health field for more than 30 years. As First Lady of Georgia, the United States and in the years since, Mrs. Carter has pushed for reform in a host of mental health issues — reducing stigma, parity for treatment options and payment by insurance providers, greater research on the brain, better access to improved mental health services and early intervention for children.

When her husband, Jimmy Carter, was governor of Georgia, Mrs. Carter worked with other members of the governor's commission to improve services for the mentally and emotionally disabled. As First Lady of the United States, Mrs. Carter served as honorary chair of the President's Commission on Mental Health. Within one year, the commission made recommendations for new legislation through a series of public hearings across the country. In September 1980, Congress passed the Mental Health Systems Act.

Today, she continues her advocacy on mental health issues through The Carter Center in Atlanta. Founded in 1982, the Center is dedicated to improving the quality of life for people around the world through health and peace programs. Mrs. Carter chairs the Center's Mental Health Taskforce and guides the activities of the Mental Health Program, which works to:

- Reduce stigma and discrimination against people with mental illness
- Promote services for young children and families that focus on prevention of mental illness and early intervention
- Promote fair and non-discriminatory access to quality mental health care
- Increase global awareness of relevant issues and improve status of mental health worldwide

In addition to working with mental health professionals, the program awards fellowships every year to U.S. journalists writing or producing works on mental health issues, as they are often the best communicators to the general public. Beginning with the 2001-2002 class of fellows, two international fellows from New Zealand will be included.

In 1985, Mrs. Carter initiated the Rosalynn Carter Symposium on Mental Health Policy, which brings together representatives of national mental health organizations to focus and coordinate their efforts on key issues. They have investigated such topics as mental illness and the elderly, child and adolescent illness, family coping, financing mental health services and research, treating mental illness in the primary care setting and stigma and mental illness. The success of the symposia led to the formation of the Center's Mental Health Program in 1991.

Responding to the need for local collaboration, she instituted an annual Georgia mental health forum in 1995. Designed to focus primarily on mental health concerns within Georgia, the forum brings together field experts, advocates and consumers. Forum issues have included improving access to quality mental healthcare and reviewing legislation that impacts the mental health community.

Following each symposium and forum, The Carter Center's Mental Health Program publishes a report that summarizes recommendations from the meeting and suggests strategies. These comprehensive reports are then distributed to thousands of mental health organizations and other appropriate parties nationwide.

Additionally, the program has produced a video, "Coping With the Stigma of Mental Illness." Filmed at The Carter Center and narrated by Joanne Woodward, the video features Rod Steiger and author Kathy Cronkite relating their own experiences with depression. The video also includes remarks from Mrs. Carter, and it's available through the Mental Health Program.

At the international level, the Inaugural World Conference for the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders was held at The Carter Center in December 2000. Also, Mrs. Carter has chaired the World Federation for Mental Health's International Committee of Women Leaders for Mental Health since its establishment in 1992.

A global coalition of nearly 50 first ladies, royalty and heads of state, this committee allows the expertise and influence of these prominent women to be channeled. The committee's goals are to raise awareness about mental health issues, to identify and prioritize related needs in individual countries and to implement appropriate actions. Under Mrs. Carter's leadership, this prestigious group meets periodically to continue its work to improve mental health worldwide.

In addition to helping those with mental illness, Mrs. Carter has long addressed the concerns of those who care for them. Through the Rosalynn Carter Institute (RCI) at Georgia Southwestern State University, programs are available to improve coping skills and foster greater emotional and physical well being for caregivers.

Mrs. Carter also addresses the needs of caregivers in her 1994 book, *Helping Yourself Help Others: A Book for Caregivers*, co-authored with Susan Golant. Following on its success, Mrs. Carter teamed up again with Susan Golant to write *Helping Someone with Mental Illness: A Compassionate Guide for Family, Friends, and Caregivers*. Building on her 25 years of experience in the field, Mrs. Carter discusses the latest treatments and research. She also addresses how best to help those with illnesses such as depression, schizophrenia, manic depression, panic attacks and obsessive-compulsive disorders by being an effective, compassionate caregiver and advocate.

Mrs. Carter has received many honors and awards for her support of mental health causes including: the Volunteer of the Decade and "Into the Light" awards from the National Mental Health Association, the Dorothea Dix Award from the Mental Illness Foundation and the Nathan S. Kline Medal of Merit from the International Committee Against Mental Illness. She is also an honorary fellow of the American Psychiatric Association.▼

Founded in 1982, the Center is dedicated to improving the quality of life for people around the world through health and peace programs.

TRIUMPHING OVER AN UNSEEN ENEMY

Psychological and Emotional Processing of the World Trade Towers Attack

by Tian Dayton, Ph.D., T.E.P.

There are moments in life that can turn our world upside down — permeate our carefully constructed boundaries and desecrate our sense of an orderly and predictable world. September 11th was such a moment. Two hijacked planes flew into the world trade towers shattering glass, lives and our sense of personal safety. Stunned New Yorkers coped as best they could while events unfolded. Stories of workers dutifully turning computers off, holding the door out of politeness or sitting employees down in an orderly fashion became chilling examples of the first stage of the disaster response, shock and disbelief. In stage two, those involved began to realize that that their lives were in danger. Then stage three — panic. Men and women ran in every direction with high heels in hand and briefcases held above their heads for shelter. Others watched from office windows not believing what they were seeing in front of their won eyes. Shockwaves moved through New York as cell phones rang with people trying to contact friends and loved ones to see if they were safe. And soon, all of America and the rest of the world looked on in disbelief as the events of the day unfolded. The fourth stage, adjustment, is what we're experiencing now as we return to our normal routines process our thoughts and feelings surrounding these events; take actions to preserve our peace of mind and way of life; and make order and sense of what happened. This article outlines the cluster of symptoms that has come to be known as post-traumatic stress disorder. It is part of the legacy of trauma, the affect of which can be a loss of trust and faith in an orderly, predictable world. For anyone with a history of prior traumatization, symptoms may worsen as a result of the fallout from these events. For addicts of any kind, there is a risk of relapse when trauma is added to trauma.

This is a time to band together with family and friends, to take extra good care of ourselves and to muster up as positive an attitude as possible to meet this and the challenges ahead.

Today's Young People

For young adults, just beginning to build their lives and actualize their dreams, this represents a significant invasion of their sense of predictability and orderliness. The peaceful world they previously knew has been threatened. Because of its seriousness and suddenness, the event has been shocking and disequilibrating. With the enemy lurking in the shadows, we all feel an unidentifiable threat. Where next? How can one keep safe? What just happened?

Something terrifying happened, and people's responses vary. Even so, there is a laundry list of predictable effects caused by trauma. They are related to the fight, flight or freeze apparatus built into humans that allows us to function effectively in times of high stress. Experiencing at least some of these effects is natural. Knowing that it's normal helps a lot. It places the responses into some kind of manageable framework. This is a time to band together with family and friends, to take extra good care of ourselves and to muster up as positive an attitude as possible to meet this and the challenges ahead.

For Children

The meaning that children make out of this disaster may be magical. One nine-year-old boy felt upset because he shot down the World Trade Center towers over and over again in his video game. In his world, they always bounced back up. Here they did not. He worried about his possible complicity. Children who are already living with parental addiction are robbed of one of their primary sources of support and avenues for returning to normalcy at this critical time. They will need help from other adults to restore a sense of normalcy. Listening to their fears and anxieties while understanding that some acting out behavior may be related to this extra stress can help. Listen to the child's version of what he or she thinks happened. Explain the disaster as well as you can. Children may display a fear of continued injury, death or separation from loved ones as well as other symptoms. The more stable their environments can be and the more they witness competent adults taking charge, coping and restoring normalcy, the more reassured they should be.

Typical Reactions

You may experience any number of the following reactions and be well within a normal range. You might say these are normal responses to an abnormal situation. Some may persist over time but they should lessen as things around you stabilize.

Initial Responses

- Disbelief — events don't make sense in context of normal life; life feels surreal, like a movie
- Numbness: a trauma response that allows us to function through times of danger
- Disorientation or confusion: things aren't working in their normal way
- Somatic disturbances: nausea, headaches, heart racing, sweating, vomiting, muscle tension or soreness
- Feelings of helplessness alternating with anger or rage
- Unusual fear with an increased sense of vulnerability
- Dissociation — the mind goes somewhere else; doesn't feel in sync with emotions
- Clarity — a heightened sense of awareness

Ongoing Responses

- Sleep disturbances — trouble falling or staying asleep; nightmares
- A shaken sense of trust and faith
- Flashbacks
- Hypervigilance — waiting for the other shoe to drop; edgy; jumpy; reactive
- Free-floating anxiety
- Restimulation of previous painful emotions and memories
- Survival guilt
- Continued somatic effects — muscle soreness, tension, unusual tiredness
- Difficulty modulating emotional reactions; swinging from shut down to high intensity
- Depression with feelings of despair
- Desire to engage in high risk behaviors
- Impaired ability to conceptualize a positive future
- Desire to self medicate with drugs, alcohol, food, sex, spending etc.
- Fear for personal safety
- Denial and minimization

Bystander Reactions

In our television society, there may be many Americans and others around the world who experience some form of vicarious traumatization from watching the disaster over and over again on TV. After all, this is an attack on all of us - on our way of life in the free world. Guilt, sadness, fear, helplessness and rage, along with other symptoms mentioned above, may be a part of the reactions from those witnessing this assault from their living rooms. Much in the way an earlier generation was mobilized by Vietnam, the first televised war, people the world over are experiencing shock and horror from the events witnessed on their TV sets.

