Frequently Asked Questions

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CE for Colorado Mental Health Professionals

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CE for Colorado Mental Health Professionals

Chapter 1: Elderly Abuse in America: Prevalence, Etiology and Prevention

5 CE Hours

By: Deborah Converse, MA, NBCT with Kathryn Brohl, MA, LMFT

Learning objectives

- Identify five warning signs that may indicate elderly abuse.
- List and describe five forms of elder abuse.
- Describe the prevalence of elder abuse, including gender and age.
- Discuss five facility regulations included in the Nursing Home Reform Act.
- Define five resident rights included in the Nursing Home Reform Act.
- Explain the scope and severity categories of deficiency citations.
- Describe five strategies that can be used to prevent elder abuse.
- Discuss three current trends in nursing home reform.

Introduction

Elderly mistreatment and care are critical and troubling areas in America, with state and federal governments spending far less on research and prevention compared with peer nations. On October 21, 2011, the media reported plans to cut Medicaid benefits further, affecting millions of aging Americans. As baby boomers continue to age, this becomes an even more pressing problem. The over-65 population of 39.6 million in 2009 will grow to 78 million in 2040, according to the U.S. Census Bureau (Daschle, 2008). Though the rate of disability among the elderly has declined, life expectancy continues to rise. The number of cases of elderly mistreatment will undoubtedly rise over the next several decades as the population ages.

The National Academy of Sciences published an extensive panel review of mistreatment of the elderly in 2002. The panel investigated the increasing prevalence, risk factors, social issues, legislation and research on prevention and intervention to address elder mistreatment (Bonnie and Wallace, 2002).

Since 2002, the National Institute of Justice (NIJ) has conducted additional research. Its goal was to build a body of knowledge to assist caretakers, medical personnel and law enforcement officers to recognize abuse indicators, known as forensic markers, and isolate factors that put elderly individuals at risk (Dyer, Connolly and McFeeley, 2003).

Catherine C. McNamee and Mary B. Murphy (2006) cite the following example of the scope of elderly abuse and lack of prevention:

> *To most people, Charles Cullen was an experienced nurse attending to the elderly in hospitals and nursing homes. The perception of Cullen as a devoted caretaker came to an abrupt end in 2004 when he admitted that he intentionally administered fatal doses of medication to almost 40 patients in various institutions over a 16-year period. Because most of Cullen's early victims were elderly and seriously ill, and because toxicology and other tests were not done to detect whether there had been wrongdoing, medical examiners did not classify the deaths as homicides. As a result, no criminal investigations were initiated for several years, which resulted in the loss of valuable forensic evidence.*
>
> — Quigley (2004)

Cullen's case is an extreme example of what happens when care staff and professionals fail to recognize, prevent or prosecute incidences of elder abuse.

Researchers note there are different definitions for elder abuse, and there is no "gold standard" test for abuse and neglect (Dyer et al., 2003). Those working with elders who have been abused and neglected must rely on forensic markers. This presents a problem because adult protective services agencies and physicians are not trained to distinguish between injuries caused by mistreatment and those that are the result of accident, illness or aging.

Adding to the difficulty in diagnosis is that many elderly individuals suffer from diseases and conditions that produce symptoms that mirror those resulting from abuse. Because these symptoms may mask or mimic indicators of mistreatment, their presence does not send up a red flag for physicians or medical examiners determining cause of death. Doctors may fail to recognize psychological conditions, such as depression and dementia, which may put an elder at greater risk for falling victim to abuse. Psychological conditions may indicate that neglect or abuse has taken place (Jones et al., 1998).

Even if a physician suspects abuse, police officers are rarely trained to investigate elder abuse and may not know how to interview an older adult, especially a person with dementia; may not collect forensic evidence; or may not recommend charges be brought when responding to injuries at care facilities or in homes.

At the next step, the National Institute of Justice (NIJ) researchers noted prosecutions might be impeded by the absence of qualified experts to testify to a reasonable medical certainty that the injuries were a result of abuse and neglect. Medical testimony is critical because victims are often too ill or incapacitated to provide a coherent explanation of how the injury occurred. Again, the absence of a standardized law defining elder abuse further complicates and constrains the ability to prosecute offenders (McNamee and Murphy, 2006).

The Government Accountability Office completed a comprehensive study on the effectiveness of sanctions to improve the quality of care (2005). The study concluded that even when nursing homes are inspected, issued citations, sanctioned and corrective action was enforced by state and federal agencies, some nursing homes were not deterred from repeatedly harming residents. Many facilities continued to cycle in and out of compliance, so abuse and neglect continued.

Definitions of elderly abuse

The National Academy of Science research panel has noted there is no universal definition of elderly mistreatment, and "the development of a widely accepted operational definition and validated and standardized measurement methods for the elements of elder mistreatment is urgently needed to move the field forward." (Bonnie and Wallace, 2003). The panel traced the terminology that has been used to define individuals who need care in order to receive protective services. The U.S. Department of Health Education and Welfare in 1966 defined these individuals as "people with physical and /or mental limitations, who were unable to manage their own affairs, or who were neglected or exploited" (2011).

In 1974, the Congress amended the Social Security Act to require states to establish protective service units for adults. The funding for these services came from the federal government and gave the states social services block grants (SSBG) and directed the states to provide protective services to "adults who as a result of physical or mental limitations, are unable to act on their own behalf, are seriously limited in the management of their own affairs, are neglected or exploited, or are living in unsafe or hazardous conditions" (2011).

There are definitions that outline the type of assistance required by elderly individuals. The Administration on Aging (1997) identified individuals with age-related diseases and disabilities requiring assistance in one of the following types of activities:

- Assistance with activities of daily living (ADL).
  - Eating.
  - Dressing.
  - Bathing.
  - Transferring from bed to chair.
  - Toileting.
  - Controlling bladder and bowel.
- Instrumental activities of daily living (IADL).
  - Preparing meals.
  - Performing housework.
  - Taking medications.
  - Managing finances.
  - Making phone calls.
  - Running errands.

The nursing home population tends to be older and more severely disabled than elders residing elsewhere, with about half of the residents 85 or older and about half having five ADL limitations. Four out of five elderly persons with ADL or IADL impairments live in the community setting (Alecxih et al., 1997).

Regardless of where they reside, the elderly population is vulnerable to age-related infirmities and suffering from disease and disability as well as neglect, abuse and exploitation from others, including caregivers.

The National Institute on Aging (NIA) found elderly mistreatment research had been confined to a small community of investigators who produced a limited body of knowledge. Efforts to prevent and improve the quality of care have been sporadic, inconsistent and underfunded across the United States. Because of the lack of research, the NIA asked the National Research Council to commission a study in an effort to broaden and deepen the knowledge about the mistreatment of elders. A panel was convened, and the study was completed in conjunction with the National Institute of Health, the Agency for Health Care Research and Quality and the National Institute on Aging (Bonnie and Wallace, 2003). Results from the panel study will be referenced throughout this course.

The National Center on Elderly Abuse (NCEA) defines elderly abuse as "intentional or neglectful acts by a caregiver or trusted individual that leads to harm of a vulnerable, elderly individual" (2002). It may take the form of:

- Physical abuse and neglect.
- Emotional and psychological abuse.
- Verbal abuse and threats.
- Financial abuse and exploitation.
- Sexual abuse and abandonment.
- Self-neglect.

The NCEA study notes that mental health issues and substance abuse affecting the elderly victim or the abuser are common factors in elderly mistreatment cases. Here are specific definitions and descriptions of the forms of abuse outlined by the NCEA:

- **Physical use of force** – To threaten or physically injure a vulnerable elder.
- **Emotional, psychological, verbal abuse** – Attacks, threats, rejection, isolation or belittling acts that cause or could cause mental anguish, pain or distress to vulnerable elders.
  - Even though this form or abuse leaves no physical injury, it is no less serious than physical abuse. It can range from threatening to abandon an elderly person or to put them in a nursing home to threatening the elder if he or she does not cooperate in daily tasks or taking medication. Repeated insults and shouting are forms of psychological abuse because they undermine the victim's sense of self-worth and security.
- **Sexual abuse** – Contact, force, or threatened or coerced sexual contact upon a vulnerable elder who cannot grant consent.
- **Neglect** – Failure or refusal to provide for the vulnerable elder's safety and physical or emotional needs that put the elder at risk.
- **Exploitation** – Theft, fraud, misuse or neglect or the use of undue influence as a lever to gain control over an elder's money or property.
- **Financial abuse** – May include using the victim's ATM card, checks, investments or online accounts without permission, or using the victim's power of attorney to take property or money from bank accounts. More covert forms of financial exploitation may occur when the abuser has close and frequent contact, such as a relative who lives with the victim. The caregiver with access to the elder's accounts can secretly spend monthly retirement or Social Security benefits for their own use or for other family members or friends.
- **Abandonment –** Desertion of a frail, vulnerable elder.
- **Self-neglect –** Inability to understand the consequences of one's own actions, taking actions that lead to harm or endangerment, or inaction that leads to harm.
  - Self-neglect refers to an elder person's inability to care for him- or herself or make appropriate arrangements for care. This form of mistreatment is included in most state statutes as a basis for instituting protective action to ensure the elder's safety. When intervention is warranted, it may make take the form of voluntary protective services, such as home-delivered meals or housekeeping assistance, or involuntary measures such as guardianship. The type of protective intervention service depends on the degree of self-neglect and the ability of the vulnerable elder to make rational decisions for daily independent functioning, self-care and safety.

Abusive acts often contain elements that are physical, psychological and financial. A family member may take an elderly relative home for a visit and then seek permanent guardianship over the elderly relative, arguing that he or she is no longer capable of managing home maintenance, housekeeping, personal care and financial decisions. Using guardianship as a means of control over the elder person and his or her assets can be a form of legal kidnapping when the individual is not in the position to object to the arrangement (Whitton, 2007).

Threats of abandonment or nursing home placement may pressure the elder to agree to this arrangement. Controlling family members have been known to cut off communication between elder family members and friends, isolating them from the outside world. There is an increase in the frequency of adult children fighting over their parent and their parent's assets, which have prompted some elder advocates to call these "will contests while the person is still alive" (Frolik and Whitton, 2010).

Indicators of mistreatment

As mentioned above, the NIJ research projects identified 14 potential abuse and neglect indicators known as forensic markers (McNamee and Murphy, 2006). They include:

- Abrasions.
- Lacerations.
- Bruising.
- Fractures.
- Restraints.
- Decubiti (bedsores).
- Weight loss.
- Dehydration.
- Medication issues.
- Burns.
- Cognitive and mental health problems.
- Hygiene.
- Sexual abuse.
- Financial fraud and exploitation.

In one NIJ study, researchers examined bruising, one of the most common indicators of abuse and neglect. There is a body of research on the site, pattern, and dating of bruising in children, but research on the differentiation between accidental and intentionally inflicted bruising in the elderly population does not exist.

Researcher Laura Mosqueda, M.D., of the University of California, Irvine, documented the occurrence, progression and resolution of accidentally inflicted bruising on elderly individuals (Mosqueda et al., 2006). The research indicated that accidental bruising occurred in predictable locations on older adults as follows:

- 90 percent of all bruises were found on the extremities.
- No accidental bruises were observed on the ears, neck, genitals, buttocks or soles of the feet.
- The color of the bruise at the initial appearance is unpredictable.
- More bruising was observed on individuals taking medications known to impact the blood clotting system.
- More bruising was noted on individuals with compromised functional ability.

The NIJ researchers also examined data on the deaths of elderly residents in long-term care facilities to identify potential markers of abuse. Led by Erik Lindbloom, M.D., of the University of Missouri-Columbia, the study examined coroner's reports of elderly nursing home residents in Arkansas over a one-year period (Lindbloom et al., 2005).

This ongoing research is contributing to a body of data that officials can use when they suspect that an elderly person with bruising has been abused.

The study found that a majority of coroner investigations did not raise suspicions of mistreatment, but the researchers in Lindbloom's study identified four categories of markers that often led to further investigation:

1. **Physical condition/quality of care.** Specific markers include:
    - Documented but untreated injuries, undocumented injuries and fractures, multiple untreated or undocumented pressure sores.
    - Medical orders not followed.
    - Poor oral care, poor hygiene and lack of cleanliness of residents.
    - Malnourished residents who have no documentation for low weight.
    - Bruising on non-ambulatory residents; bruising in unusual locations.
    - Statements from family concerning adequacy of care.
    - Observations about the level of care for residents with non-attentive family.
2. **Facility characteristics.** Specific markers include:
    - Unchanged linens with strong odors of urine and feces.
    - Trashcans not emptied.
    - Unclean food prep areas or previous food sanitation issues violations.
3. **Inconsistencies.** Specific markers include:
    - Inconsistencies between medical records, statements from staff or observations of investigators.
    - Inconsistencies between the reported time of death and the condition of the body.
4. **Staff behavior.** Specific markers include:
    - Staff members who follow an investigation too closely.
    - Lack of knowledge or concern about a resident.
    - Unintended or purposeful verbal or nonverbal evasiveness.
    - The facility's unwillingness to release medical records.

Lindbloom's research team also conducted focus group interviews with medical examiners, coroners and geriatricians across the United States to assess the state of forensic investigation of nursing home deaths. They hoped to determine ways to identify how abuse and neglect leading to mistreatment deaths might be identified. Results from the focus groups revealed that many professionals believe that deaths due to mistreatment are rare, so forensic investigations would be of little value in improving the quality of care.

Researchers also identified a number of medical examiners and coroners who exhibited ageism, a belief that focusing on nursing home deaths was "a waste of their time and resources because of the poor health status of most nursing residents who would die anyway." (Lindbloom et al., 2005).

These beliefs are major impediments to improvements in the forensic identification of elder deaths. Improvements in identification could help investigators and prosecutors take action against nursing homes where mistreatment occurred and take steps to improve the quality of care in the future.

Researchers in the NIJ study also examined how psychological conditions place elders at risk for abuse, in particular, sexual abuse. Ann Burgess, Boston College, examined 20 nursing home residents who had been sexually assaulted and found that the presence of a preexisting cognitive deficit such as dementia not only impairs the ability to communicate but also compounds the trauma of the assault (Burgess and Hanrahan, 2006). The vulnerability of this population places them at unusually high risk to severe traumatic reactions to assault.

Many victims had remain silent, and the incidents were discovered after suspicious signs were noted by staff or family members (Jones, et al., 1998).

The study highlighted the importance of training caregivers to identify signs of assault-related trauma, particularly in victims who are not likely to report the assault. Researchers noted disturbing evidence that nursing staff diminished the seriousness of assaults on residents, with responses ranging from cynical disbelief to amusement.

NIJ's portfolio of research will help in identifying forensic markers that can be used to help define abuse, identify cases of abuse and prosecute offenders.

Historical perspectives

The National Research Council, as part of the panel study, reexamined the issue of elderly mistreatment and the recent recognition that it is a distinct and important social problem. The study reveals that over the past 50 years, the social response toward the mistreatment of the elderly has evolved in part due to the response to child protective services and family violence. The increasing concern, acknowledgement and protection for victims of child and spouse abuse developed awareness and concern for elderly neglect and victimization (Bonnie and Wallace, 2003).

Until the late 19th century, there was no legal basis for intervention in family issues of abuse or neglect. "The juvenile court system in the early 20th century represented the first example of a collective responsibility for protecting children who were ungovernable, and over the following decades, this was extended to protect children who were neglected or abused by their parents" (Platt, 1969).

The legal foundation for modern policies and programs for elderly protection were put in place after World War II. Panel researchers noted an emphasis on remediating social problems that can be traced to the 1970s, with significant changes in programs to address child protection and family violence. The study by the National Research Council (2003), part of the panel research, presented a summary of the origins of adult protection programs beginning in the 1960s and traced the development of protective services. Here are the results of the National Research Council study as reported to the panel:

- New adult protective service units were established to provide social services and legal guardianship as well.
- Federal interest increased in 1962, and Congress passed the Public Welfare Amendments to the Social Security Act, authorizing payments to states for protective services for "persons with physical or mental limitations, who were unable to manage their own affairs … or who were neglected or exploited" (U.S. Department of Health, Education and Welfare, 1966).
- A demonstration project by a team at Benjamin Rose Institute (1974) in Cleveland compared elders in the community receiving traditional services to those receiving protective services. The study found those receiving protective services had a higher mortality and higher nursing home placement rate than those receiving traditional services.
- The questions raised by that important study prompted Congress to amend the Social Security Act to require states to establish protective service units for the elderly and fund them with social service block grants (SSBG), which had been used exclusively for child protective services.
- This new federal program directed states to provide protective services to adults who "as a result of physical or mental limitations, are unable to act in their own behalf; are seriously limited in the management of their affairs; are neglected or exploited; or are living in unsafe or hazardous conditions" (Bonnie and Wallace, 2003).
- Congressman Claude Pepper held widely publicized hearings, calling attention to the "hidden problem" of elder abuse in the nation's families, including what one witness characterized as "granny battering" (Wolf, 1986).
- Pepper's hearings led to state action in the early 1980s with many states requiring mandatory reporting of abuse, bringing the problem within the scope of adult protective services.
- By 1984, 46 states had designated a responsible agency for elderly protective services.
- Pepper continued to press for a federal response to elder mistreatment, and a 1981 report (Pepper and Okar, 1981), provided evidence that elder abuse was increasing and recommended that Congress act immediately to help the states identify and assist elderly abuse victims.
- Spouse abuse and other varieties of intimate partner violence have received increasing professional and political attention since the 1980s, leading to a variety of interventions and a substantial investment in research (National Research Council, 1996; National Research Council and Institute of Medicine, 1998).
- As the consciousness of health professionals was raised, family violence was viewed as a public health problem, recruiting researchers and advocates for injury prevention and public health to the field (Institute of Medicine, 1999).

Determining prevalence and incidence of elderly mistreatment

The NCEA in a 2005 study and the Government Accountability Office (GAO) study from 2000-2005 reported that no one knows precisely how many older Americans are abused, neglected or exploited. These studies indicate there are no official statistics for a number of reasons:

- Definitions of elder abuse vary, and the problem often remains hidden.
- State statistics vary widely, and there is no uniform reporting system.
- Comprehensive national data is not collected.

The studies did highlight the most widely used estimates of elder abuse prevalence and incidence in the United States today. Prevalence refers to the total number of people who have experienced abuse, neglect or exploitation in a specified time period. Incidence is the number of new cases identified or reported at a given point in time, usually one year (NCEA, 2005).

Many factors affect actual prevalence and incidences. National estimates vary due to differences in research, inspections, reporting methods, sample sizes and definitions across studies conducted by different states. It is widely recognized that reported cases are highly selected samples, and there are large numbers of unreported and undetected cases of elder mistreatment, particularly in community and home settings. Samples of reported cases may suggest common patterns and correlates of mistreatment when paired with a control group, but the data must be interpreted with great care (Wolf, 1986).

The question of the extent of elder mistreatment cannot be answered by studies of reported cases, according to the National Academy of Science study panel (Bonnie and Wallace, 2003). There are major problems with focusing on reported cases of mistreatment to determine prevalence:

- The studies are primarily based on cases uncovered through surveys of community professionals, nurses, social workers, legal aid lawyers and law enforcement agencies. They are cases that have come to the attention of the public. However, other studies of family violence using non-clinical populations show that only a fraction of cases gain public attention, and those cases are not representative of the problem at large (Gallup Poll, 1995).
- Because the information and research data did not come directly from the victim but instead from professionals and outsiders, it is secondhand knowledge. This may distort the evidence and the actual events by failing to present the problems and their effects as the actual participants perceive them.
- Case reports have little value in studying forms of mistreatment that are rarely reported to adult protective services agencies. Unreported cases may occur in institutional and community settings.

In an effort to generate a national estimate of the incidence of elder abuse and neglect based on case identification by professional "sentinels," the NCEA in conjunction with Westat Inc. conducted the National Elder Abuse Incidence Study (NCEA, 1998). In this study it was acknowledged that the findings detected only the most overt cases and thus underestimated the incidence of elder mistreatment. Research concerning elder mistreatment is underdeveloped, and the National Academy of Sciences panel identified the following factors to explain this issue:

- Many investigators believe the victims and family members are not suitable respondents for interview studies because they are not reliable, not willing to be interviewed or incapable of giving the necessary consent.
    - In fact, many victims are more willing to be interviewed and are reliable respondents able to give the necessary consent. Surveys including these respondents have uncovered serious cases of mistreatment, and a variety of studies have been conducted in which victims were interviewed.
- In general, methods used successfully to investigate forms of family violence have not been applied to research on elderly mistreatment. Gerontologists who study elder mistreatment tend to

follow their interests in family care giving and view the problem in this context.
    - Because elder mistreatment does not often occur in family care giving situations where a gerontologist is involved, this has been a serious limitation to research.
    - Furthermore, the technology for studying elder violence has not been developed and refined by gerontologists, and many have not been trained in sampling methods and measurement techniques.
- It is very difficult to obtain access to perpetrators of mistreatment. In studies of intimate partner violence, researchers have used treatment programs for abusers as a source for research subjects. These treatment programs do not exist for elder abusers.
- The exclusion of some abuse victims can seriously bias research findings. The problem is most evident when residents of institutions with cognitive challenges are excluded from population samples. When studying targeted populations, whether community-dwelling or residing in an institution, excluding elders based on cognitive deficits can seriously limit or alter results.
    - There is anecdotal evidence that institutional review boards have restricted categories of respondents, severely limiting and excluding valuable data.
- Few investigators have been drawn to this field of research. Reviews of the literature reveal a small set of researchers entering and continuing in the field. This can be explained by the lack of funding available for research on elder mistreatment. Annual expenditures by NIA, the leading agency for aging research, have increased less than $300,000 per year in 1990 to $1.3 million in 2001. Funding to study elderly mistreatment is modest even when compared to the underfunded area of child abuse research, where federal agencies spend $3.8 million a year (Bonnie and Wallace, 2003).
- The existing body of research is largely descriptive rather than empirically based on concepts measured using sound research methods. This type of research results in the practice of combining all forms of mistreatment within a single category.
- Individuals who conducted research on elder abuse report they have been hindered by limited cooperation from agencies responsible for identifying and treating elder abuse victims. Adult protective agencies have been reluctant to assist researchers, particularly when it involves interviewing victims and their families. Reasons for lack of agency cooperation include patient privacy issues, disruption to victim's lives, additional trauma to the victim, concern over the results of evaluation research, a shortage of staff and time to devote to research.
- Although every state has statutes requiring and regulating intervention, they vary widely in methods of implementation and level of compliance. States use different ages for eligibility, approach home and institutional abuse differently, employ different definitions of abuse, and have varying classifications of abuse as civil or criminal (Bonnie and Wallace, 2003).
    - These state statute variations lead to confusion and lack of comparability when studying reported cases. When data is reported, the same statute may trigger reports in different categories in different states (GAO, 2005).

Prevalence

According to NCEA, the best available estimates for elder mistreatment are:

- Between 1 million and 2 million Americans age 65 and older have been injured, exploited or mistreated by someone they depended on for care or protection (National Research Council Panel, 2003).
- Estimates on frequency of elder abuse range from 2 percent to 10 percent based on various sampling, survey methods and case definitions (Lachs and Pillemer, 2004).
- Data on elder abuse in domestic settings suggest that 1 in 14 incidents, excluding incidents of neglect, come to the attention of authorities (Pillemer and Finkelhor, 1988).
- Current estimates put the overall reporting of financial exploitation at only 1 in 25 cases, suggesting there are 5 million financial abuse victims each year (Wasik, 2000).
- It is estimated that for every one case of elder abuse, neglect, exploitation or self-neglect reported to authorities, there are five more that go unreported (NCEA, 2003).