Your Personal Response to Trauma

Everyone's reaction and ongoing responses to traumatic events vary. Factors that influence how a person reacts include:

- History of prior traumatization or loss such as death, divorce or addiction
- Age or developmental level
- Preexisting personality
- Severity of the stressor
- Genetic predisposition
- Access to support surrounding the actual events and general support system

Our "At Risk" Populations

For those who have histories of addiction, neglect or abuse — present day trauma can get mixed up with the past and separating the two becomes difficult. They might feel anxious, vulnerable and at risk all over again. There might be an urge to cope in some dysfunctional ways, such as self-medicating emotional and psychological problems with excessive use of drugs, alcohol, food, sex or gambling. Acting on these urges can lead to relapse for those who have been addicted in the past. Past traumas have the potential to make this trauma feel more intense and difficult to resolve if there are unresolved feelings attached or if the trauma has occurred within the past year or so. Previous traumas that may influence how you experience a disaster are:

- Parental or spousal divorce or breakup
- A death in the family
- Living with addiction abuse or neglect
- Recent sobriety
- Losses that have had a serious and painful impact
- Serious illness

Self Care

Adequate self-care and support from others at such a critical time can make all the difference in how we experience the effects of this trauma. Here are some suggestions that can help:

- Reach out for community and support
- Restore you normal routines; return to those activities that give you a sense of normalcy
- Exercise, eat well and get extra rest
- Talk about what is happening inside and outside of you; put words to your experience
- Re-empower yourself by taking positive actions, however small, to feel better or to improve your situation or others
- Prioritize — first thing's first, take the next right action in order to counter feeling overwhelmed; keep it simple
- Restore hope in whatever ways work for you
- Try not to catastrophize or minimize; look for a balanced response
- Journal — use free writing to express your inner and outer worlds
- Cry when you need to, tears are nature's healers
- Pray and/or meditate

Take it a Day at a Time

After a traumatic event, life can be divided into "before" the disaster and "afterwards," and the ground rules may feel different for each. This can mirror previous traumatic experiences such as divorce, addiction, neglect or abuse. An example would be when you feel the need to walk on eggshells to keep something bad from happening. Trying to get opposing realities — drunk and sober life, before the disaster and afterwards — to match up and make sense can leave us feeling crazy, discouraged or confused. Don't try. Accept it for what it is, process it with any and all tools available to you, including self help groups and professional support, and keep going. Don't forsake your ordinary pleasures — laughter, dance, playing and smiling are natural stress busters and more important than ever. While you hypervigently scan your environment for signs of danger, scan for signs of beauty and hope as well — it uplifts the spirit and elevates the immune system. Look for ways to find or create positive meaning, it can be very healing. Affirming our sense of appreciation for life, helping others in need or eradicating the world of terrorism are all attitudes that can restore hope and faith. These shifts in our perception can give meaning to what feels like senseless death and destruction if we can place it into a context that has some larger purpose. We can see ourselves as rising to meet an important challenge rather than as helpless victims. Trust that has been shattered can be rebuilt, and a deeper more resilient self can be developed if we are willing to work with the effects of trauma honestly and sincerely rather than deny them.

While you hypervigently scan your environment for signs of danger, scan for signs of beauty and hope as well — it uplifts the spirit and elevates the immune system.

If terrorists have cells that can operate independently, than together we can mobilize and sustain "healing cells" that operate independently and lessen the negative effects of trauma.

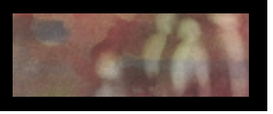
The Greek religion has a saying that is spoken at funerals after a loved one is laid to rest. It is ***"Zoës e mas,"*** or ***"life to us."*** These words of comfort reflect the accumulated wisdom that realizes our most pressing and profound human need to affirm life in the face of deep loss so that we can have the strength to go on with our day-to-day lives. ▼

Dr. Tian Dayton *is the director of program development at Caron Foundation in Wernersville, Pennsylvania and New York City. She holds a doctorate in clinical psychology, a master's in educational psychology and is a fellow and certified trainer of the American Society for Psychodrama, Sociometry and Group Psychotherapy.*

She has authored many books, including her latest — Trauma and Addiction *(Health Communications). Dr. Dayton is a national speaker and has appeared on* Geraldo, Montel Williams, MSNBC, Rikki Lake, Lifetime, The Health Network *and* Gary Null. *Once an assistant professor at New York University for seven years, she now offers psychodrama training and has a private practice in New York City.*

Its Use and Abuse in Adults and Adolescents RITALIN

by Susan Merle Gordon, Ph.D. and Karen C. Adam LSW, CAC Diplomat/CCS



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It is often abused when taken at high dosages for its euphoric effect and by students who believe that it improves their concentration and prolongs their ability to study.

When one thinks of the prescribed drug Ritalin, it's usually associated with hyperactive children and adolescents. But now there is growing evidence that adults as well as young people are abusing this often prescribed drug.[1] These adults are becoming hooked on its caffeine-like jolt and breaking the law to obtain it.

Ritalin is the brand name of a prescription drug that is primarily used to treat Attention Deficit/Hyperactive Disorder (ADHD) and narcolepsy. Its main active ingredient is the central nervous system stimulant, methylphenidate. Methylphenidate affects an important neurotransmitter in the brain, dopamine, and is thought to activate the brain stem arousal system and cortex.[1]

Although methylphenidate is similar to cocaine and amphetamines, it acts as a mild-to-moderate stimulant if it is taken within its prescribed dosage. It has a calming effect on people with ADHD and makes it possible for them to focus on tasks. But, for children and adults who do not have ADHD, they are discovering that this drug can produce an emotional high resembling an extreme caffeine-like buzz. It is often abused when taken at high dosages for its euphoric effect and by students who believe that it improves their concentration and prolongs their ability to study.

Because methylphenidate has a high potential for abuse and dependence, the federal government strictly regulates its production as a Schedule II controlled substance under DEA guidelines, which means dealing this drug is considered a serious offense. Unlawful possession of psychostimulants and selling or distributing them can lead to a prison term or a fine of up to $10,000 under federal law. Despite this, there has been a tremendous increase in its manufacturing and use since 1990.[2] Specifically, legal production has increased over 600 percent in the past five years[2] to meet the demand for prescriptions — making the United States account for approximately 90 percent of the world's production and consumption of the medication.[2]

Psychostimulant drugs, when taken orally as prescribed, are an effective and appropriate course of treatment for ADD/ADHD. But prescribing physicians must be acutely aware that even when taken correctly at prescribed dosages, Ritalin has the potential for abuse and dependence.

Ritalin Abuse

Most illicit drug use in the United States involves drugs that are manufactured illegally and often smuggled into the country. This is not the case with Ritalin, which reaches the illegal drug market by deliberate diversion from legitimate production. Similar to other prescription medications, Ritalin is diverted through theft, illegal sales from pharmacies and users, forged prescriptions and by consumer scams involving "doctor shopping" — when a consumer obtains prescriptions from multiple physicians. ***Ritalin was listed among the top ten drugs most frequently stolen from pharmacies between 1990 and 1995***.[2]

Ritalin also is diverted to illegal use by school children, the segment of the population that abuses the drug the most. A recent survey of Wisconsin schools found that most schools did not control how Ritalin was stored or dispensed on school property, making it easy to steal, give away or sell the drug.[3] Approximately 16 percent of the students surveyed reported that they had been asked to sell, give or trade their Ritalin to other students. Even some parents have reported abuse of the Ritalin prescribed to their children.[4]

College students are increasingly vulnerable to Ritalin abuse. They begin abusing Ritalin recreationly, as well as in an attempt to stay awake, soon reaching a tolerance that requires even more of the drug. The usual progression of addiction symptoms is predictable, with drastic changes in sleep patterns that include long periods of wakefulness and "crashes" of long sleep periods. Family, friends and school performance are also negatively impacted.

Students at a New England liberal arts college were surveyed on their non-prescription use of stimulants.[5] Over 16 percent of the students reported they had used Ritalin recreationally and over 12 percent had snorted it. A majority of the students reported that they knew other students who used Ritalin without a prescription. Among traditional college students, those under 24 years of age, levels of Ritalin abuse appear to be the same as that of cocaine and amphetamine use.

There have been several cases where adults became so addicted to the high they get from Ritalin that they began to break the law. A mother in Wisconsin was suspected of robbing eight pharmacies in order to obtain more of the drug. An elementary school teacher in Utah was sentenced last year to 30 days in jail for stealing Ritalin from a school safe. And a Baltimore police officer was suspended without pay and charged with altering a prescription to obtain Ritalin.[7]

Ritalin is abused in a variety of ways, often with unrecognized consequences. The tablets are taken orally, crushed into powder and snorted or dissolved in water and injected. Ritalin is also mixed with heroin, known as a "speedball," for more potent effects.[4] The inert ingredients in Ritalin tablets are not harmful when the medication is taken orally, but they can cause serious medical complications when the drug is snorted or injected.[1] Since Ritalin is a psychostimulant drug, it is classified as an amphetamine — carrying all of the physical and emotional complications associated with the abuse of this classification of drug. These include appetite loss, tremors, muscle twitching, convulsions, severe headaches, irregular heartbeat and respiration, anxiety, paranoia and hallucinations. Injection of Ritalin also exposes the user to other dangerous consequences such as severe infections, overdose, blood clots and poisoning, skin and circulatory problems, hepatitis and HIV/AIDS. Snorting the drug may also damage the nasal cavities. Ritalin abuse can also result in fatality. A recent medical report described the death of a 19-year-old man who had been snorting Ritalin and drinking with friends. He had not abused Ritalin on a regular basis.[6]

Ritalin abuse may lead to a tolerance that requires higher doses of the drug to produce its euphoric effect. Dependence and addiction to Ritalin are characterized by increasingly higher doses of the drug that are taken during increasingly frequent binges and followed by periods of marked depression.[2] This pattern continues to escalate despite serious medical and social consequences.

Recommendations

Ritalin is not a "bad" medication. Controversy surrounds the increasing number of ADHD diagnoses and the consequent increased prescription of Ritalin. However, when used and monitored correctly, Ritalin does appear to enable people with ADHD to focus and concentrate while possibly reducing their potential for substance abuse.

Problems arise when Ritalin is not taken therapeutically. Young people and adults who think that Ritalin isn't dangerous need to be educated about its potential for abuse, dependence and death. Stricter controls on how Ritalin is dispensed in public settings, such as schools, need to be developed. All those take or are involved with someone who takes the drug should be educated about adverse side effects.

Drug and alcohol clinicians need to be aware of this trend of Ritalin abuse and be prepared to treat both the addiction and ADD/ADHD concurrently in order to prepare individuals for an appropriate recovery program. Treatment of the addiction to psychostimulants should include assistance in coping with the physical and psychological symptoms of Ritalin abuse. Many individuals think that they are no longer able to think clearly at work or school, as the high created by the psychostimulant had become their normal state of being.

Treatment of the ADD/ADHD and prevention of Ritalin abuse must include the exploration of medication alternatives, such as bupropion hydrochloride and methylphenidate HCI. Bupropion hydrochloride, usually prescribed for depression, has shown to be an effective, non-addictive treatment. Methylphenidate HCI is like Ritalin in that it's also a psychostimulant, but it's formulated to be non-crushable and generally taken only once per day. This allows greater control of the medication by parents, schools and doctors. Behavioral-cognitive approaches should also be employed to assist the patient with impulse control and organization of schoolwork.