Incidence

- In 1996, 450,000 adults aged 60 and over were abused or neglected in domestic settings. Factoring in self-neglect, the total number of incidents was 551,000.
- A University of Iowa study based on 1999 data found 190,005 domestic elder abuse reports from 17 states; 242,430 elderly abuse investigations from 47 states; and 102,879 substantiations from 35 states. Significantly higher investigation rates were found for states that require mandatory reporting and tracking of reports (Jogerst, et al., 2003).
- In 2000, states were asked to indicate the number of elderly abuse reports received in the most recent year for which data were available. Based on figures from all states, the total number of reports was 472,813 (NCEA, 2003).
- In 2003, state long-term care ombudsman programs nationally investigated 20,673 complaints of abuse, gross neglect and exploitation on behalf of nursing home and board-and-care residents. Among seven types of abuse categories, physical abuse was the most common type reported (2003).

The National Academy of Sciences (NAC) study panel agrees that elder mistreatment is a recognized social problem of increasing magnitude. The aging population is a well-recognized demographic fact, and the life expectancy of people born in the United States has been rising throughout the past century. Between 1950 and 2000, the total population of the country increased by 87 percent. The study included the following information relating to prevalence and incidence:

- The population age 65 and older increased by 188 percent, and the population 85 and older increased by 635 percent (Eberhardt et al., Hetzel and Smith, 2001).
- From 1950 to 2000, the life expectancy of people age 65 increased from 13.9 years to 17.9 years (National Center for Health Statistics, 2001).
- The U.S. Bureau of the Census predicts that by 2030, the population over age 65 will likely triple to more than 70 million people, and older people will make up more than 20 percent of the population (Populations Projection Program, 2000).
- Among people age 75 and older in 1999, 70 percent described their health as good or excellent (Eberhardt et al.). However, aging populations are associated with age-related diseases and disabilities.
- Of the estimated 12.8 million Americans reporting need for assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), 57 percent were over the age of 65 (Administration on Aging, 1997).
- Dementia is present in approximately 5 to 10 percent of persons over age 65 and older and 30 to 39 percent of people age 85 and older (Rice et al., 2001).
- Among people 85 and older in 1999, 16 percent had Alzheimer's disease (Brookmeyer et al., 1998).

Given the projected growth in the elderly population, long-term care for the elderly has become an increasingly urgent policy concern (Institute of Medicine, 2001). The settings in which long-term care is provided depend upon a number of factors, including the person's needs and preferences, availability of informal support, and the source of funding or reimbursement for care. Statistics on care facilities from the panel show:

- Among the 34 million persons over age 65 in 1995, 5 percent were in nursing homes and 12 percent lived in the community setting with ADL and IADL limitations. The estimate is 1.8 million of the 39.6 million over age 65 reside in nursing homes in the United States.

- Roughly 75 percent of the residents in nursing homes were women, and 50 percent of them were age 85 or older.
- In 1999, another 500,000 elderly people were living in assisted living facilities (Hawes et al., 1999).
- Nursing home residents are younger today than 10 years ago, and the percentage of nursing home residents under the age of 65 has doubled from 7 percent to 14 percent, with the average age of 79, down from 83.
- In 2003, the average cost for a room in a private nursing home was $66,000 a year. By 2021, the average annual rate may rise to $175,000 (2010).
- Among people age 85 and over, 21 percent were in nursing homes in 1995 and 49 percent were community residents with long-term care needs (Alecxih, et al., 1997).
- The nursing home population tends to be older and more severely disabled than elders residing elsewhere, with about half of the residents being 85 or older and about half having five ADL limitations, in1996 (Stone, 2000).
- More than 7 million Americans, mainly family members, provided 120 million hours of care to elders with functional disabilities living in the community, according to the National Long Term Care Survey (1994).

Most long-term care for elders in the community is provided in a traditional home setting, in an the elder person's home with or without a spouse, or in the home of a relative. However, the nature and character of long-term care services in the home may change (Stone, 2000). The potential pool of adult children who can serve as caregivers is already decreasing as a result of demographic trends, including divorce, smaller families and increasing workforce participation (Himes, et al., 1996). These factors increase the pressures on families caring for their elderly relatives and may increase the demand for institutional care.

ETIOLOGY OF ELDER ABUSE

Most elders who need assistance get the care they need from family members or friends. Some receive help from caregivers who work for agencies or independently. Despite the significant physical and emotional demands of providing care, the majority of caregivers are meeting the challenge (NCEA, 2002). But reports of abuse by caregivers are not uncommon and are on the rise.

Elder abuse occurs in institutional settings, which include nursing homes, assisted living facilities and board-and-care homes. It also happens in non-institutional settings, such as the victim's home or the home of a caregiver, who is often a family member. The impact of the abuse on victims is essentially the same no matter where it occurs, and it happens more frequently to elders who are dependent and isolated.

The term caregiver refers to anyone who routinely helps others who are limited by chronic conditions. Formal caregivers are volunteers or paid employees connected to social services or health care systems. The term informal caregiver refers to family members and friends who are the primary source, providing care for three-quarters of impaired older adults who live in the community. Beyond the ADL and IADL activities, some caregivers have added responsibilities, including administering medication, turning patients who are immobile to avoid pressure sores, and other tasks related to the elder person's illness or disability.

Published in 2009, Donna Reed's book, "An Insider's Guide to Better Nursing Home Care: 75 Tips You Should Know," cites specific newspaper articles that outline the horrific forms that elderly mistreatment may take and situations and circumstances that lead to abuse. Her research covered long-term care nursing homes through out the United States, but these cases are found in private homes and other types of care facilities as well.

Medication control

Overmedication is a serious problem for elderly individuals. Some elders have difficulty keeping track of when and how often they take various medications or the correct dosage to take. Sometimes one or more physicians may prescribe medications that may interact adversely with other drugs the person is taking. Long-term care facilities can add to this problem by encouraging residents to take "as-needed" medications, such as sedatives, relaxants and sleeping medications, on their own.

Reed stresses the importance of monitoring all medications taken by residents using the following procedures:

- Keep a written record that can be reviewed by physicians and family.
- Have a policy for periodic review of all medications the resident is taking.
- Have a policy that the physicians clear all new medications or supplements and inform the family.
- Have a clearly stated policy about a resident's right to refuse unwanted medication and a system to inform the physician and family.

Mistreatment in care facilities

Abuse and neglect are more common in institutions that serve impoverished residents. These institutions are operating on limited funds and may not be able to provide the same level of quality in terms of employees and care. Undertrained, overworked and poorly supervised employees are the ones who may lash out at the residents in frustration. Financially stressed institutions may cut corners on the amount of staff and other services in order to meet their budgets. The isolation and dependency of residents and their lack of housing alternatives leaves them no choice but to endure unsatisfactory living conditions.

Even institutions that serve the middle class frequently have too few staff, low wages and provide inadequate training. One of the primary reasons for these problems is inadequate public funding for residents who have run out of funds to pay for their own care. Medicaid, financed by both federal and state governments, is the sole source of payment for a majority of nursing home residents. Unfortunately, the Medicaid reimbursement rates pay only about 70 percent of the actual cost of resident care, leaving nursing homes to find creative ways to balance their budgets.

Reed's review of abuse that occurred throughout the country uncovered the following incidences:

- **Neglec**t – This form of abuse often includes inadequate attention to resident needs, such as not responding to call buttons, providing substandard care or failing to provide a decent emotional atmosphere of safety and concern for the elder's well-being. Individuals left unattended have suffocated when wedged between a mattress and wall; suffered from malnutrition, dehydration, infected sores and heatstroke from lack of air conditioning; frozen from the cold; choked while eating and drinking unattended and choked or suffocated from restraints; been bitten by ants and had maggots in wounds, feeding tubes and body cavities; and died from failure to monitor breathing and heart rate to know when to resuscitate.
- **Physical abuse –** This includes striking, slapping, pulling hair, tripping, kicking, pushing, choking, withholding food or water, dropping patients and restraining improperly.
- **Sexual assault.**

- **Medical malpractice –** This can include over- or under-medicating and mixing or switching medications resulting in injury or death; improper use of catheters, feeding tubes and oxygen supplies; failing to monitor vital signs or misuse of monitoring equipment; improper emergency procedures and techniques, including fire safety, failure to apply CPR or attend to seizure disorders; and the lack of trained medical personnel and staff.
- **Staffing-related issues** – This might include no trained medical staff in charge at the facility or consulting in the home, improper medical charting or falsified charts and documents, errors in following doctors' orders or in reports on medical issues to the physician or nursing supervisors, inadequate staff numbers, an untrained or inattentive staff, lack of background checks and drug testing for staff, theft by staff, overscheduling staff or extended shifts, and a lack of certification and continuing education availability.
- **Issues related to special needs –** Some facilities are not equipped to handle Alzheimer's or dementia patients and may not have a facility that provides separate living arrangements. This may cause difficulties for both types of residents. In the mixed setting, the long-term care residents may be subjected to the behavioral incidents common in Alzheimer's or dementia residents. These residents may wander and take things that belong to other residents. They need constant supervision, which means additional staff members trained to meet their unique needs.
- **Unsafe facility –** These include fire safety violations and lack of accessible escape routes; unguarded stairs or low or unguarded windows; lack of railings in bathrooms, hallways and stairs; unlocked storage of medications and supplies; unprotected heating sources, such as radiators or space heaters, or a lack of proper heating, cooling and ventilation systems; improperly maintained devices for lifting and moving patients; unsanitary conditions and poor hygiene techniques and poor sanitation in food preparation and storage; flooring that is unsafe; lack of safety procedures for evacuation or lockdown during natural disasters or emergencies and a lack of communication or alarm notification systems, including procedures to contact emergency personnel inside and outside the facility; and a lack of controls, alarms and procedures to prevent wandering incidents and the lack of safe grounds to allow clients to exercise and socialize safely.
- **Financial exploitation –** Although residents are discouraged from keeping cash and valuables in their rooms, theft still occurs in the institutional setting. Financial abuse not only includes theft of petty cash but also jewelry, radios, computer, televisions and other items of value. This can easily occur when residents are sleeping or out of their room for meals and activities.

Mistreatment in the traditional home setting

According to NCEA data, in 90 percent of all reported elder abuse cases, the abuser is a family member. It is not known how many of the abusive family, the victim's friends or other family members may be unaware it is happening. Some victims endure the abuse because they fear they will lose the caregiver or that the caregiver, usually an adult child, will get into trouble with the law. Other victims are too isolated or too physically or mentally incapacitated to seek help.

Some abuse occurs when caregivers fail to understand the elder person's medical or dietary needs and do not provide the proper diet, which may affect the medical condition and effectiveness of the medication. Other abuse is negligent care giving and may range from failing to seek medical attention soon enough to more intentional abuse, such as leaving bedridden elders to lie in their own waste or refusing to feed them by hand because it is too much work or too time consuming.

Financial exploitation by caregivers is fairly common and difficult to uncover. When the caregiver lives with the victim, it is easy to commingle funds and use the elder's money for the caregiver's support. The elderly victim may be lonely or depressed and believe that flattering attention by a caregiver or a "new best friend" is genuine. The victim can be manipulated into making gifts or giving the abuser access to the victim's bank accounts or other property (NCEA, 2003).

Some abusers have the specific intent to exploit or injure their victims. They select the victims because they are available, vulnerable and less likely to report the abuse. The Internet has increased access by those seeking to exploit vulnerable elder citizens. Others, often family members, believe they are entitled to use the victim's property and money as payment for care giving or as part of an inheritance that will eventually be theirs. In other cases, caregivers simply become so frustrated with their duties and so angry with the older person that they lash out from the fatigue of caring for someone who may be physically or verbally abusive to the caregiver.

To be sure, the stress of care giving can lead to despair, anger and resentment, but abuse is never an acceptable response. Researchers have estimated that 23 percent of all caregivers are physically abusive, and most agree this is often due to stress associated with providing care (NCEA, 2003).

Caregiver stress

Stress is often described as the body's "fight or flight" response to danger when the body goes on high alert to protect itself. Essential functions like respiration and heart rate speed up while the less essential functions, such as the immune system, shut down. Although the stress response is a healthy reaction, the body needs to repair itself once the danger is removed. Because caregivers' stress often results from fatigue and conflicts that never go away, their bodies never get a chance to heal. If the immune system is not functioning fully, the caregiver is at greater risk for infections and disease. Some experts believe that stress causes hypertension, coronary disease or even premature death.

Some stress is normal, and researchers for NCEA have found stress affects caregivers very differently. Some who provide high levels of care experience no stress, while others who provide relatively little care experience high levels of stress. Experts feel that these differences can be explained by subjective factors, such as how caregivers feel about providing care, their current and past relationship with the elder, and their coping abilities. Some caregivers find certain behaviors by elder to be particularly stressful, including aggression, combativeness, wandering and incontinence. Others report that they experience stress because they do not get enough rest, privacy, support or time for themselves (NCEA, 2003).

It was found in the NCEA report that some of the same factors that are believed to cause caregiver stress also raise the risk of abuse. For example, when the relationship between a caregiver and elder was poor to begin with, the caregiver is more likely to become stressed and become abusive. The link between caregiver stress and abuse is not fully understood, and more research is needed to understand what factors predict and contribute to caregiver abuse. Specific areas that need to be explored include how aggression by caregivers raises the risk of abuse, why some caregivers fear they will become aggressive or abusive, whether those who fear they will become abusive are more likely to actually abuse, and how coping patterns play a role.

Drawing on the NCEA study on caregiver abuse, there are some factors that may lead to abuse:

- **The caregiver**:
  - Expresses fear that he or she will become violent.
  - Suffers from low self-esteem.
  - Says he or she is not getting adequate support and help from others.
  - Expresses that care giving is a burden.
  - Experiences emotional or mental "burnout," anxiety or depression.
  - Feels caught in the middle of providing care to children and elderly family members at the same time.
  - Feels anger toward the care of the elder that can be traced to their relationship in the past.
- **The elder**:
  - Is aggressive or combative.
  - Is verbally abusive.
  - Exhibits disturbing behaviors, such as inappropriate behavior or embarrassing public displays.
- **The caregiver and the elder**:
  - Live together.
  - Had a poor relationship before the onset of the illness or disabling condition.
  - Are married and have a marital relationship characterized by conflict.

Family discord and mistreatment was seldom a public issue for much of this country's history. Responsibility for assisting families in need was assumed mainly by religious organizations and private charitable organizations. There was no legal basis for intervention into families until the late 19th century, when industrialization, immigration and urbanization increased family problems, including poverty and internal conflict, and also exposed them to public view (Bonnie and Wallace, 2003).

Many of the preventative and protective tools developed in the context of intimate partner violence have now been directed to violence against elders. Bringing elderly mistreatment into the domain of family violence brings new ideas about etiology. Researchers note that it also exposes tensions between social service agencies, with their traditional helping approach, and many family violence specialists, with their greater emphasis on criminalization and punishment of abusers.

Studies have found that some abuse is revenge motivated, adult children retaliating against their older parents for abuse committed against them as children. Other abusers consider violence a normal and acceptable way of handling someone who is uncooperative or burdensome. Many abusers are suffering from drug or alcohol dependency and financially exploit the victim to support their addiction. For others, abuse is a way of gaining control and satisfying an emotional need to dominate the victim.

Agency factors

The current system for protection for the elderly has its roots in the child protection system legislation, The Child Abuse Prevention and Treatment Act of 1974, that mandated reporting and investigation for the protection of children (Nelson, 1984).

Relying on the parens patriae authority to protect helpless citizens, a few states started public welfare systems in the 1940s and 1950s to protect adults who could not independently care for and protect themselves. Adult protective services were developed to provide social, legal and guardianship services.

The context of elder mistreatment varies, from the forgotten and helpless nursing home resident, the battered or exploited elder, the stressed caregiver, and the abusing spouse or relative. The system of adult protective services has emerged to respond to these varied problems as well as other issues related to adults with disabilities.

The system for adult services is based on ideas and structures borrowed from policy and practice in child mistreatment, and more recently, partner violence. Prevailing policies and practices in these related domains are not fully applicable to elder mistreatment and are often controversial (Bonnie and Wallace, 2003). The National Research Council and Institute of Medicine panels have repeatedly called for sustained and aggressive research on the magnitude, etiology, consequences and interventions for elder mistreatment (National research Council, 1993, 1996; National Research Council and Institute of Medicine, 1998).

Overall, the panels found the national response to elder mistreatment to be weak and incomplete. Adult protection is poorly funded, and Rep. Pepper's emphasis on the issue has not been sustained by his successors in Congress. In addition, the panel noted that this problem is compounded by the public's preoccupation with youthfulness, and that the nation seems to be uncomfortable with the process of aging and the issue of elder care. As a result, elder mistreatment remains hidden, poorly defined and largely unaddressed more than two decades after Claude Pepper's hearings first exposed it to the public.

PREVENTION AND INTERVENTION

Reducing the risk of elder abuse by caregivers will require the effort of caregivers, agencies and the community. The NCEA offers the following suggestions:

- **Family caregivers should:**
  - **Get help**. Make use of social and support agencies, including support groups, respite care, home delivered meals, adult day care and assessment services, which can reduce stress associated with abuse.
  - **Recognize the triggers** that cause the stress and anxiety.
  - **Learn to recognize and understand the causes** of difficult behaviors in elders and techniques for handling them more effectively.
  - **Develop relationships with other caregivers.** Caregivers with strong emotional support from other caregivers are less likely to report they experience stress or to fear they will become abusive.
  - **Get healthy**. Exercise, relaxation, good nutrition and adequate rest have been shown to reduce stress and help caregivers cope.
  - **Hire help**. Attendants, homemakers or personal care attendants can provide assistance for most daily activities. Caregivers who cannot afford to hire help may qualify for assistance.
  - **Plan for the future.** Careful planning can relieve stress by reducing uncertainty, preserving resources and preventing crises. A variety of instruments exist to help plan for the future, including powers of attorney, advanced directives for health care, trusts and wills (NCEA, 2005).
- **Agencies providing assistance for in-home caregivers should**:
  - **Carefully screen** caregivers and patients for the risk factors associated with caregiver abuse.
  - **Provide information** and support to caregivers to lower their risk.
  - **Provide instruction** to caregivers though materials, classes, websites or support groups. They could address conflict resolution and how to deal with difficult behaviors such as violence, combativeness and verbal abuse.

- **Promote better coordination** between agencies that offer protection to victims and those that offer services to caregivers. This can be achieved through cross-discipline training, interagency protocols and multidisciplinary teams (NCEA, 2005).

- **Concerned citizens can**:
  - **Lend a hand** to a caregiver who needs help.
  - **Report abuse**. In most communities, an adult protective services (APS) agency can accept and investigate reports.
  - **Advocate** for public policy to increase the scope and access to services available for caregivers.
  - **Volunteer.** Volunteers can make friendly visits, serve as guardians, run errands and provide respite care.
  - **Arrange for educators** and speakers to make presentations at churches, clubs or civic organizations (NCEA, 2005).

Kentucky residents led by Bernie Volderheide recently formed a grass roots organization called Kentuckians for Nursing Home Reform (2008). They developed an action agenda for nursing home reform to address the needs of the 23,000 people in the state's nursing homes. They describe Kentucky's nursing home residents as the "forgotten people," and their statewide initiative addresses areas in need of reform to bring the state into compliance with all federal regulations. They targeted the following areas:

- **Quality staffing** – To continue to press lawmakers and state government officials to create minimum staffing standards for caregivers in all nursing homes.
- **Transparency in ownership and enforcement** – To urge the state of Kentucky to maintain and display on its website an up-to-date and complete file of information on the ownership of every nursing home; notify the public about serious deficiencies in nursing homes; and to release a quarterly report of nursing home deficiency citations and those with no deficiencies.
- **Oral health** – To urge state enforcement of oral health requirements in the care of nursing home residents.
- **Criminal background checks** – To amend current state law to require that all employees of nursing homes receive a criminal background check before they are hired.
- **Random drug testing** – To address the evidence that drug abuse problem exists among nursing home staff and urge that a law be enacted to require random drug testing of all nursing home employees.
- **Train Alzheimer's caregivers** – To address the more than half of the states' nursing home residents who suffer from some form of dementia, including Alzheimer's disease. To urge the establishment of a program to train all caregivers in best practices to care for these residents.
- **Standardized end-of-life regulations** – To address the lack of a standardized system to address residents' end-of-life decisions, including DNR, by incorporating a combination of wristband I.D. and DNR documentation in residents' charts.
- **"Dumping" of nursing home residents** – To form a committee to study the serious situation that occurs when nursing home residents are forced from nursing homes because of alleged "bad behavior" and moved to an out-of-state nursing home.
- **Use of anti-psychotic drugs** – To address the overuse of drugs to quiet over-active residents that has become prevalent in many nursing homes.
- **Form a committee to oversee the Civil Monetary Penalties Fund** – To form an advisory committee to created by the governor to oversee the use of these funds to benefit nursing home residents.
- **University research on long-term care** – To urge the University of Kentucky to expand its ongoing research on aging to establish an institute on long-term care, and to use the Cooperative Extension Service to deliver the results of research on long term-care through its county offices across the state.

Culture change

"Culture change" is a grassroots movement to transform the culture of aging as a way to address elder mistreatment and nursing home reform. Through culture change, nursing homes and other senior living facilities change from hospital-like institutions to communities that more closely resemble home. In "Almost Home," filmmakers Brad Lichtenstein and Lisa Gildehaus (2006) chronicled the daily lives of staff and residents at Saint John's on the Lake, a retirement community in Milwaukee whose leaders are striving to improve quality of life for residents and staff. Part of the Nursing Home Reform Act of 1987 declared, "Residents in nursing homes need a home where they can live for the rest of their lives as individuals." Social, spiritual, emotional, occupational, recreational and cultural needs are deemed as important as physical ones.

Culture change in long-term care is described as an ongoing transformation based on person-directed values that restore control to elders and those who work closest to them.

In March 1997, progressive thinkers in the long-term care field, those who believed that aging could be a gratifying and dignified experience, convened in Rochester, N.Y., to exchange ideas for culture change. This change would involve the transformation of the nursing home atmosphere and structure as a whole, including the physical environment, staff routines, authority structure and daily care. In Rochester, four models of culture change were introduced. Each demonstrated that changing the way the nursing facilities operated had a major impact on residents as well as staff. Although there were different approaches to culture change, each focused on the individual resident and reinstating choice in daily life.

The following changes would be implemented in the new model for culture change to reform nursing homes:

1. No agenda would be kept, so residents could enjoy choice and control over daily activities that bring them pleasure.
2. Staff is trained to handle stress and attend to their own needs to become better caregivers.
3. All staff is evaluated on the joy they bring to elders' lives.
4. The focus is promoting feelings of home and community among residents and staff.
5. Dining is a social experience with made-to-order meals.
6. Décor is warm, home-like and pleasing.
7. Doing nothing is an activity choice as well.

"Almost Home" explores the New York-based Pioneer Network, which includes seniors, family members, physicians, caregivers, educators, researchers and friends all working to educate seniors, their families, legislators and nursing home administrators. Their goal is to create deep and lasting change in the way society ages and the way our culture cares for the elderly. The tenants of the Pioneer Network include:

- Know each person, identify unique talents.
- Promote choice and creativity.
- Respect individuality and risk-taking.
- Trust staff.
- Keep decision-making close to the resident.
- Shape environments, social, physical and organizational policies and activities to reflect values.
- Ensure representation of all community members in policy decisions.
- Expect leaders to model values.
- Respect the need of all to give as well as receive.
- Support relationships with people of all ages, animals and nature.
- Support function and mobility.
- Build on strength and potential for healing growth.
- Devote time and space to building community.
- Look for meaning in all behaviors.
- Work with residents, do not argue with them.
- Respect ethnic and cultural identities and religious beliefs.