As more individuals are diagnosed with ADD/ADHD, the potential for Ritalin abuse and addiction increases. Many do not realize the potential dangers, and it is the role of prevention specialists to educate individuals about this new trend.▼

Dr. Susan Merle Gordon *is the Director of Research and Professional Training at the Caron Foundation and also has a private practice in Bryn Mawr, Pennsylvania. Dr. Gordon has more than eight years experience in counseling and psychological evaluation of chemical addiction and mental health issues and has worked extensively with women and adolescents. She has a master's degree and a Ph.D. in psychological services from the University of Pennsylvania and a psychology license from the Commonwealth of Pennsylvania. She is a member of the Pennsylvania Psychological Association, the American Psychological Association and its Addictive Behaviors Association division.*

Karen C. Adam *is the director of adolescent services at the Caron Foundation. She is responsible for the day-to-day operations of adolescent services, which includes both primary and extended care. Ms. Adam has been working with adolescents for 15 years. She holds a master's degree in social work from Marywood University, and she is a licensed social worker and a certified CAC Diplomat.*

Dependence and addiction to Ritalin are characterized by increasingly higher doses of the drug that are taken during increasingly frequent binges and followed by periods of marked depression.

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Elder RAGE

Helping Families Manage a Challenging Elder

by Jacqueline Marcell

Shockingly, Alzheimer's Disease costs American businesses $33 billion a year, largely due to lost productivity from the absenteeism of employees who must care for their elderly parents.

Healthcare professionals who haven't personally experienced the nightmare of caregiving for a difficult elder may have a hard time comprehending the heartache and despair that families go through. So often when the doctor meets with the "challenging" individual, the loved one is very pleasant and certainly not the demon that the family witnesses at home. Since the doctor will not prescribe medications for inapparent conditions, the family is sent home to suffer.

I have lived this nightmare and can attest to how devastating it is. I was a successful television executive when my life suddenly took a left turn and I had to take care of my aging parents. My once-adoring father turned against me verbally and even physically twice — and I cried rivers to have lost his love. Every professional I turned to did not have the answers, nor the compassion, for the solid year of hell I barely survived. Had just one professional understood the complexity of the problem and shown me the way, I could have been saved a lot of tears, time and our family's entire life savings.

I had been the light of my father's life, but the stress of my mother's near death illness pushed him over the edge. He did and said things I never thought possible — especially to me, his favorite. Yet when I'd take him to the doctor, he'd act totally capable, loving and normal. I had grown up with his raging temper tantrums, so I assumed that this was just more of his bad behavior — intensified by old age and a lifetime filled with stress — which it was, but it was *also* the beginning of Alzheimer's Disease. Unfortunately, since I had no experience with any kind of dementia, I just didn't get it.

Once, when I discarded two little dilapidated hand towels, my father threw them at me — screaming and swearing for having gotten rid of them. I was stunned and sobbed my heart out. With the knowledge I have now, I would say, "This seems illogical — this seems irrational. **A BIG flag — it is!**" I wouldn't get mad or hurt, I would recognize this as a warning sign and haul him off kicking and screaming to the Alzheimer's Association's highest recommended geriatric dementia specialist for evaluation. I would have known not to waste time with his regular doctor who didn't specialize in dementia nor take the time to perform the tests that could uncover it.

Recognizing Dementia Symptoms Before It's Too Late

The stereotype of a person with dementia, of which Alzheimer's is just one of many types, is that of someone who doesn't know what they are doing. Often that is the case with stage three, but it is a long road that passes through stage one and stage two first. One out of every 10 people has some form of dementia by the age of 65, with one out of every two by the age of 85. Since the fastest growing segment of our population is comprised of 85 years and older, a lot of unprepared families will soon need professionals who can help them understand the subtleties of this disease.

Dementia starts *very* intermittently and is generally ignored by families and many doctors at the early stage, mainly because they incorrectly believe that the occasional strange behavior is senility andr just a normal part of aging. Because there are usually long periods of normalcy in between, the tendency is to forget about any irrational incidents once the loved one is back to acting normal — rather than seeking treatment immediately.

It is imperative for everyone to know the early warning signs of Alzheimer's *(see sidebar page 11)*, because the dementia symptoms may be improved with medication such as Aricept, Exelon or Reminyl. Since stage two often requires fulltime care, seeking early treatment and keeping a loved one in stage one as long as possible can save families a lot of heartache and money. Early diagnosis can also save our society the burden of caring for so many elders who progress into stage two sooner than need be.

Shockingly, Alzheimer's Disease costs American businesses $33 billion a year, largely due to lost productivity from the absenteeism of employees who must care for their elderly parents. If everyone knew the warning signs and reached out to specialists early, much less time would be lost in the workplace — and much less frustration would be experienced in the home.

Behavior Modification Techniques

Once the brain chemistry is properly balanced for the dementia, the often-present depression and possible aggression, behavior modification techniques of rewards and consequences may help with difficult behaviors.

As amazing as it sounds, the use of tough love, coupled with rewards and consequences, worked to turn around the most obstinate man on the planet — my father. By being 100 percent consistent and only rewarding and encouraging his good behavior, I was able to change his life-long behavior patterns of screaming and yelling to get his way. As my mother would say, he finally learned that he could catch more flies with honey than vinegar.

We learned not to argue with him and practiced using distraction instead. We developed a calm attitude — giving simple directions with direct, soothing language. Since he loved the affection he got for good behavior and hated that we walked away from him when he was yelling at us, he gradually started to behave better. We also validated his feelings and gave him a sense of control over many things - thereby allowing him to feel in charge of his own life while removing much of the frustration.

Adult Day Health Care

Once we got my father chemically and behaviorally balanced, Adult Day Health Care helped my parents rediscover the joy of living. Previously they would lie in bed, simply waiting to die — but now they had a place to go with friends to see. This gave them the social, physical and intellectual stimulation on an everyday basis that they were not getting at home. Oh yes, my father hated it at first, but gradually he got into the routine and looked forward to it. Keeping busy kept him from focusing on his ill health and allowed him to spend quality time with us during the evenings and on weekends.

How to Help

As professionals, you can make a *huge* difference in the lives of the families you meet. Listen to their frustrations, be compassionate and strongly recommend a support group so they don't feel so alone or burdened. Suggest that family members try hiding a small tape recorder in a pocket to record bad episodes — allowing the severity of the behaviors to be heard and thus treated by a doctor. Let them know that you understand how many elders rarely show their "Hyde" personality to anyone outside the family. Make sure they understand that demented does not mean stupid and many manipulative behaviors can occur. All individuals employ techniques to gain control, but those suffering from dementia use them in extreme ways that often seem "over-the-top" even for them.

A Success Story

After turning around a seemingly impossible situation, I knew it was all worth the horror and heartache to hear my father say he loved me again. The ordeal compelled me to write a book so that others wouldn't have to struggle as I did.▼

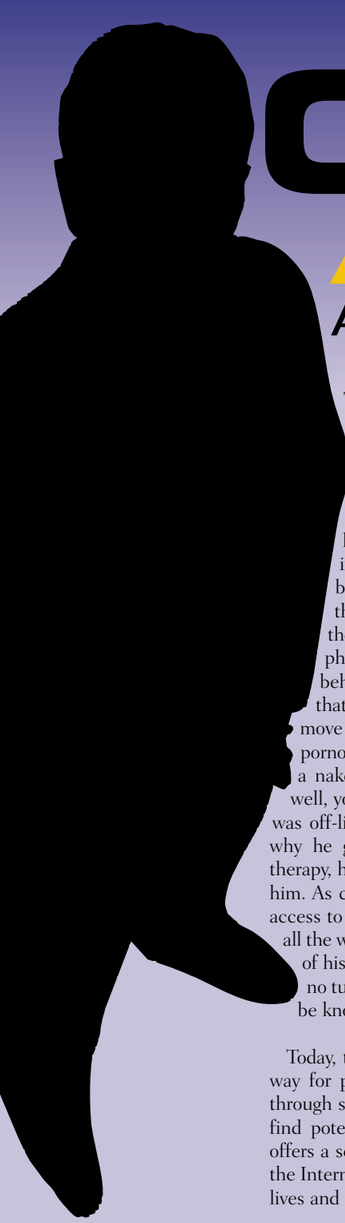
The 10 Warning Signs of Dementia

(Reprinted with permission of the Alzheimer's Association)

1. **Recent memory loss** — loved one may ask the same question over and over, forget the name of a family member or continue to tell the same story repeatedly.
2. **Difficulty performing familiar tasks** — tying a necktie or shoelaces, the knitting that one has enjoyed for years.
3. **Problems with language** — using the wrong word or unable to remember the right one.
4. **Disorientation of time and place** — mistaking hours for days or giving incorrect directions in the town that has been home for many years.
5. **Poor or decreased judgment** — for example, completely forgetting about the child they are supposed to be watching while babysitting.
6. **Problems with abstract thinking** — inability to balance a checkbook, adding becomes difficult or insisting that a one dollar bill is a twenty dollar bill.
7. **Inappropriate misplacing of things** — the wristwatch in the sugar bowl, the iron in the microwave or a hat in the freezer.
8. **Rapid mood swings** — switching from tears to anger for no apparent reason.
9. **Changes in personality** — a noticeable tendency toward fear and paranoia, for instance.
10. **Loss of initiative** — loved one may not want to get out of bed, withdraws socially or says he or she doesn't want to live anymore.

As my mother would say, he finally learned that he could catch more flies with honey than vinegar.

Jacqueline Marcell, *author of* Elder Rage, *or* Take My Father... Please! How To Survive Caring For Aging Parents, *has also been a professional photographer/cinematographer, college professor and television executive. Her book talks of a serious subject with a humorous tone — helping countless families and physicians better manage the "Jekyll and Hyde" syndrome that overtakes many elders suffering from dementia. Elder Rage, a self-help work of non-fiction that is required reading for several university graduate psychology programs, can be purchased online at www.elderrage.com or by calling Impressive Press at (949) 975-1012.*



Cybersex ADDICTION

As Lethal As Crack Cocaine

by M. Deborah Corley, Ph.D.

The first time I was exposed to cybersex was in the early 1990s. As a clinician in an inpatient residential program for professionals with problematic sexual problems, a patient requested to use the phone to have a conversation with his attorney. When I returned, he had his rather large laptop computer plugged into the phone jack. Having never seen this before, I asked him what he was doing. He replied that he had already spoken to his attorney and was then checking the "news" through a computerized phone service. I chastised him for this inappropriate behavior. As I looked over his shoulder, I saw nothing that looked like news on the screen. I asked him to move aside. There I read some of the most graphic pornography I had ever been exposed to, plus images of a naked woman tied to bedposts while her partner... well, you get the picture. Needless to say, the computer was off-limits and the patient had to explain to his wife why he got to stay longer in treatment! Over time in therapy, he described the power this pornography had over him. As classic as any addict, he described how this easy access to pornography had made his life unmanageable in all the ways crack cocaine had ruined the careers of many of his colleagues — once he got a taste of it, there was no turning back. Little did I know this was what would be known today as cybersex addiction.