Efforts to improve long-term care facilities

Donna Reed**,** nurse and attorney, in her book, "Better Nursing Home Care: 75 Tips You Should Know," provides insight into improvements that could prevent abuse in care facilities. She addresses the forms of abuse she noted throughout the country as listed above in the etiology section (Reed, 2009).

Reed points out that most nursing homes are understaffed, and that is one of the main reasons for poor care. They are understaffed because the nursing home industry in almost every state is not bound by any legal standard that would mandate a specific staffing requirement. Facilities are therefore free to value profit over adequate nursing staff. There is no federal law to tell nursing homes how many nurses and nursing assistants they must have on duty for a certain number of residents, although a few states have mandated their own staffing standards. Because most facilities employ a small number of nursing personnel to care for a large number of residents, many shortcuts must be taken during the delivery of nursing care.

The second point Reed makes is that nursing home nurses may be trained and encouraged to conduct nursing business in a manner that protects the facility. The staff must move quickly and deliver care in a systematic manner, which she describes as sometimes "robotic" and done at the convenience of the staff in some situations.

Staffing issues

> *I've had my call bell on for twenty minutes. It's too late. I've already wet the sheets. I'm sorry.*
> – Nursing home resident (Reed, 2009)

The Nursing Home Reform Act of 1987 addresses the issue of nursing staff in the following regulations:

- **483.30**
  - The facility must post the following information on a daily basis: the total number of the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses, licensed vocational nurses and certified nurses aides per shift.
  - The facility must post the nursing staff data (A) in a clear and readable format and (B) in a prominent place readily accessible to residents and visitors.
  - The facility must, upon oral or written request, make staffing data available to the public for review at a cost not to exceed the community standard.
  - The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by state law, whichever is greater.
  - The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care.

Determining the appropriate ratio of nurses to residents depends on a number of factors. These include availability of support staff, the level of care required by the residents, the time of day or night, the nursing assistant-to-resident ratio, and the capability of the nursing staff.

Without sufficient support staff, the nursing staff will be answering phones, doing paperwork and handling facility issues such as plumbing, heating and electrical emergencies that occur at all hours of the day and night. These issues take time and energy away from patient routine and emergency care.

There should always be a nursing supervisor on staff, preferably in the building. Minor emergencies occur on a constant basis, and it takes time to handle and document them effectively.

Not all emergencies are of a magnitude to require much of a nurse's time, but if the duty nurse is expected to handle both a nursing assignment of 30 residents and supervisory responsibilities, then the nurse-resident ratio would actually be higher.

Reed states from experience that if nurses do their own documentation, treatments and medication passes for their residents, 15 to 25 non-skilled-care residents for a day and evening shift is realistic and safe if the unit has the appropriate number of nursing assistants. In addition, Reed notes the only true test to determine the appropriate nurse-to-resident ratio is to know whether nurses are able to get their work done within the allotted time frame. If a nurse is getting all work done, she has a reasonable workload with room for additional assignments. If the nurse is taking shortcuts to get it done, the workload is too heavy. Unfortunately, most facility managers do not consider a workload test but may overload nurses to get the most nursing care for their dollar.

Likewise, if there is no overtime policy, rather than risk being reprimanded by management for a late punch-out, the staff may neglect tasks or leave tasks to be done for the next shift in order to leave on time. The oncoming shift cannot be responsible for any unfinished documentation, so the departing staff often neglects it or completes it hurriedly to leave on time.

Other staffing issues involve the number of hours nurses may be required to work. Nurses often have to work a 16-hour shift because of the illness of a coworker, weather conditions that prevent a relief nurse from traveling or other emergencies. Reed explains that there are many jobs that can be performed safely for 16 consecutive hours, but nursing is not one of them. The continuous physical and mental demands dull the abilities of even the sharpest nurse when working those hours.

Registered and licensed nurses

Two types of nurses usually occupy the position of staff or floor nurse. The significant difference between the registered nurse (RN) and the licensed practical nurse (LPN) or licensed vocational nurse (LVN) is that the RN has completed at least one more year of education. Both can fill the position of staff nurse, sometimes known as the medication nurse.

Ideally, when the same nurse works with the same residents everyday, better care is delivered because the nurse will be familiar with residents, their routines, desires and special needs. Many facilities have full-time, part-time, and per diem nurses who work on an as-needed basis (Reed, 2009).

Medication control

> *"I don't have enough staff to babysit her. She needs to be medicated."*
> – A statement made by nursing home nurse who medicates overactive residents because there is not enough staff to closely monitor everyone (Reed, 2009).

Overmedication is a serious problem for elderly individuals. Some elders have difficulty keeping track of when and how often they take various medications or the correct dosage to take. Sometimes one or more physicians may prescribe medications that interact adversely with other drugs the person is taking. Long-term care facilities can

add to this problem by encouraging residents to take "as-needed" medications such as sedatives, relaxants and sleeping medications.

For these reasons, it is important to have the facility monitor all medications using the following procedures:

- Keep a written record that can be reviewed by physicians and family.
- Have a policy for periodic review of all medications the resident is taking.
- Have a policy that the physician clear all new medications or supplements and inform the family.
- Have a clearly stated policy about a resident's right to refuse unwanted medication and a system to inform the physician and family.

The following guidelines and regulations from the Nursing Reform Act focus on overmedication issues:

- **483.25**
  - The facility must ensure that each resident's drug regimen is free from unnecessary drugs.
  - The facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless anti-psychotic drug therapy in necessary to treat a specific condition as diagnosed and documented in the clinical record.
  - The facility must ensure that residents who use anti-psychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.
- **483.60**
  - A licensed pharmacist must review the drug regimen of each resident at least once a month.
  - The facility must ensure that residents are free of any significant medical errors.

Infection control nurse

A registered nurse is usually on staff to monitor residents with infections and those at risk for developing infections. Often they assumed the title of infection control nurse, which can be a full-time position depending on the type of facility and the number of non-ambulatory or diabetic residents.

The nurse reviews resident/patient charts and conducts educational training for employees to ensure that the facility remains in compliance with infection control policies. The nurse would watch for communicable disease that could spread between roommates and work to ensure the safety of patients with compromised immune systems. Regulations require that a sign be placed on the door telling potential visitors to report to the nurse's station before entering the rooms.

- **483.65**
  - The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.
  - When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
  - The facility must prohibit employees with a communicable disease or infected skin lesions from direct contract with residents or their food if direct contact will transmit the disease.

Wound care nurse

Residents can get wounds quite easily because their skin is thin and fragile and can be broken from simply rubbing against an object, such as a door or wheelchair. Facilities may designate a nurse to focus on wound care. A common type of wound treated by a nurse is a pressure sore or bedsore. These sores are usually found over bony areas such as the heel, hip, coccyx or any area of the back.

The treatment nurse inspects and treats all wounds and implements skin-care regimens for all residents in the facility. This nurse would have advanced training in the newest and best-practice methods for wound care and skin treatment. A wound is usually measured, and a record is kept in the patient's chart. The same nurse regularly treating the wound can notice changes in the size, color or drainage of the wound. The nurse would consult a wound specialist if the wound does not improve or worsens.

The following regulations of the Nursing Home Reform Act focus on pressure sores:

- **483.25**
  - The facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable.
  - The facility must ensure that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Nurse's aides and licensed nursing assistant

Nurse's aides or licensed nursing assistants are the backbone of the nursing home, often the hardest working and lowest paid. They are closest to the resident and often have the most difficult and unpleasant jobs. Many times they are the primary caregivers and have the most to do in the least amount of time.

Reed says the optimal ratio of a nurse's aides to residents should be no more than six residents requiring moderate to maximum care to one nurse's assistant. Her studies show this is not the ratio found in most facilities, which may explain the high rate of job-related injuries and turnover among nurse's aides.

Comprehensive care plan

The Nursing Home Reform Act outlines the following regulations addressing the comprehensive care plan:

- **483.20**
  - The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment.
  - The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.
- **483.25**
  - Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

Care plan meetings are federally mandated and designed to improve the quality of care for nursing home residents by identifying care issues and implementing a preventive or corrective plan for treatment. Nursing homes that accept Medicare or Medicaid are bound by this requirement by law.

The meetings should be held every month or quarter and are normally attended by the nursing home resident and one nursing home employee from each discipline involved in the resident's care. For example, representatives from dining services, rehabilitation therapies, nursing and social services gather together to discuss the current plan of care for the resident. The resident's family is encouraged to attend in person or a conference call can be arranged. This is the best forum for all parties to ask questions and offer suggestions about the elderly resident's care. It is important for a family member or representative to be there in case the resident cannot be present or is not alert or competent to make comments about the way care is delivered.

Researchers note that when a staff is accountable to a family member for finding a solution to a complaint, greater results are achieved than when the staff is accountable only to the resident. The resident and family member should always be present, and all documents that were generated during the care plan meeting should be reviewed.

Nutrition documentation

The nurse's notes should include a description of everything that was done for the patient that day, including documentation of complaints, behavioral changes, medication changes, new symptoms, bruises, status of medical equipment, vital signs, feeding, toileting, weight, how and when care was delivered, who delivered it, and how it was tolerated by the elder patient. The resident, family, or legal representative should have access to that documentation at any time.

- **483.25**
  - Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.
  - Based on a resident's comprehensive assessment, the facility must ensure that the resident receives a therapeutic diet when there is a nutritional problem.
  - The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.
  - If a qualified dietician is not employed full time, the facility must designate a person to serve as the director of food services who receives frequently scheduled consultations from a qualified dietician.
  - The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.
  - The facility must provide food that is palatable, attractive and at the proper temperature.
  - The facility must provide substitutes of similar nutritional value to residents who refuse the food served.
  - The facility must provide at least three meals daily at regular times comparable to normal meal times in the community.
  - There must be no more than 14 hours between a substantial evening meal and breakfast the following day.
  - The facility must offer snacks at bedtime daily.
  - The facility must provide special eating utensils and equipment for residents who need them.
  - The facility must provide feeding assistance if warranted.

Regulations on physician and therapist care

- **483.25**
  - Residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.
  - The facility must, if necessary, assist the resident in (1) making appointments, and (2) by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.
  - The facility must promptly refer residents with lost or damaged dentures to a dentist.
  - The facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.

To provide optimum, quality care, a number of professionals should be available to provide care for routine checks and to consult as needed. These include dentists, ophthalmologists, audiologists, occupational therapists, physical therapists, mental health professionals, podiatrists and speech therapists for speaking and swallowing issues.

The facility must provide a safe and homelike environment

This regulation requires the facility to promote an atmosphere that resembles a home rather than an institution.

- **483.15**
  - The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belonging to the extent possible.
  - The facility must provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior.
  - The facility must provide clean bed and bath linens that are in good condition**.**
  - The facility must provide comfortable and safe temperature levels. Facilities certified after October 1, 1990, must maintain a temperature range of 71-81 degrees Fahrenheit.
  - The facility must provide for the maintenance of comfortable sound levels.
  - The facility must ensure that residents' environment remains as free of accident hazards as possible.
  - The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.
  - The facility must maintain an effective pest control program to ensure that the facility is free from pests and rodents.

The facility must have policies against mistreatment

The facility must have policies in place that prohibit mistreatment, neglect, abuse and theft. Most facilities distribute a basic version of these policies to their employees at the time of hire. The following Nursing Home Reform Act regulations address mistreatment in a nursing home:

- **483.15**
  - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
  - The facility must not employ individuals who have been found guilty in a court of law of abusing, neglecting or mistreating residents.