Today, the Internet has created access to every possible way for people to explore, enjoy and exploit each other through some expression of sex. This has allowed some to find potential partners who share similar behaviors and offers a sense of safety due to the perceived anonymity of the Internet. For others, it has been the destruction of their lives and the lives of many around them.

With over 55 percent of American homes having access to the Internet and over 158 million users of the World Wide Web (Neilson-Net Ratings, 2001), it is no wonder that pornography Web sites have found their niche. In fact, pornography is among the most profitable businesses on the Internet, exceeded only by the sale of computer software and equipment. But viewing and downloading pornography is not the only way people engage online in sexual behaviors referred to as cybersex. People also visit sexually-oriented chat rooms, sexualize conversations in other chat rooms or exchange sexually explicit emails at home, work or any place they have Internet access. Additionally, some engage in masturbation during these activities — along with the use of alcohol and other drugs. Some people go a step further with video streaming, which enables them to request and see video footage transmitted in real-time. The ultimate step is actually meeting for a skin-to-skin encounter.

These online sexual activities are so popular because the Internet has made them accessible, affordable and in some ways anonymous. This new ability is the passport for the less affluent because you can present yourself as anyone, any age with any career and any amount of assets. In fact, in research done by Al Cooper and his colleagues (2001), over half of the over 9,000 sampled admitted to lying about some aspect of who they are. Not surprisingly, 60 percent lied about their age and 5 percent even lied about their gender. Because this "store" is open 24 hours a day, 7 days a week, you can shop while your mate is asleep or your boss is in a meeting. In fact, about 70 percent of all e-porn traffic occurs *during the workday* between 9:00 a.m. and 5:00 p.m. Since chatting, writings and many images are free; this form of entertainment is certainly affordable at the price for Internet access.

The Recreational User vs. The Abuser Or Addicted User

While the enormity of cybersex seems mind boggling, not all online sexual behavior causes problems with people. A recent survey of Internet users indicated there are three categories of people who use the Internet for sexual undertakings;

- recreational,
- at-risk and,
- addicted or compulsive users (Cooper, Delmonico, & Burg, 2000).

Using the Kalichman Sexual Compulsivity Scale (1994), the research indicated that 84 percent of the respondents did not meet criteria for cybersex compulsivity. However, 33 percent showed the early stages of cybersex compulsive use and another 6 percent suggested cybersex addiction. If you take this into account with conservatively 158 million Internet users, that's a lot of folks with a problem.

Recreational users access online sexual material out of curiosity or for entertainment but they do not report difficulty stopping or that it has caused any problems. The at-risk users have had no previous sexual addiction problems, but use the cyber activity as an escape. This group is more likely to be depressed and stress reactive. If they continue this behavior, it will most likely progress to compulsive or addictive use. The addictive or compulsive user often has a history of problematic sexual behavior and uses the Internet to act out in the same way a drug addict uses drugs. This user is unable to tolerate emotional distress, and the welcomed isolation and anonymity of the Internet allows for use to progress beyond what is controllable.

In her research, Schneider (2000) reported differences between male and female users. Males objectified the "partner" more often and preferred viewing pornography or voyeuristic behaviors. Females sought romantic relationships via chat rooms. Men were more likely to be anonymous in their interactions, while women were more exhibitionistic with their talking and video streaming. About 80 percent of the women progressed from online pursuits to real-life sex as compared to only 30 percent of the men.

Is My Client's Behavior Compulsive?

Compulsivity is the loss of the ability to stop engaging in certain behaviors. Usually the behavior feels out-of-control and people have obsessive thoughts accompanied by distinct rituals.

How Do I Know If My Client Is Addicted?

Like all addiction, cybersex addiction starts with a person engaging in behavior that results in a mood change combined with a sense of mastery over something in life. The chemical changes that occur in the brain during this type of activity actually make the person feel better for a period of time. Unfortunately, as with alcohol or other drugs, the good feeling soon wears off and requires even more of the behavior or a bigger risk to provide the same "high." Someone is addicted when the behavior or ritual around the behavior becomes all encompassing. An unhealthy or obsessive relationship with a mood altering behavior or substance develops that he or she compulsively engages in despite negative consequences. There are three indicators of this type of addiction — obsession, compulsive use and continuation despite negative consequences.

In their book *In the Shadows of the Net* (2001), Carnes and his colleagues describe ten criteria of what they refer to as problematic online sexual behavior. These include:

1) Pre-occupation with sex on the Internet.
2) Using the Internet more frequently, more often and for longer than intended.
3) Repeated and unsuccessful efforts to stop or limit use.
4) Noted irritability or restlessness when attempting to stop or limit cybersex use.
5) Using cybersex to escape from problems or relieve emotional distress.
6) Returning online in hopes of again achieving a more intense sexual high.
7) Lying to family members, therapists and others to conceal involvement.
8) Committing illegal acts such as downloading or sending child pornography.
9) Jeopardizing a significant relationship, job or education/career opportunity through online sexual behavior.
10) Incurring financial consequences as a result of engaging in cybersex activities.

TAKE THE TEST

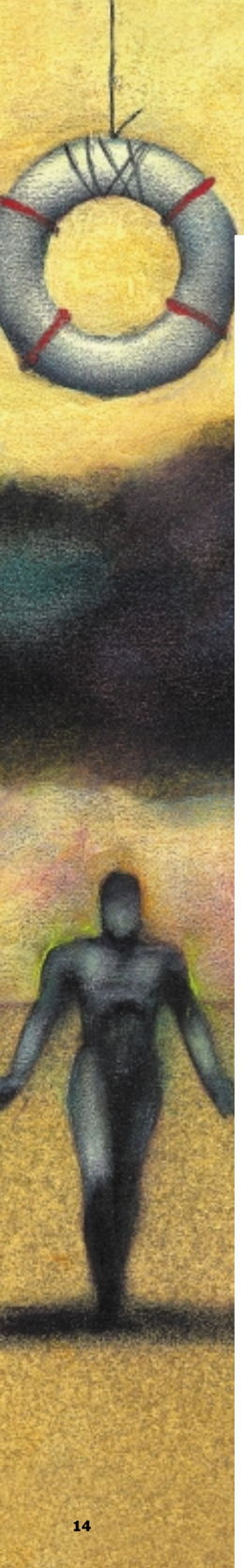
Read each statement carefully and answer honestly. Mark true or mostly true statements with a T — mark false or mostly false statements with an F.

1) I have some sexual sites bookmarked.
2) I spend more than five hours per week in online sexual pursuits.
3) I have joined sexual sites to gain access to online sexual material.
4) I have purchased sexual products online.
5) I have looked for sexual material though an Internet search tool.
6) I have spent more money for online sexual material than I planned.
7) Internet sex has sometimes interfered with certain aspects of my life.
8) I have participated in sexually related chats.
9) I have a sexualized user name or nickname that I use on the Internet.
10) I have masturbated while on the Internet.
11) I have accessed sexual sites from other computers besides my own.
12) No one knows I use my computer for sexual purposes.
13) I have hid what is on my computer or monitor so others cannot see it.
14) I have stayed up late to access sexual material online.
15) I use the Internet to experiment with aspects of sexuality such as bondage, homosexuality and anal sex.
16) I have my own Web site that contains sexually explicit material.
17) I have made promises to myself to stop using the Internet for sexual purposes.
18) I sometimes use cybersex as a reward for accomplishing something like finishing a project or enduring a stressful day.
19) When I am unable to access sexual information online, I feel anxious, angry or disappointed.
20) I have increased the risks I take online (i.e. giving out real name and phone number or meeting people offline).
21) I have punished myself when I use the Internet for sexual purposes. (i.e. Arranged a time-out from the computer or canceled Internet subscriptions.)
22) I have met face-to-face with someone I met online for romantic or sexual purposes.
23) I use sexual humor and innuendo with others while online.
24) I have run across illegal sexual material while on the Internet.
25) I believe I am an Internet sex addict.

If you answered true 19 or more times, you probably have a problem.

Today, the Internet has created access to every possible way for people to explore, enjoy and exploit each other through some expression of sex.

Continued on page 22



Transforming the Chaos:

Managing Mental Illness in the Workplace

by Rita R. Handrich, Ph.D.

On a daily basis in this country, human resource departments are overwhelmed by the time required to deal with the emotional overload of managers and workgroups affected by mental illness in the workplace. Confusion regarding the most effective responses to mental illness in the workplace has been long-standing. Recent attempts to clarify the issue (i.e., the Equal Employment Opportunity Commission guidelines for psychiatric disability) have brought it to public awareness, but have done little to provide effective responses to day-to-day workplace dilemmas. Supervisors, managers and human resource professionals need strategies that will provide consistency and equity in human resource decisions related to mental illness in the workplace. This article will focus on the impact of mental illness at work and on how supervisors can respond more effectively, professionally and humanely to employees struggling to balance psychological needs with employment responsibilities.

Supervisor Reactions to Mental Illness in the Workplace

Supervisors often find they have complicated reactions to employees with mental illness. They find themselves frustrated, dreading the employee's approach and angry or resentful over the burden placed upon the workgroup by the individual's low level of productivity. They feel sorry for the person and make ongoing exceptions for the employee. In workplace consultations with supervisors, several themes tend to emerge:

- The supervisor hopelessly feels that things won't change
- They are unsure how to respond to growing co-worker frustrations
- They feel isolated and unsupported by the larger workplace organization
- They often have had a family member with mental illness, or conversely, have had no experience with mental illness and are intimidated by it
- The supervisor feels a responsibility to do something — but doesn't know what
- The supervisor often questions his/her own sensitivity in enforcing performance standards when an employee is suspected of having a mental illness

These personal feelings are just some of the factors that discourage many supervisors from taking action to address workplace problems. Additional supervisory concerns revolve around a lack of information about mental illness and human resource policy, fears about what might happen if action is taken and, often, an uncomfortable sense that what is happening in the workgroup mirrors personal or family experiences. Of special concern is the fear of legal action by employees in response to disciplinary procedures. As a result, supervisory passiveness and a growing sense of helplessness emerge as supervisors watch their workgroups disintegrate.

Workgroup Reactions to Mental Illness in the Workplace

A relatively consistent pattern emerges when supervisors do not respond to the mental illness of a workgroup member. Often the distracting behavior is clearly observed within the workgroup, and it can be roughly broken down into eight phases:

- *Awareness* of the problem
- *Confusion* over what is happening and how to respond
- *Enabling* the co-worker by taking over work duties
- *Advising* the co-worker on problem-solving strategies
- *Resentment* grows, often toward the affected co-worker and the ineffective supervisor
- *A 'problem focus'* emerges as the workgroups' attention turns to the behavior of the mentally ill co-worker rather than to the work that needs to be done
- *Distancing* from the employee occurs with social shunning, and some employees actually leave the workgroup in frustration
- *Hopelessness* over the thought that nothing will change becomes the workgroup's general outlook — often accompanied by absenteeism and generally low morale.

What to do to Effectively Address Mental Illness at Work

In general, supervisory action plans should be to:

1) Seek consultation on effective management strategies or the specific situation
2) Refer the employee for professional help while keeping yourself, as the supervisor, focused on the work

This approach is productive from multiple perspectives (e.g., human resource management, legal and clinical). In many larger companies, this sort of consultation is available through the human resources office or through an employee assistance program. Through consultation, supervisors can identify the necessary steps to get the affected workgroup back on track. There are no simple answers and the specific strategies for addressing mental illness in the workplace will vary depending upon the circumstances of the situation — most importantly, it's necessary to consider both the employee with mental illness and the other members of the workgroup.

1) *Considering the employee* — While supervisors express concerns about what is happening in the workgroup, often the most affected is the employee. Those with mental illness often describe themselves as being in an uncomfortable position. If they do not disclose the mental illness, they can find themselves in a tense and uncomfortable work environment with deteriorating communication. Yet, if they do disclose the mental illness, they run the risk of being closely scrutinized with everyday "ups and downs" being interpreted as an aspect of their mental illness.

There is little agreement in the literature about the best ways to proceed in terms of disclosure in the workplace. Some authors advocate it while others oppose it, but most say "it depends." The strain of living and working with a mental illness is exacerbated by the ambiguities and uncertainties surrounding the issue of disclosure. When dealing with an employee with mental illness, bear in mind that the employee may be struggling with:

- Fear over how disclosing a potential mental illness wil affect work relationships
- Fear of job security due to a lack of clarity regarding workplace processes for addressing mental illness or psychiatric disability
- A sense of shame as they feel increasingly overwhelmed by and isolated within the interpersonal climate of the workplace

2) *Considering the co-workers* — Co-workers often express their feelings about workplace situations and relationships to supervisors. This expression of feelings can be difficult as supervisors are forced to walk a line between fostering communication and maintaining the privacy rights of workgroup members with various medical conditions.

Co-workers often raise important concerns related to the high levels of emotional tension in the workgroup. These tensions are closely related to our societal discomfort with mental illness. These tensions are particularly difficult for supervisors when they are expressed in the form of resentment by co-workers.

General Supervisory Strategies

There are a number of particularly effective ways to manage the work performance of employees who may be affected with a mental illness. The following paragraphs represent four general guiding principles for the supervisor.

1) *Focus on the work, not the personal* — By definition, the primary tasks of the supervisor are to manage workflow and maintain work performance. Part of this responsibility is to evaluate the performance of work duties. In instances involving mental illness, it is quite common for supervisors to simply stop evaluating performance or to evaluate in an excessively positive fashion. When the focus of the workgroup, and the supervisor, is on the "personal" rather than the "work," it is difficult to objectively evaluate due to a concern that negativity might make things worse for the affected employee. When you are not clearly or consistently communicating your expectations for work performance, the work often does not get done — or is done by other members of the workgroup. Communication should always be clear and direct with all employees, while the focus should be on the work that needs to be done. When members of a workgroup have personal problems, they should be provided with assistance to address those concerns while being offered additional support and structure so that work can be completed.

2) *Focus on the relevant, not the interesting* — Often when supervisors come in for consultations on particularly difficult mental illness situations, they are filled with details about the employee's personal life and illness history. There are often "interesting" details on which supervisors may focus, thereby paralyzing supervisory action. Remember that work performance and workplace behavior are the relevant issues. Respond with direct, clear and respectful performance feedback while referring the employee to a professional counselor, your organization's employee assistance program or human resources office for assistance.

3) *Focus on clear, performance-based goals* — What are a supervisor's goals? Ultimately they should be performance and positive, productive workgroup interactions. Clear communication and respectful treatment of all workgroup members can aid in obtaining those goals.

4) *Practice good management* — Like all employees, workers with mental illness will benefit from good management practices. *These practices are exemplified by supervisors who:*

a) Approach each employee with an open mind about his/her strengths and abilities
b) Clearly delineate expectations for performance
c) Deliver positive feedback along with criticisms of performance in a timely and constructive fashion
d) Be available regularly during the workday for consultation with employees
e) Demonstrate flexibility and fairness in administering policies and work assignments

In addition to general supervisory strategies, it is helpful to have a structured consultation process for supervisors struggling to deal with mental illness issues in the workplace. The following model describes various steps and stages of a recommended consultation model for use in the workplace.

Workplace Consultation: A Seven-Step Model for Managing Mental Illness in the Workplace

Step 1: *Recognize the dilemma and seek consultation*

When supervisors first seek help for a difficult workplace situation, they should be reminded of what behaviors are important to discuss. While it is tempting to attempt diagnosis, it is best to focus on noting specific behaviors that are causing concern as work performance is most important. By staying focused on work performance, supervisors are better able to manage the employee, the workgroup and themselves. *The following questions serves as a guide to the initial consultation meeting:*

1) What are the specific behaviors observed in the employee that are of concern?

Supervisors, managers and human resource professionals need strategies that will provide consistency and equity in human resource decisions related to mental illness in the workplace.

Continued on page 18

A Community Partnership Tackles A Community Problem

by Donald Turnbaugh

Hundreds of thousands of people with severe and chronic mental illnesses are either homeless on the streets, living at home with aging parents or locked up in jails and prisons as state mental hospitals continue to close! While attempts to improve each of these intolerable situations continue, the fact is that few residential programs could ever handle the housing of massive numbers of "longtime" homeless or a "new generation" of homeless caused by the mortality of their parents. The one place that always seems to have room is the county jail, the last place anyone would take a loved one for medical or mental treatment. It appears that these conditions will continue until the new programs are fully staffed, completely developed and sufficiently effective to have an impact on the situation. With a population of about one million persons, Pinellas County, Florida — the area surrounding the cities of St. Petersburg and Clearwater — chose not to wait for government or other funded programs.

The officers begin to realize that people with the illnesses, even when in a psychotic stage, are not criminals in the traditional sense of the word.

In July 1997, an informally structured volunteer group called the Mental Health Coalition (MHC) was formed. It was comprised of advocates, consumers, mental health providers, practitioners, elected and appointed government officials, university professors, and, most important, representatives of four law enforcement agencies. The purpose of the MHC was to focus on a jail diversion program. At that time, a similar program had been successfully operating for nine years in Memphis, Tennessee called Crisis Intervention Teams (CIT). The program had two major purposes: to provide specialized training to uniformed patrol officers in the proper and professional dealing with people with mental illness in crisis and the placement of such individuals in a program for treatment and not jail.

Early in the development of the Mental Health Coalition, all involved grasped the importance of such a program and set about the task of designing, developing and delivering one specific to their community. It took twenty months of networking, briefings, lobbying and separate subcommittee meetings, but Florida history was made in March 1999 when the first class of sheriff's deputies, police officers and state troopers completed the 40-hour crisis intervention training course.

To accomplish this task, which some doubted could be done, it took dedicated people donating their time and talent. So far, over 300 officers have taken the course, and the entire process has been cost-free to the participating law enforcement agencies. This means that even in the most modest of terms, the MHC presented the citizens of the county with a gift valued at $150,000 or more! Every one of the 13 sessions was tailored and structured to ensure that the officers would take something practical from the classroom environment that they could immediately use in the performance of their everyday duties "on the street." Difficult subject matter such as delusions, hallucinations and medication side effects are all covered in depth in layman's terms and presented by experienced mental health professionals, family members and persons with the various illnesses.

The five-day course follows a logical pattern of progression. First, an obvious segment to introduce the program's concept, objectives, goals, etc. Prior course attendees also provide real-life experiences to demonstrate the usefulness of the training. Statements such as, "I don't know how I've done my job for the past 10 years without CIT" or "In my 12 years on the job, I've received a lot of valuable training that I sometimes use, like SWAT and pursuit driving. I use CIT everyday." These endorsements are very powerful when delivered by a fellow officer in full uniform. Not to mention that all this takes place in the first 90 minutes of the course!

A surprising fact discovered during the course is that many law enforcement officers have family members or friends who suffer from serious mental illness. These officers have come forth and described very moving accounts of their individual situations and incidents. These, too, are invaluable to other officers to truly understand mental illness.

A three hour block of time is then provided for in-depth coverage of the various signs and symptoms of the illnesses as well as the medications and their often devastating side effects. This takes the officers from having a predisposition about mental illness and the people who suffer from it to a higher level of learning and understanding.

The second day is an all-day field trip to various facilities such as a day treatment program, an emergency receiving facility, supervised apartments, an assisted living facility (ALF) or care home, etc. Here, the officers and mentally ill individuals talk either one-on-one or in groups about their dealings with each other. The difference is that, in these settings, no one is in crisis or nervous. This is when the first signs of an attitude change, by both sides, is detected. The officers begin to realize that people with the illnesses, even when in a psychotic stage, are not criminals in the traditional sense of the word. And, the ill individuals see that the officers, while in plainclothes, are not the faceless, nameless guns and badges that would previously show up to calm potentially explosive situations.

By the next morning, they have learned terms such as consumer, client, patient, prisoner or worse. The time devoted to the family and consumer perspective session teaches new terms — loved one, family member, son, brother, mother. This is where a truly human face is put on the illness. Presenters are two family members and two consumers, all of whom have had considerable experience with law enforcement as a result of having or having a loved one with a mental illness. Throughout the entire course, and especially now, great care is taken to make it a learning experience of valuable practical information — not a "cop bashing" session to air long held grievances. In most instances, the damage is done when a paranoid or delusional person meets someone who is untrained and afraid. These can become "fatal encounters" that, although rare, occur more than they should.

Another compelling three-hour block of time is dedicated to aggressive, homicidal and suicidal behavior. The average citizen would be amazed at how often law enforcement responds to calls related to suicides or other attempts. The group learns that it is primarily a sense of hopelessness that drives most people to suicide, whether diagnosed with a mental illness or not. However, they also learn that people with mental illness are at highest risk.

Three hours in the afternoon are spent in discussion and video presentation concerning how to calm, assess and facilitate a person who is acting out. This is when a positive attitude and gentle approach are stressed.