- The facility must not employ individuals who have had a finding entered into the state nurse aide registry concerning abuse, neglect, and mistreatment of residents or misappropriation of their property.
- The facility must report any knowledge it has of actions by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aid registry or licensing authorities.
- The facility must ensure that all alleged violations involving mistreatment, neglect, abuse, (including injuries of an unknown source) and misappropriation of resident property are reported immediately to the administration of the facility and to other officials in accordance with state law established procedures.
- The facility must have evidence that all alleged violations are thoroughly investigated and steps are taken to ensure that the resident is not subjected to further abuse during the investigation.
- The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with the state law (including the state survey and certification agency) within five working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken.

Addressing resident problems and complaints

A facility must have specific procedures for residents and family members to make complaints or discuss a problem. This could include a problem with a particular staff person, a method or type of care, facility rule or condition.

The danger of not having an explicit complaint procedure is that a resident or family member will not know with whom to speak, or may be dismissed by staff members who claim they have no authority to address the issue. An organized and effective complaint procedure will guarantee a response from an identifiable person in authority. There should also be a procedure for registering a complaint or discussing problems about a roommate or other resident.

The procedures for addressing residents' complaints and the legal rights of the resident will be discussed further in the following section on laws related to resident rights.

Long-term care ombudsman

The federal government funds a program administered by each state's agency on aging, which makes available to nursing facility residents an ombudsman. The ombudsman acts as a mediator to address unresolved problems between residents or their families and a nursing facility. The ombudsman has regular visiting hours and days at the facility and is also available by phone. There is no charge for the services of the ombudsman.

Although the ombudsman does not have the direct authority to bring civil or criminal penalties against the nursing home or abusive employee, the ombudsman may assist the state agency that supervises the nursing home and the state attorney general's office to pursue civil fines and criminal charges against abusers and the facilities in which abuse has occurred.

The victim or someone who suspects that a resident has been abused may also make a complaint directly to the state regulatory agency for nursing homes or the state attorney general's office. State attorney general's offices have Medicaid fraud and control units that are required to investigate and prosecute patient fraud, abuse and neglect in facilities that participate in Medicaid.

Fingerprinting

Section 483.15 includes regulations requiring fingerprinting of designated personnel, including certified nurse assistants (CNAs), home health aides, students enrolling in CNA/HHA training programs, home health agency owners and administrators in all types of facilities. These include skilled nursing, intermediate care, home health agencies, intermediate care for developmentally disabled, nurse assistant and home health training programs, accredited nursing schools, general acute care hospitals and hospices.

Abuse notification procedures

Current regulations in section 483.15 require skilled, long-term care facility staff to report suspected abuse immediately to the administrator, and the administrator's investigation must be reported to the state agency, including to the department of health licensing and certification agency and either the ombudsman program or the local police department, within five working days. A detailed description of 483.15 was provided in the last section.

Residents' rights

In 1987, the federal government approved the Nursing Home Reform Act in response to public concern over the poor quality of care the elderly were receiving in nursing homes across the nation. The new law provided rights to all nursing home residents and required facilities that accept payments from Medicare and Medicaid to abide by these rules. These were designed to improve the quality of care for residents in all care facilities.

The law created a set of rights for residents and a set of specific guidelines for nursing home operation. A portion of the act gave residents clear, enumerated entitlements and was named the Residents' Bill of Rights. On the wall of every nursing care facility, the Residents' Bill of Rights should be posted for all to see.

The formal source of these rights is the Code of Federal Regulations (CFR), Title 42-Public Health, Part 483, Requirements for States and Long-Term-Care Facilities (Reed, 2009). These laws can be divided into two sections:

- The rights of residents.
- The responsibilities of a nursing facility.

483.10 The resident has a right to a dignified existence, self-determination, communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:

- To exercise his/her rights as a resident of the facility and as a United States citizen.
- To be informed of his/rights and responsibilities, both orally and in writing, in a language that the resident understands.
- To mange his/her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

- To choose a personal attending physician and participate in planning treatment.
- To be fully informed in advance about care and treatment and of any changes in that care and treatment that may affect the resident's well-being.
- Unless adjudged to be incompetent or otherwise found to be incapacitated under the laws of the state, to participate in planning care and treatment or changes in care and treatment.
- To personal privacy and confidentiality of his or her personal and clinical records.
- To voice grievances without discrimination or reprisal and have the facility respond to those grievances.
- The resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.
- To examine results of the most recent survey of the facility conducted by federal or state surveyors and an any plan of correction in effect with respect to the facility.
- The resident or his/her legal representative has the right, upon oral or written request, to access all records which pertain to him/herself, including current clinical records within 24 hours (excluding weekends and holidays).
- To refuse to perform services for the facility.
- To privacy in written communication.
- To resident has the right and the facility must provide immediate access to any resident by the following:
  - Any representative of the state.
  - The resident's individual physician.
  - The state's long-term care ombudsman.
  - Immediate family members.
  - Others who are visiting with the resident's consent.
- To use a telephone where calls can be made without being overheard.
- To retain and use personal possessions, including some furnishings and appropriate clothing as space permits unless to do so would infringe upon the rights or health and safety of other residents.
- To share a room with his/her spouse when married residents live in the same facility as long as both consent to the arrangement.
- To self-administer drugs if the interdisciplinary team has determined that the practice is safe.
- To refuse a room transfer to another room within the institution if the purpose of the transfer is to relocate a resident of a skilled-nursing facility (SNF) to a distinct part of the institution that is not a SNF, or a resident of a nursing facility (NF) to a distinct part of the institution that is a SNF. This regulation ensures that the resident cannot be moved to a part of the facility that provides a different level of care unless it is part of the care plan designated by the interdisciplinary team.
- In a case of a resident adjudged incompetent under the laws of the state by the court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.
- In the case of a resident who has not been adjudged incompetent by the state court, any legal surrogate designated in accordance with state law may exercise the resident's right to the extent provide by state law.
- To refuse treatment, to refuse to participate in experimental research, and to formulate an advanced directive.
- To have access to stationery, postage and writing implements at the resident's expense.

Medication control

Overmedication is a serious problem for elderly individuals. Some elders have difficulty keeping track of when and how often they take various medications or the correct dosage to take. Sometimes one or more physicians may prescribe medications that may interact adversely with other drugs the person is taking. Long-term care facilities can add to this problem by encouraging residents to take "as-needed" medications, such as sedatives, relaxants and sleeping medications.

For these reasons, it is important to have the facility monitor all medications using the following procedures:

- Keep a written record that can be reviewed by physicians and family.
- Have a policy for periodic review of all medications the resident is taking.
- Have a policy that the physician clear all new medications or supplements and inform the family.
- Have a clearly stated policy about residents' right to refuse unwanted medication and a system to inform the physician and family**.**

Right to be free from restraints and abuse

483.13

- The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.
- The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.

Quality of life

483.15

- The resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences except when the health or safety of the resident or other residents would be endangered.
- The resident has the right to receive notice before the resident's room or roommate in the facility is changed.
- The resident has the right to organize and participate in resident groups in the facility.

LEGAL REQUIREMENTS AND REGULATING THE NURSING HOME

The Nursing Home Reform Act requires nursing homes to assume the responsibilities of meeting individual needs of each resident. These regulations dictate the specific actions the facility must take to ensure proper care is delivered to each resident.

The facility must inform the resident and family

483.10

- The facility must inform each resident of the name, specialty and method of contacting the physician responsible for his or her care.
- The facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an

accident involving the resident that results in injury and has the potential for physician intervention.
- The facility must immediately inform the resident, consult the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental or psychological status, deterioration in health, mental or psychological status in either life-threatening conditions or clinical complications.
- The facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or interested family member when there is a need to alter treatment significantly or a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment.
- The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

The facility must post information

483.10
- The facility must furnish a written description of legal rights that includes the posting of names, addresses and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit**.**
- The facility must furnish a written description of legal rights that includes a statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility and noncompliance with advanced directives requirements.
- The facility must allow representatives of the state ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

The facility must assess the needs of the resident

483.20
- The facility must conduct initially, and periodically, a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity**.**
- At the time the resident is admitted, the facility must have physician orders for the resident's immediate care**.**
- The facility must maintain all resident's assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive plan of care.

Nursing home surveys

"I love working here when the state is here. We always have all the staff we need."
– A nursing assistant during a three-day inspection.
(Reed, 2009)

The Nursing Home Reform Act requires facilities that accept Medicaid and Medicare reimbursement payments to undergo regular inspections called surveys of the facility to ensure compliance with the laws set forth in the act. Each state has a designated agency in charge of inspecting the facilities within its jurisdiction. The contact information for this agency must always be posted in the facility for all to see. The state agency is responsible for conducting several types of surveys, with the most common type being the annual survey. Other surveys are follow-up inspections and inspections that are conducted in response to a complaint.

The annual survey takes place within 12 to 18 months (although it is called "annual"). This type of inspection is typically performed during the same time frame each year, usually on a weekday. Inspectors occasionally stay into the evening shift so they can conduct part of the investigation on the later shift. Rarely do they inspect in the middle of the night or on weekends.

A follow-up inspection is conducted when a facility has failed a previous inspection and corrective action was required. The corrective action indicates the need to rectify a failing grade or address a situation deemed potentially dangerous for residents. This inspection is conducted to determine whether the facility has appropriately identified and completed the necessary action to bring the facility into compliance with all regulations.

An inspection will also take place if a complaint is filed with the inspecting agency and it is determined that the complaint warrants additional inspection. Inspectors may perform an additional inspection to investigate specific allegations of:
- Abuse.
- Neglect.
- Mistreatment.
- General complaints of poor care.

Complaints may be made by residents, family members, staff or anyone with knowledge or suspicion that a facility is not in compliance with regulations that results in potentially placing residents in harm's way. In order to verify such allegations, the agency will conduct an investigation, which may include an additional inspection.

The annual survey process

For this inspection, the facility administrator knows in advance when the inspection will take place and so is able to prepare. Before their arrival, the surveyors have gathered necessary information about their subject. They review previous survey results to determine whether the facility has any pattern of citations and review any complaints reported to the state ombudsman's office.

Once the surveyors arrive at the facility, they conduct an entrance conference. The team of inspectors, usually three to five people, meets with the administrator and begins the inspection. Inspectors request information from the administrator and review written policies and procedures, mealtimes and staffing information.

The surveyors assign themselves to the areas of the facility that require inspection:
- They check for cleanliness, including the kitchen and dining areas.
- They observe and speak to residents.
- They observe an entire medication pass to ensure compliance with physician orders and federal regulations.
- They inspect the building for compliance with building codes.

- They observe eating and feeding practices.
- They monitor wound care techniques and procedures.

At the end of the inspection, they will analyze all of the information they have collected. If any of the areas of the facility failed to meet the legal requirement during the inspection, a deficiency is issued. Each deficiency is broken into two parts (GAO, 2005):

1. Severity.
2. Scope.

A deficiency is categorized as one of four possible levels of severity:

- **Level 1 deficiency –** Potential for minimal harm. This is the lowest grade with the potential to cause harm.
- **Level 2 deficiency –** Potential for more than minimal harm**.**
- **Level 3 deficiency –** Actual harm noted and cited.
- **Level 4 deficiency –** Immediate jeopardy. This is the highest level of severity and requires the implementation of an emergency plan of correction to avoid eminent danger to residents.

The scope of the deficiency refers to the number of residents affected by the deficiency and is reported using the following terms:

- Isolated.
- Pattern.
- Widespread.

A deficiency may affect as few as one or two residents or it can be widespread, affecting every resident in the facility.

The final part of the inspection process is the exit conference. The administrator and other members of management meet with the inspectors at the conclusion of the final day of the inspection. During this meeting, the deficiencies issued against the facility are disclosed.

Interpretation of the annual survey results

The results of all Centers for Medicare and Medicaid Services (CMS)-mandated nursing home inspections are available at *http://www.medicare.gov*. Copies of the inspection results can also be obtained directly from the state survey agency or from the nursing home facility administrator.

The annual survey results include staffing data divided into three categories:

- The amount of nursing time the facility provides each resident each day.
- The comparison of the facility's average nursing time per resident per day and the state average.
- The comparison of the facility's average and the national average.