Every officer in the class has received some prior instruction and most have actually instituted actions to initiate involuntary evaluations for people who are a danger to themselves or others (called the Baker Act in Florida). They all admit that this session has taught them even more valuable aspects that should be particularly useful when dealing with people in the mental health field who have not received the level of instruction the officers get in CIT!

An unusually controversial session is the one hour that covers dual diagnosis issues. While officers readily accept that people with mental illness might need to self-medicate, there is considerable reluctance to accept that all drug users suffer from some "disorder." The officers are too experienced in dealing with "pushers" and "dealers" in a different light.

The impact of the weeklong course on the attending officers is evident. On Monday, the officers arrive somewhat apprehensive and skeptical, but curious about the human mind, its workings and its impact on law enforcement. By Friday, the officers leave with a tremendous amount of knowledge, a new understanding about a chronic problem and, in most cases, a newly acquired sense of compassion concerning the difficulties dealt with by those who have mental illness affect their lives or the lives of their loved ones. As one graduate of the course with the previous reputation of being a little too "rough" with emotionally disturbed people said, "It was like having blinders lifted off my eyes."

At the present time there is no standardization of curricula for CIT courses. Even in Florida, a state that has really jumped on the issue, the version for Pinellas County is different from that of Hillsborough County (Tampa), which is different from Duval County (Jacksonville) and Orange County (Orlando)! Although each course is 40 hours, the time allocated to each session, role-playing, family/consumer perspectives, etc., differs widely. The state office of NAMI (National Alliance for the Mentally Ill) in Florida is working on developing a standardized curriculum.

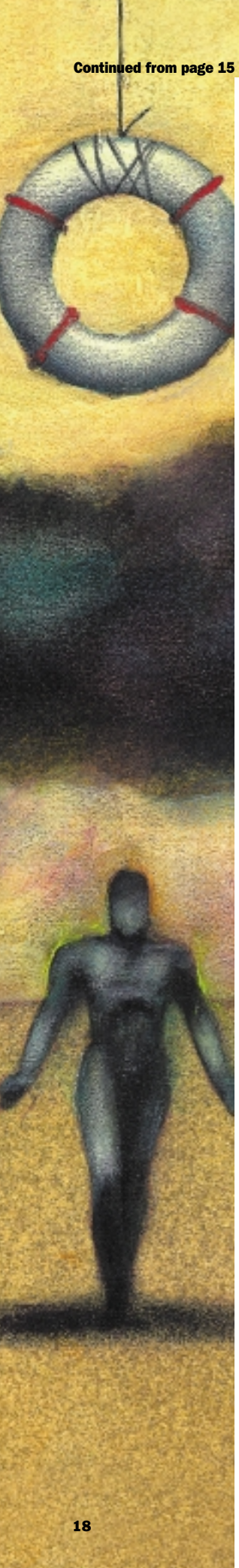
Law enforcement is involved in so many areas of society outside of "fighting crime" that their future role is being constantly shaped and reshaped. Dealing with people with mental illness is certainly one of those reshaping issues. Every change brings new meaning to the well-established motto, "To protect and serve." And, as law enforcement does more for those with mental illness, we will see that how law enforcement responds to behavior influences how society views that behavior.▼

The group learns that it is primarily a sense of hopelessness that drives most people to suicide, whether diagnosed with a mental illness or not.

Donald Turnbaugh *was in law enforcement for over 35 years — five as a police officer in Baltimore and 30 with the U.S. Customs Service, where he retired as a special agent in charge. He is now chair of NAMI, Florida's decriminalization committee.*

For additional information about CIT, you may contact the author at (727) 942-8140 or turnj@aol.com. Major Sam Cochran, Memphis Police CIT Coordinator, can be reached at (901) 545-5735.

Continued from page 15



2) What warning signs are visible in the workgroup?
3) What has kept action from being taken before now?
4) What are you afraid will happen?

Step 2: *Clarify the facts of the situation*
In step 2, supervisors need to identify what is real — to gather "just the facts." Typically, before you can get to the facts, it helps to review the history of the experience. This process also helps to reveal the larger impact on the workgroup. During a consultation with the human resources or a mental health consultant, hypotheses are made as to whether the situation described appears to be related to behavioral problems, to mental illness or to conditions described as a psychiatric disability under the Americans with Disabilities Act (ADA). *The following questions may help in classifying the situation:*

1) When did this dilemma/problem begin?
2) How serious is this situation? Are there risks for physical safety?
3) Has work within the workgroup been redistributed? Is work being done?
4) What is the relevance of ADA or other statutes/policies in this situation?
5) What do you think are your responsibilities?

Step 3: *Understand and manage workgroup response*
In this step, it is important to analyze the particular workgroup dynamic. Recall that workgroups go through fairly predictable cycles when mental illness comes to work. Part of being able to move forward with the action steps in this model requires understanding of what is happening in the workgroup to prepare for likely responses. *First understand and then manage the workgroup response by focusing on the following three issues:*

1) Learn the workgroup dynamic (and where the workgroup in question falls)
2) Identify obstacles to change (from the employee, the supervisor, the supervisor's management chain and from the workgroup)
3) Develop an action plan and identify supports for the supervisor

Step 4: *Take the first step*
Step 4 often instills enormous trepidation in supervisors. Sitting down with an employee and honestly discussing workplace performance problems can be daunting even on a good day. When considering the reality that, in some situations, work performance has not been discussed for an extended period of time, that the workgroup is in disarray and that a supervisor may be feeling overwhelmed and responsible, the task can appear insurmountable. It doesn't have to be. Planning what to say and remembering that work is the focus can go a long way to creating a feeling of calm. Simply remember that it's only a conversation with an employee about his or her work.

Step 5: *Monitor the employee's progress*
This is critical. Many supervisors complete step 4, breathe a sigh of relief and never ever approach this topic again! Needless to say, things are soon back to where they started and tensions build quickly. Think about what this lack of follow-through will communicate. It says that there are no consequences for lack of work performance and the supervisor is not to be taken seriously. These are hardly the messages to communicate to employees. In many cases, clearly communicated expectations and subsequent feedback on performance will result in satisfactory performance. In these cases, the supervisor continues to monitor performance and provide coaching as needed. In other cases, there will not be an improvement in performance, despite multiple efforts to provide adequate coaching. In the latter cases, it is necessary to proceed to step 6.

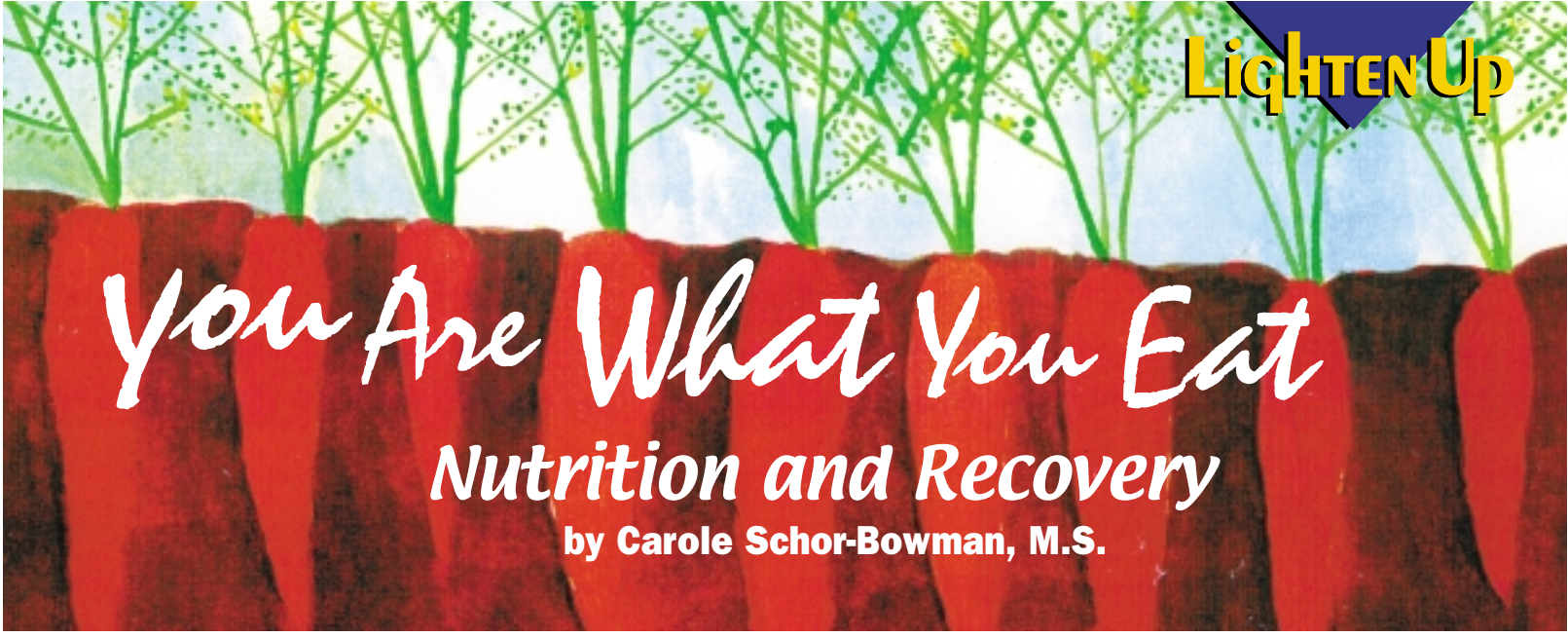
Step 6: *Follow-through with disciplinary consequences*
At this point, the supervisor moves into standard performance management mode. The message is that meeting work performance expectations is necessary and that there are consequences to a lack of work performance. [For this step it is important that supervisors consult with their human resources office to ensure that all actions taken are consistent with company or institutional policies.] This step is often a very difficult one for supervisors to complete. There are often questions about whether it is cold or unfeeling to enter the disciplinary process with an employee in the midst of personal distress. It can be helpful at this point to remember that without consequences, there is often no impetus to change behavior. The supervisor's responsibility is both to the other employees and the employer. Providing employees with a fair opportunity to get help and to improve the situation within a reasonable timeframe is the most that any supervisor can hope to accomplish.

Step 7: *Debrief and solidify learning*
This step helps supervisors to review the situation and educate themselves on handling potential future situations. Some supervisors may find it difficult to see the importance of reviewing a situation that has been resolved when there is so much other work that demands attention. Supervisors should take the time to let the HR representative or mental health consultant know how the situation has concluded, either by phone, email or in person. It's then important to learn how to apply these lessons to future situations at work.

Summary

Learning strategies that aid in attending to work performance issues rather than personal concerns and using consultation to effectively tailor interventions for specific workgroup concerns can help supervisors feel more confident and competent to manage even the most difficult situations. While mental illness issues are challenging to supervisors, good management practices, clear communication, unbiased expectations for work performance and making adjustments (sometimes known as "reasonable accommodations") to allow each worker to do his or her best all represent practical strategies through which the workplace can be better for people in general as well as for those people who happen to have mental illnesses.▼

Dr. Rita R. Handrich *is a licensed psychologist specializing in workplace training and consultation around issues related to mental illness at work. She can be reached at rhandrich@austin.rr.com.*



You Are What You Eat

Nutrition and Recovery

by Carole Schor-Bowman, M.S.

You are what you eat. A funny thing to say to people in recovery. We're concerned about what our clients drink and what drugs they take, not the foods they eat. And that's the problem.

Everything you put inside your body has an effect — good or bad. What is your body made of? If you answered food, drink and air — you're right. After all, what else is there?

Congratulate your clients on their recovery, but don't stop there. Now it's your responsibility to lay the groundwork for a healthy life and a strong body. Recovery means more than abstaining from alcohol and other harmful substances. It means changing negative behaviors into positive ones. It means rebuilding damaged cells, tissues, organs, bones, muscles and brain matter that are the result of abuse.

For instance, all alcoholics are malnourished because they don't get nutrition. The resulting effect on the liver is insidious, as the body is unable to metabolize the excess of alcohol. Even worse, the damage is deceiving as it actually makes the abuser feel better. Alcohol in the body converts to acetaldehyde, a substance that is poisonous and must be expelled. In the nonalcoholic liver, this poison is rapidly turned to acetate and eliminated. In the alcohol abuser's body, the system malfunctions — breaking down the alcohol way too fast and eliminating the acetaldehyde way too slowly. This toxin begins to attack the brain, which doesn't react as though it's sick. The brain enters a state of euphoria, making the alcoholic feel elated and craving more to drink.

This poison offers no nutritional value to the body, yet its ironic effect on the brain means that the more one drinks — the more one feels satisfied. Therefore, the more one drinks — the more one becomes malnourished.

Alcohol blocks the absorption of essential vitamins and minerals. It irritates the esophagus and inflames it. It destroys the stomach and causes poor digestion, diarrhea, constipation and acid indigestion. Internal organs are repeatedly abused and slowly destroyed by too much work and not enough fuel.

Recovery is a glorious and worthy goal — but without nutritional therapy, many abusers will never fully recover. A study by the American Dietetic Association found that "Those receiving nutritional therapy experienced less cravings for alcohol." (Reid, Janet, *Journal of American Dietetic Association*, April 1991) Nutritional therapy not only eliminates the cravings for alcohol, it also repairs the internal damage that has been done by years of abuse while also balancing the body's blood sugar.

Sugar. Ahh — so sweet, but oh so evil. To the alcoholic, sugar and alcohol are almost the same. Look around a recovery room and what do you see? People eating cookies and doughnuts and drinking coffee loaded with sugar. Giving up alcohol creates a need to balance one's blood sugar in order to counteract hypoglycemia. It's no wonder that the symptoms of low blood sugar — irritability, depression, aggressiveness, insomnia, fatigue, confusion, nervousness and a desire to drink — are the same symptoms of dry drunkenness.

How does one go from substance abuse to sugar addiction to wellness? Start with nutritious, healthy foods that benefit a person's body. Foods that carry vitamins, minerals and enzymes equal health. Brown foods instead of whites, whole grains instead of processed. Fibers help elimination. High complex carbohydrates metabolize slowly and leave behind needed nutrients. Lean proteins repair tissues and build cells. This is the road to recovery, a route of constant peace and harmony — inside and out.▼

After all, you are what you eat.

Recovery is a glorious and worthy goal — but without nutritional therapy, many abusers will never fully recover.

Carole Schor-Bowman *is the owner of Body Benefits — a company dedicated to coaching clients on total wellness, nutrition and weight management, stress management and successful life achievement. Carole is the former Wellness and Nutrition Director for the Safety Harbor Resort & Spa near Tampa, Florida where she developed a series of daily lectures on motivation and success, nutrition and wellness, and a variety of other topics related to integrative medicine and alternative therapies.Carole also has a Masters degree in Holistic Nutrition and operates a low fat catering company. She continues to author articles and is working on a book. Carole can be contacted at bodybenfts@aol.com or (310) 428-3287.*

Frequent Gambling in Adolescents

♣ | ♦ | ♠ | ♥

Who Plays Which Game Matters

by Lera Joyce Johnson, Ph.D. and James R. Westphal, M.D.

The adolescents in therapy today have emerged from an environment rich with gambling opportunities and advertisements that herald its glamour. They have grown up with electronic-game toys and embraced the point rewards gleaned from much practice. It should not be surprising to find that these same young people have transferred their fervent zeal to earn points from toys to winning real money at gaming activities. Research has shown that frequency at play is a reliable predictor of problem gambling. More importantly, this research shows which games are better predictors of gambling problems in boys and girls within different ethnic groups.

Some barriers arise from the adolescents' denial of their problem behavior or their lack of awareness and/or access to gambling treatment programs.

Adolescents with gambling problems are underserved when it comes to treatment in most parts of this nation. Many reasons have been suggested for this gap between prevalence and treatment. Some barriers arise from the adolescents' denial of their problem behavior or their lack of awareness and/or access to gambling treatment programs. Some of these barriers exist because communities have not prepared their therapists quickly enough to anticipate these outcomes from the changed gaming environment. In some cases, a community's therapists are trained to help adults with gambling problems — not adolescents. The most likely culprit is that comorbid symptoms of alcohol and/or other illegal substance use are given priority in treatment over gambling problems in adolescents.

Therapists who are treating adolescents primarily for alcohol, substance use or behavioral problems and begin to detect signals of gambling problems may feel this presents a separate issue for their clients. What guidelines can researchers offer clinicians that would sharpen their attention to a potential gambling problem and trigger them to offer their client a gambling screen instrument? Two primary signals of a gambling problem are when the client lies about the extent of gambling activities and gambling losses to friends and family and when the individual continues to gamble in order to win back money that has been lost — this tendency is called "chasing." We know now that after lying and chasing, frequency of play is the next clear indicator that an adolescent is developing a gambling problem. More recently, we have found that frequency of play alone is not as strong an indicator as frequency at particular games. Further, which game played frequently differs for boys and girls within different ethnic groups.

A stratified, randomized statewide survey of adolescents' grades 6-12, who were enrolled in public or private schools in 57 of 64 parishes in Louisiana, was conducted in 1997. At the same time, data were collected from all adolescents' grades 6-12 who were residing in juvenile detention or adolescent prison facilities. The combined community and criminal justice samples yielded 13,059 responses. The survey contained questions based on the criteria for gambling disorders from the fourth edition of the *Diagnostic and Statistical Manual* that had been adjusted for adolescents (*DSM IV-J*). The survey listed 17 adolescent gaming activities, including licensed games that would have been illegal for students under age 18 (legal age is now 21). Students were asked if they had ever played each game and if yes, whether they played the game never, less than monthly, monthly, weekly or daily in the past year. A frequency index was created that indicated which games were played on a daily or weekly basis. Scores on the *DSM IV-J* were used to estimate the prevalence of gambling problems. Binary logistic regressions were performed on problem gambling outcomes for the global subject pool, followed by analyses for subgroups by gender, ethnicity (Caucasian, African-American and Native American) and gender within ethnicity.

First, we generated a global profile of which games, if played frequently, best predicted a gambling problem in **ALL** adolescents across both genders and all ethnicities. Next, we generated a profile by gender that crossed all ethnicities. The profile for males and females differed from the global adolescent profile. Next, we generated a profile by ethnicity without regard to gender. Those profiles for Caucasian, African-American and Native American adolescents differed from both the global profile for all adolescents and the profiles generated for boys and girls. Finally, we generated separate profiles for males and females within each ethnic group. Every subgroup profile differed from its global referents, the overall gender profile, the overall ethnic profile and, certainly, from the global adolescent profile. These differences can be clearly seen in the accompanying table. In each subgroup, there were other games played frequently that had a greater prevalence rate than the game that presented the best prediction of gambling problems for that subgroup. Frequent play, alone, may not be the best predictor of teen gambling problems. Clinicians need to take the gender and the ethnicity of their client into consideration as they look for indicators of problem gambling behaviors.

Each state, province or community would benefit from a replication of this research to indicate the profiles that best predict problem gambling among local adolescents. The best predictors for adolescents in Louisiana could be specific to that environment. Each state or region may need to identify which games, when played frequently, present the best predictors for their subgroups — based on the unique array of gambling opportunities in their area. This research was the first study of its type. While analyses report the outcomes in three ethnic groups — Caucasian, African-American and Native American — the survey also collected data on Asian/Pacific Islanders, Hispanic youths and some adolescents that marked "other" as their self-reported racial identification. Further information could be gleaned from data on the unique patterns of males and females within these ethnicities. Similarly, replications of this study should customize racial identifications and select analyses to fit an area's target population.

It is our common goal to remove the barriers to treatment for adolescents, to recognize symptoms of problem gambling behavior among adolescents who present for other therapies and to have trained treatment providers available that can help adolescents overcome their gambling problems. Studies like this one allow researchers to provide tools for treatment providers that can facilitate the early identification of problem gambling symptoms in youths.▼

Dr. Lera Joyce Johnson *is a developmental and experimental psychologist and former assistant professor of psychology at Centenary College of Louisiana in Shreveport. She and Dr. James Westphal have conducted several research studies, made numerous presentations and published a number of articles on a wide range of gambling topics. You may contact Dr. Johnson by calling (318) 425-0135 or sending an email to drjpsyntst@yahoo.com.*

Dr. James R. Westphal *has a BS in biochemistry and an MD from the University of Wisconsin-Madison and completed his psychiatric residency at Stanford Medical Center. Now a clinical professor of psychiatry at the University of California-San Francisco Medical Center, Dr. Westphal is also the medical director of San Francisco General's substance abuse consultation service and medically assisted detoxification services. He has published research on the epidemiological aspects of gambling and organized national continuing medical education courses on gambling disorders.*

Daily Weekly	All Ethnic Groups	African-American	Caucasian	Native American
Cards	♣	♦	♥	
Races Dog/Horse	♣	♦		
Dice	♣	♦	♥	♠
River Casinos	♣		♥	♠
Slots				
Bingo	♣	♦	♥	♠
Teams	♣		♥	♠
Scratch				
Video Poker				
Lotto				
Coins				

Males Only

Daily Weekly	All Ethnic Groups	African-American	Caucasian	Native American
Cards	♣	♦	♥	♠
Races Dog/Horse	♣			
Dice	♣	♦	♥	♠
River Casinos	♣		♥	
Slots		♦		
Bingo				
Teams			♥	♠
Scratch				
Video Poker				
Lotto				
Coins				

Females Only

Daily Weekly	All Ethnic Groups	African-American	Caucasian	Native American
Cards	♣	♦	♥	
Races Dog/Horse				
Dice	♣	♦	♥	
River Casinos				
Slots				
Bingo	♣	♦		
Teams				
Scratch	♣	♦		
Video Poker			♥	
Lotto			♥	
Coins				♠

... we have found that frequency of play alone is not as strong an indicator as frequency at particular games.