Reed noted that some researchers conclude this data is misleading because it does not indicate whether the nursing care is exclusive to the resident. The facility nursing time is determined by dividing the number of nursing hours in the facility by the number of residents in the facility. A nurse who spends much of his time in an office but delivers some nursing care may be factored into this equation. Inappropriately adding these eight hours of nursing care results in a misleading figure.

Another issue to be considered is the level of care provided in the facility that is not considered in the calculation of nursing time per resident in the three categories. In a facility that accepts skilled-care residents, researchers note that most of the nursing hours are dedicated to treating skilled-care residents because they are more dependent and require a more intense level of care than the long-term-care residents.

After nurse staffing time calculations, the annual inspection includes a comparison of 19 quality control measures of the facility with state and national averages.

These quality measures include the following percentage areas:

- Long-term residents given flu and pneumococcal vaccinations.
- Number of residents who require help with daily activities.
- Residents who have moderate to severe pain.
- High-risk residents with pressure sores.
- Low-risk patients with pressure sores.
- Long-stay residents who are physically restrained.
- Long-stay residents who are depressed or anxious.
- Low-risk, long-stay residents who lose control of bowel or bladder.
- Long-stay residents who have had a catheter inserted or left in their bladder.
- Long-stay residents who spend most of the day in their chair or bed.
- Long-stay residents whose ability to move about in and around their room has decreased.
- Long-stay residents with urinary tract infections.
- Long-stay residents who have lost weight.
- Short-stay residents given flu and pneumococcal vaccinations.
- Short-stay residents with delirium.
- Short-stay residents with moderate to severe pain.
- Short-stay patients with pressure sores.

The next part of the inspection report reviews the results of the standard health inspection and compares the average number of deficiencies in the facility to the averages for the state and the national level. This section also lists the dates of any complaint investigations and any mistreatment deficiencies and includes:

- The type of mistreatment and corrections the facility failed to complete.
- The severity of harm from Level 1 to Level 4.
- The scope of the mistreatment, which is measured by the number of residents in terms of isolated (few), pattern (some), or widespread (many).

The next section of the inspection report reviews deficiencies related to fire safety:

- Inspections of the walls and doors.
- Vertical opening deficiencies, such as stairways and vertical shafts.
- Hazardous area deficiencies.
- Emergency plan and fire drill deficiencies.
- Fire alarm system deficiencies.
- Automatic sprinkler deficiencies.
- Results of the severity of harm from Level 1 to Level 4.
- Scope of residents affected.

Finally, the inspection report ends with the number of deficiencies for the previous three annual inspections for the facility. Each of the annual reports from the past three years are compared in the following deficiency categories:

- Mistreatment.
- Quality care.
- Resident assessment.
- Resident rights.
- Nutrition and dietary.
- Pharmacy service.
- Environmental.
- Administration.
- Number of complaints between inspections.

After the inspection: Sanctions and enforcement study by the Government Accountability Office (GAO) 2000-2005

A comprehensive nationwide study was conducted to review federal enforcement efforts and sanctions to address nursing home deficiencies. Four states with the highest level of deficiencies and sanctions were identified and studied to determine whether the sanctions resulted in a decrease in deficiencies and thus an improvement in the quality of elder care.

The states reviewed were Texas, Michigan, Pennsylvania and California. The study was conducted by the Government Accountability Office (GAO), which is the audit, evaluation and investigative arm of Congress. It was developed to support Congress in meeting constitutional responsibilities and to help improve the performance and accountability of the government. The study was conducted to determine whether sanctions were effective in encouraging nursing homes to maintain compliance with federal quality requirements. The GAO study analyzed sanctions from 2000-2005 against 63 nursing homes previously reviewed and assessed by the Centers for Medicare and Medicaid Service's (CMS) overall management of enforcement. The 63 homes had a history of harming residents and were located in four states. Those states account for about 22 percent of homes nationwide and were located throughout the country.

The GAO noted that ensuring the quality and safety of nursing home care has been a focus of considerable congressional attention since 1998. With the Omnibus Budget Reconciliation Act of 1987 (OBRA87), Congress focused on the requirements of quality care provided in the nursing home. OBRA87 also established the range of available sanctions.

CMS contracts with the state survey agencies to assess whether homes meet federal quality requirements through inspections, known as standard surveys, and complaint investigations as discussed in previous sections. Registered nurses, social workers, dieticians and other specialists are normally included on the state survey teams. Deficiencies identified during the surveys are classified in 1-12 categories according to the scope, based on the number of residents potentially and actually affected, and the level of severity. The A-level deficiency is the least serious, and an L-level deficiency is the most serious and considered to be widespread throughout the nursing home. Throughout the GAO study, the term "serious deficiency" is used to refer to care problems that were at the level of actual harm or immediate jeopardy. When the state surveyors identify a B-level or higher, the home is required to prepare a plan of correction, and the surveyor will conduct a repeat visit to ensure the plan has been implemented and the deficiency has been corrected. Below is the breakdown of severity and scope as outlined by the CMS.

Scope and severity of deficiencies identified in nursing home surveys

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy*	J	K	L
Actual harm	G	H	I
Potential for more than minimal harm	D	E	F
Potential for minimal harm**	A	B	C

* Actual or potential for death/serious injury.
** The facility is considered to be in substantial compliance.

Homes with A, B and C level deficiencies are considered to be in substantial compliance with the federal regulations required for quality. D level or higher deficiencies are considered to be out of compliance or noncompliant. The noncompliance period begins when the survey inspection rating notes noncompliance and continues until the nursing home either achieves the required compliance rating by correcting the deficiency or when the home is terminated from the Medicaid or Medicare agency.

Since 1998, the deficiencies cited during the surveys have been summarized on CMS's Nursing Home Compare website (see last section), and CMS has added data on the results of complaint investigations. In addition to federal sanctions, states also impose sanctions under their state licensing or certification agencies, and those are located on the individual state department of health websites.

CMS and the states use a variety of federal sanctions to help encourage nursing homes to meet compliance with quality requirements. These range from less severe sanctions, such as indicating specific actions needed for correction within a specific time frame, to sanctions that affect the home's revenue and provide financial incentives to correct deficiencies and maintain compliance. Two sanctions, CMPs and DPNAs, represented 80 percent of federal sanctions between the years of 2000 to 2005. The following list outlines the different types of sanctions and their descriptions (Table 1).

Table 1: Sanctions and Descriptions

Sanction	Description
CMP	Civil Monetary Penalties fund. The home pays a fine for each day or incidence of noncompliance.
DPNA	Denial of payment for new admissions. Medicaid/Medicare payments for all newly admitted residents may be denied.*
Directed in-service training	The home is required to provide training to staff on the specific noncompliance issue.
Direct plan of correction	The home must take action within a specific time frame to plan corrections developed by CMS, the state or a temporary manager.
State monitoring	An on-site monitor is placed in the home to help ensure that the home achieves and maintains compliance.
Temporary management	The nursing home accepts a substitute manager appointed by the state with the authority to hire, terminate and reassign staff, obligate funds and alter nursing home procedures.
Termination	Loss of Medicare/Medicaid funds for beneficiaries residing in the nursing home.

*CMS may also deny payment for all Medicare- or Medicare-covered residents, but seldom does so because it would severely limit the home's revenues for patient care.

From 2000 to 2005, about 54 percent of the sanctions were CMPs, which range from $50 to $10,000 per day for each day the home is out of compliance. If the CMP cannot be collected, Medicaid/Medicare payments are withheld.

Although nursing homes can be terminated, which can result in the home's closing, it is used infrequently. When a home is terminated, it loses all Medicaid/Medicare income, which accounted for 40 percent of nursing home payments in 2004. If termination occurs, residents must be moved to other facilities. A terminated home can apply for reinstatement if it corrects deficiencies. Termination is required if the home fails to correct immediate jeopardy deficiencies within 23 days, or within six months if the home fails to correct nonimmediate jeopardy deficiencies.

According to CMS, substandard quality of care exists when a home is cited for a deficiency at the F, H, I, J, K, or L level in any of the three following areas:

- **Quality of care** – Deficiencies such as inadequate treatment or prevention of pressure sores.
- **Quality of life** – Deficiencies such as failure to accommodate the needs and preferences of residents.
- **Resident behavior** – Deficiencies such as failure to protect residents from abuse.

Enforcement of nursing home quality of care is a shared federal-state responsibility. In general, sanctions are:

1. Initially proposed by the state agency based on a cited deficiency.
2. Reviewed and imposed by CMS regional offices.
3. Implemented by the same CMS regional office.
4. State inspectors make follow-up visits.
5. The CMS regional office implements the sanctions if deficiencies are not corrected.
6. In the case of an appeal, an informal dispute resolution at the state level may occur or there may be a hearing before an administrative law judge as well as before the Department of Health and Human Services Appeals Board.

The GAO study addressed the issue of the effectiveness of federal enforcement as a deterrent to repeated harm committed by nursing homes on their residents.

The number of sanctions did decrease for the 63 nursing homes studied over the five-year period, which is consistent with nationwide trends. The decline may reflect improved quality or changes in enforcement policy, or may mask weaknesses in the inspection process, which the GAO has reported on since 1998. Although the number of sanctions declined, the homes generally were cited for more deficiencies that caused harm to more residents than other homes in their state. Almost 50 percent of the nursing homes studied continued to cycle in and out of compliance; 19 homes did so four times or more. These homes did correct deficiencies but only temporarily, and were found to be out of compliance in subsequent inspections.

A number of factors seemed to decrease the effectiveness of sanctions implemented against the nursing homes studied:

- Civil money penalties were often imposed at the lower end of the allowable dollar range, with the median CMP ranging from $350 to $500, significantly lower than the maximum of $3,000 per day.
- CMS favored the use of sanctions that gave homes more time to correct the deficiencies; therefore, fewer sanctions were imposed.
- There was no record of a sanction for about 22 percent of the nursing homes reviewed that met CMS's criteria for immediate sanctions, which was identified as a problem by GAO in 2003.
- 60 percent of the DPNAs imposed as immediate sanctions were not implemented until one to two months after the deficiency was cited.
- Involuntary termination of homes was rare because of concerns over locating nearby homes and resident trauma over the transfer. Only two of the 63 homes were terminated over quality problems.
- CMS's management of enforcement was hindered by the complicated immediate sanctions policy and by inconsistent and incomplete data collection. This might explain why the 63 homes reviewed only had 69 cases of immediate sanctions despite 444 citations for deficiencies that harmed residents.
- Although CMS developed a new enforcement policy six years ago, it is still plagued by a fragmented and incomplete system for national reporting. Many researchers, as noted in previous sections, repeatedly reference this.

GAO recommendations

The GAO recommends that the CMS administrator:

1. Develop an administrative process for collecting civil money penalties in a timely and effective manner.
2. Strengthen its immediate sanctions policy so that issues that cause harm to residents can be addressed quickly and uniformly to provide assistance to remedy quality-care issues expediently.
3. Expand its oversight of homes with a history of harming patients.
4. Improve the effectiveness of its enforcement data systems.

Beyond the recommendations of the GAO to improve the enforcement of sanctions to improve the quality of nursing home care, the four states cited in the study made significant reforms of their own.

Texas initiated language as a result of the report that included a state maximum penalty amount that could be assessed per violation, per day at $20,000, exceeding the federal amount of $10,000 per day. It was noted that state officials often use state rather than federal sanctions for G-level or higher deficiencies because the state penalty amount that may be imposed may be greater than the amount of the federal CMPs that may be imposed (Horn, 2007).

Michigan recommended that termination compliance deadlines of less than six months be implemented for all specialized, high-end care facilities and facilities that had recently completed an enforcement cycle and failed to maintain compliance. State officials noted that decreased time frames provide a clear incentive for the early correction of deficiencies.