Continued from page 13

Severe Consequences Even When You Are Not Addicted

Not everyone who uses the Internet is an addict or a sexual predator, but naïve individuals that misuse the Internet could be asking for trouble. Take Pete, a 48-year-old attorney, who was bored with his marriage and his job. He liked to distract himself by chatting online with people at the office or while out-of-town. He had no intention of cheating on or leaving his wife, but making up stories about himself and what he would do sexually with someone else was exciting and seemed harmless. Then he began agreeing to meet people. He admitted that he was only interested in meeting them, not in having sex. Since he fabricated much about his life, he assumed others did as well. When Pete chatted with a 14-year-old girl interested in meeting older men, he assumed it was a story and went along with it. Unfortunately, it ended up in a meeting that was actually a sting operation. He was quickly arrested and his life forever changed.

Most employers have strict policies about the use of office Internet and unless one is a computer expert in hiding or erasing online evidence — there will be a trail that experts can follow.

While most people don't experience this drastic a consequence, others have lost their job or have been sued for sexual harassment due to the downloading of pornography. Most employers have strict policies about the use of office Internet and unless one is a computer expert in hiding or erasing online evidence — there will be a trail that experts can follow.

The impact on married couples and their sexual lives can be profoundly affected by all levels of cybersex. Often the "high" and fantasy that accompanies cybersex creates an expectation of a spouse that sexual encounters will somehow match that of the cybersex. Even those with a good sex life find it difficult to compete with what exists on the Internet. Many partners report that cybersex feels like an affair.

Finally, another disturbing aspect of cybersex is the potential to accidentally expose children to it. We have yet to understand the impact this type of exposure has on children because it is often met with anger or shame. Often the child, especially teenage boys, will become hooked on cybersex.

How To Balance Online Use With Safeguarding The Home

I advise parents to have a frank discussion with their children about the hazards of online pornography and chat rooms. I also recommend installing software that filters out sexual materials. Parents should encourage younger children to tell them about unsolicited encounters with online porn (entering Niki.com instead of Nike.com is an example of a shocking mistake!).

Orzack & Ross (2000) suggest that people who are trying to stop addictive or compulsive behavior set obtainable goals for online or computer use. Additionally, they encourage clients to keep a daily diary of emotional triggers associated with how the computer is used and how often. Sometimes it is necessary for clients to schedule periods of abstinence that they adhere to with an alarm clock.

Jennifer Schneider and Rob Weiss, in their excellent and very practical book *Cybersex Exposed* (2001), offer sound advice not only for curbing problematic behavior, but also for safeguarding the home computer environment. Here is what they suggest:

- Move the computer to an open area where anyone can see what is being viewed
- Don't use the Internet when alone if possible
- Use the computer only for specific, planned tasks
- Go online with family members
- Add Internet safety tools and screens
- Arrange for accountability at work

How To Find A Trained Therapist When Efforts Do Not Work

Contact the National Council on Sexual Addiction and Compulsivity for a list of therapists trained to treat sexual addiction or try one of these other resources:

NCSAC
PO Box 725544
Atlanta, GA 31139
770-541-9912
www.ncsac.org

Sex Addicts Anonymous
www.sexaa.org

Recovering Couples Anonymous
www.recovering-couples.org

In the Shadow of the Net (2001) by Carnes, Delmonico, Griffin and Moriarity from Hazelden Books.

Cybersex Exposed (2001) by Schneider and Weiss from Hazelden Books.▼

Dr. M. Deborah Corley *is in private practice and consults with several treatment centers and physician's health programs throughout North America. She is also co-owner and co-founder of Sante Center for Healing, a residential addiction treatment center near Dallas and currently serves as their Director of Research and Family Services. A past president of the Board of Directors for the National Council on Sexual Addiction and Compulsivity, Deborah has received numerous awards for her outstanding achievements in the field of sex addiction. Trained as a mediator and licensed both as an addiction specialist and marriage, and family therapist, Deborah has over 20 years experience working with and conducting research on addictive disorders. The author of many articles, she has just co-written a book entitled,* Disclosure of Sexual Secrets, *that is due out spring of 2002. She may be reached at mdcorley@msn.com.*

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Kalichman, Johnson, Adair, Rompa, Multhauf and Kelly. "Sexual Sensation Seeking: Scaled Development and Predicting AIDS-Risk Behavior Among Homosexually Active Men," *Journal of Personality Assessment.* 62, 385-397. (1994)

Orzck and Ross. "Should Virtual Sex Be Treated Like Other Sex Addiction?", *Sexual Addiction & Compulsivity: Journal of Prevention and Treatment.* 7,113-125. (2000)

Schneider and Weiss. *Cybersex Exposed.* Hazelden Books: Minneapolis, (2001).

TRAINING SCHEDULE FOR 2002

ILLINOIS INSTITUTE FOR ADDICTION RECOVERY

March 22, 2002
***Topic:* Addiction, Spirituality and Special Populations**
Father Jim Mallon, Ph.D., C.A.C.

June 7, 2002
***Topic:* Cunning, Baffling and Powerful — The New Brain Science of Addiction, Trauma and Shame**
Thomas Hedlund, M.F.T.

October 4, 2002
***Topic:* Internet Gambling, Day Trading and Stock Market Gambling — 2002 and Beyond**
Kevin O'Neal, L.C.S.W., C.C.G.C., C.A.D.C.

Above trainings will be held at the Proctor Professional Bldg., Peoria, IL. For registration and lodging information, call 1(800) 522-3784 or visit the Web site at www.addictionrecov.org.

CEUs approved by: EAPA/EACC, Illinois Department of Professional Regulation for Social Workers and Professional Counselor/clinical counselors and the American Academy of Healthcare Providers in the Addictive Disorders

Additional Training
Call for Dates

- Food Addiction
- Sex Addiction
- Internet Addiction
- Advanced Pathological Gambling Training

PROCTOR
Illinois Institute
for Addiction Recovery

If you have questions regarding addictions, call 1 (800) 522-3784, or write to Eric Zehr at Proctor Hospital, 5409 N. Knoxville Ave., Peoria, IL 61614. On the Internet, contact: zehr@bitwisesystems.com. For more answers, visit our interactive Web site at http://www.addictionrecov.org

PROBLEM/COMPULSIVE GAMBLING COUNSELING TRAINING PROGRAM

Program Purpose
The Illinois Department of Human Services, Office of Alcohol and Substance Abuse in conjunction with the Institute for Public Affairs, University of Illinois at Springfield is offering for the second year, the Problem Gambling Training Program for all counselors and therapists who want to increase their skill and knowledge in assessing and treating problem and compulsive gambling. The training program will provide participants with a strong clinical base from which to deliver problem gambling treatment services.

Overview
The program will consist of a thirty- (30) hour course delivered throughout a five-day series. Each participant will receive a copy of an IAODAPCA Counselors for Problem and Compulsive Gambling Certification: *Model and Application Manual* and a *Training for Counseling of Problem Gamblers Training Manual*.

The training is available without charge to participants employed by DHS, DHS/CASA/OMH contracted agency staff, and students enrolled in a graduate studies program. Registration is $100.00 for all other participants.

Continuing Education Units
Qualified participants may earn 30 CEUs from the Illinois Department of Professional Regulation and IAODAPCA.

Presenters
Bensinger Dupont Associates (BDA), Illinois Council on Compulsive Gambling and Illinois Institute for Addiction Recovery at Proctor Hospital, will provide the training for this program.

2002 Training Dates

January 2002
***Topic:* Problem Gambling Training Program**
January 15-17, Peoria, IL; Proctor Professional Bldg.
January 23-24, Peoria, IL; Proctor Professional Bldg.

February 2002
***Topic:* Problem Gambling Training Program**
February 5-7, Chicago, IL; Chicago Athletic Assoc.
February 13-14, Chicago, IL; Chicago Athletic Assoc.

March 2002
***Topic:* Problem Gambling Training Program**
March 5-7, Grafton, IL; Pere Marquette Lodge & Conf Ctr.
March 12-13, Grafton, IL; Pere Marquette Lodge & Conf Ctr.
March 19-21, Matteson, IL; Holiday Inn Matteson
March 26-27, Matteson, IL; Holiday Inn Matteson

April 2002
***Topic:* Problem Gambling Training Program**
April 2-4, Evanston, IL; Omni Orrington Hotel
April 9-10, Evanston, IL; Omni Orrington Hotel
April 15-18, Mundelein, IL; Crowne Plaza — Chicago N. Shore
April 23-24, Mundelein, IL; Crowne Plaza — Chicago N. Shore

May 2002
***Topic:* Problem Gambling Training Program**
May 7-9, Moline, IL; Radisson at John Deere Commons
May 14-15, Moline, IL; Radisson at John Deere Commons
May 21-23, Oak Brook, IL; University of Illinois
May 29-30, Oak Brook, IL; University of Illinois

June 2002
***Topic:* Problem Gambling Training Program**
June 4-6, Elgin, IL; Crowne Plaza Elgin
June 11-12, Elgin, IL; Crowne Plaza Elgin

For details, registration and lodging information and to request special accomodations, contact Jeri Frederick or Alice Bettis at (217) 206-7990.

We Put Troubled Lives Back Together.

The professional staff of the Illinois Institute for Addiction Recovery is uniquely qualified to help men, women and adolescents put their lives back together. We offer comprehensive addiction treatment services, intensive co-dependency treatment, corporate interventions and intervention training for family members and friends.

IIAR began treating adult and adolescent addiction and co-dependency in 1979. Since then, IIAR has become a national leader in the comprehensive treatment of addictions. Programs are established to treat addictions to alcohol and drugs, gambling, food, sex, computer/Internet use, spending/shopping and more.

There is hope. The caring, compassionate staff of IIAR offers help. For information or to make a referral call 800-522-3784

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www.addictionrecov.org