Under Michigan's state enforcement, officials noted that facilities that continue to harm residents or to provide substandard care receive more severe enforcement commensurate with their compliance history, repeat citations and scope and severity of the citations in the current survey. In addition to the "double D" determination that mandates remedies, a survey that results in two or more harm levels will result in a CMP recommendation. If the facility had a CPM imposed during the preceding 24 months or two standard survey cycles, the next CPM imposed will be at least as high as the previous CPM.

This progressive sanction approach works to stop the cycle of homes adopting temporary compliance and works to increase quality to avoid increasing sanctions. Some of Michigan's "voluntary terminations" were situations in the facility that warranted severe sanctions. The progressive sanctions served to remove the poorly performing home because the owner made the decision to voluntarily terminate before facing serious sanctions or closure.

Finally, they noted one facility cited in the Michigan study had 95 D-level deficiencies and cycled out of compliance seven times in the five-year period of 2000-2005. Because the number of citations exceeds the state average, it was to be given a special review to determine whether it should be terminated without further opportunity to correct because of poor surveys in 2006 (Dankert, 2007).

California addressed its data communications as recommended in the GAO study and implemented a monitoring alert function. ASPEN

(automated survey processing environment) enforcement manager (AEM) was not functional or available to California until January 2007. State officials point out that the workload to copy, e-mail or send survey documents overnight is now diminished, and expedited reviews and recommendations can now occur (Billingsley, 2007).

Legal representation

Residents should have one of the following types of representation in effect while in the nursing home:

- **POA (power of attorney)**
  A document created by a mentally competent individual to appoint another person to handle his or her affairs.
- **DPOA (durable power of attorney)**
  A document created by a mentally competent individual to appoint another person to handle his or her affairs. This document retains its agency power even if the mentally competent individual who issued the authority becomes incompetent.

  Sandell and Hudson (2000) in their book "Ending Elder Abuse," describe the details of this important document. The person designated by the resident as agent will make health care decisions and must be trusted to act consistently with the resident's desires as stated in the document. Except as otherwise specified in the document, the document gives the agent the power to consent to the physician not to give treatment or to stop treatment necessary to keep the resident alive.

  The document gives the resident the right to make medical and other health care decisions for themselves so long as they can give informed consent with respect to the particular decision. In addition, no treatment may be given over the resident's objection at the time, and health care necessary to keep the resident alive may not be stopped or withheld if the resident objects at the time.

  The document gives the agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition. The power of the document is subject to any statement of the resident's desire and any limitations that the resident includes in the document. The resident may state in the document any types of treatment he or she does not want. In addition, the court can take away the power of the agent to make health care decisions for the resident if the agent:
  - Authorizes anything illegal.
  - Acts contrary to the resident's known desires.
  - If the resident's desires are not known, does anything clearly contrary to the resident's best interests.

  The resident has the right to revoke the authority of the agent by notifying the agent or the treating physician, hospital or other health care provider orally or in writing of the revocation. The agent has the right to examine the resident's medical records and to consent to their disclosure unless the resident has limited this right in the document.

  Unless otherwise specified in the document, the agent has the power after the resident dies to:
  - Authorize an autopsy.
  - Donate the resident's body or parts thereof for transplant or therapeutic, educational or scientific purposes.
  - Direct the disposition of the resident's remains.
    - The document revokes any prior power of attorney for health care. Particular attention should be given to the witnessing procedure described at the end of the document because the document will not be valid unless the witnessing procedure is done correctly. It is important that the resident understands everything in the document and asks for an explanation from an attorney if anything is unclear.
    - The agent may need access to the document immediately in case of an emergency that requires a decision concerning health care. The document should be kept where it is immediately available to the agent and alternative agents, and all parties should be given executed copies of the document. The physician also may be given an executed copy of the document.
- **MPOA (medical power of attorney)**
  A document created by a mentally competent individual to appoint another person to make health care decisions on his or her behalf in the event that the mentally competent person becomes incapable of making those decisions for himself or herself.
- **Guardian**
  An individual appointed by the court to act on behalf of a resident who is incapable of managing his or her financial or medical affairs. The guardian can be a lawyer, a nurse, a social worker, a family member or a friend.

A social worker and/or an eldercare attorney can assist the elder resident and/or family to determine which type of representation is appropriate.

Conclusion

The implementation of the Nursing Home Reform Act laws improved nursing home care in many areas, but 24 years later, the quality of nursing home care remains far from satisfactory. Rights and regulations for quality care are often not adhered to because the facilities do not always have adequate resources and staff to provide the level of care the law requires.

A common thread among elder advocates and researchers is that the prevention of elder abuse will require eradication of ageism in our society and a culture of respect for our older adults. It will require that everyone becomes educated about aging to establish the resources needed to provide quality care for aging Americans.

> *"It is not enough for a great nation merely to have added new years to life. Our objective must always be to add new life to those years."*
> – John F. Kennedy, 1963

More information

The following list of organizations has publications and information available:

National Council on Aging
Website: *www.ncoa.org*

The National Center on Elder Abuse
Website: *www.elder abusecenter.org*

National Center for the Prevention of Elder Abuse
Website: *www.preventelderabuse.org*

National Health Information Center
Dept. of Health and Human Services
Website: *www.health.gov/ncih*

Family Caregiver Alliance
Website: *www.caregiver.org*

Federal Administration on Aging
Website: *www.aoa.dhhs.gov*

Visiting Nurses Association of America
Website: *www.vnaa.com*

National Parkinson's Foundation
Website: *www.parkison.org*

Alzheimer's Association
Website: *www.alz.org*

Children of Aging Parents
Website: *www.caps4caregivers.org*

National Hispanic Council on Aging
The Eldercare Locator
Telephone: 800-677-1116
9 a.m. to 11 pm (EST)

National Association of Home Care
Website: *www.nahc.org*

National Family Caregivers Association
Website: *www.nfcacares.org*

National Aging Information Resource Center
Website :*www.aoa.gov/NAIC/Notes/caregiverresourcehtml*

National Association of Professional Geriatric Care Managers
Website: *www.caremanagers.org*

National Association of Elder Law Attorneys
Website: *www.naela.com*

National Caucus and Center on Black Aged
Website: *www.ncba.org*

Nation Senior Citizens Law Center
Website: *www.nsclc.org*

National Citizen's Coalition for Nursing Home Reform
Website: *www.nccnhr.org*

American Association of Homes and Services for the Aging
Website: *www.aahsa.org*

American Association of Retired Persons (AARP)
Website: *www.aarp.org*

The Office of Geriatric Medicine/Gerontology
Email: brp@neo@neoucom.edu

References

- Administration on Aging. National Ombudsman Reporting System Data Tables. (2003), Retrieved from http://www.elderabusecenter.org.
- Administration on Aging (2011) Statistics on Aging. Retrieved from http://www.aoa.org. October 21, 2011.
- Alecxih, L. M. (1997) Demographics and Service Need Projections for the Aging Population. Retrieved from http://www.academyhealth.org.October, 21, 2012.
- Alecxih, L.M., Corea, J., Gross, D.J., Gibson, M.J., Caplin, C.F., Brangan, N. Out of Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections. Washington D.C. American Association of Retired Persons.
- Almost Home (2006) http://www.pbs.org. Retrieved October, 21, 2011.
- Billingsley, K. (2007) Comments from the State of California Health and Human Services Agency Department of Health Services. In GOA-07-241Report on Nursing Home Enforcement.
- Blencker, M., Bloom., M., Weber, R. (1974) Benjamin Rose Institute Study. Cleveland, OH.
- Bonnie, R. J. & Wallace, R.E. (2003)Elderly Mistreatment, Abuse, Neglect, and Exploitation in Aging America: A Panel to Review Risk and Prevalence of Elder Abuse and Neglect, National Research Council, National Academy of Sciences. Retrieved from September 30, 2011.htpp://www.nap.edu/catalog/10406.html.
- Brookmeyer, R. (1998) Forecasting the Global Burden of Alzheimer's. Retrieved from http://www.works.bepress.com/rbrookmeyer/doctype.html.
- Burgess, A. Hanrahan, N. (2006) Identifying Forensic Markers in Elder Sexual Abuse Final Report. National Institute of Justice, 255, 1-7.
- Caregiver Stress and Elder Abuse (2002) htpp://www.elderabusecenter.org. Retrieved October 21, 2011.
- Dankert, M. (2007) Comments from the Michigan Department of Community Health. In GAO -7-241 Nursing Home Enforcement.
- Daschle, T. (2008), What Can We Do About The Health Care Crisis, New York, NY: St Martin's Press.
- Dyer, C.B., Connolly, M. T., & Mc Feeley, P. (2003) The Clinical and Medical of Forensics of Elder Abuse and Neglect. In Bonnie, R.J. & Wallace, R., (Ed.) Elder Mistreatment: Abuse, Neglect,, and Exploitation in an Aging America (344-360). Washington, D.C. National Academies Press.
- Eberhardt, M.S., Ingram, D.D., Makuc, D.M., (2001) Urban and Rural Chartbook. National Center for Health Statistics. Retrieved from http://www.nap.edu/catalog/10406.htlm.
- Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents (2007) http://www.gao.gov/cgi-bin/getrpt?GAO-07-241. Retrieved October 21, 2012
- Frolik, A. & Whitton, S. (2010), Everyday Law For Seniors, Boulder, CO: Paradigm Press.
- Gallup Poll (1995) Retrieved from http://www.Gallup.com
- Hetzel, L. & Smith, A (2001) Recognizing and Reducing Elderly Abuse in Long Term Care Facilities. Bonnie, R.J. & Wallace, R.E., (Ed.), Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America. Retrieved from http://www.nap.edu/catalog/10406.html.
- Himes, C.L., Hogan, D.P., Eggebeen, D.J. (1996) Living Arrangements of Minority Elders. Journal of Gerontology: Social Sciences.S1B:42-48.
- Horn, A. (2007)Comments from the Texas Department on Aging and Disability. GAO-07-241 Report on Nursing Home Enforcement.
- Jogerst, Gerald J. (2003) Domestic Elder Abuse and the Law. American Journal of Public Health.93.12:2131-2136.
- Jones, J., Dougherty, J.D., Scheelbie, D., & Cunningham, W. (1998)Emergency Room Protocol for the Diagnosis and Evaluation of Geriatric Abuse. Annals of Emergency Medicine, 17, 1006-1015.
- Kennedy, J.F. (1963) Quote In Sandell, D.S., & Hudson, L. Ending Elder Abuse. Ft. Bragg, CA: Cypress House.
- Lachs, M.S., & Pillemer, K. (2004) Elder Abuse, The Lancet, 364, 1192-1263.
- Lichtenstein, B. & Gildehaus, L. (2006) Nursing Home Reform. Retrieved from http://www.ITVS.org: October 20, 2012.
- Lindbloom, E., Brandt, C .Hawes, C. Phillips, D. Zimmerman, J., Robinson, B., & McFeeley, P. (2005) The Role of Forensic Science in Identification of Mistreatment Deaths in Long-Term Care Facilities, Retrieved October 1, 2011, from http://www.ncjrs.gov/pdffiles1/ NIJ/grants/209334.pdf.
- Matthews, J. L., (2003). Choosing the Right Long Term Care, Berkeley, CA : Nolo.
- McNamee, C.C. & Murphy, M.B. (2006) Elder Abuse in the United States. Journal of the National Institute of Justice, 255, 1-7.
- Mosqueda, L., Burnight, K., Liao, S. (2006) Bruising in the Geriatric Population, final report submitted to the National Institute of Justice, Washington, DC: Retrieved from http:// www.ncjrs.gov/pdffiles1/nij/grants/2146499.pdf.
- National Center on Elder Abuse. (2003) A Response to the Abuse of Elder Adults: The 2000 Survey of Adult Protective Services. Retrieved from http://www.ncea@nasua.org.October1, 2011.
- National Center on Elder Abuse. (2005) Elder Abuse Prevalence and Incidence. Retrieved from http://www.ncea@nasua.org. October 5, 2011.
- National Ombudsman Reporting Systems Data Tables (2003) Washington, D.C.:U.S. Administration on Aging.
- NBC Nightly News (2011) October, 27, 2011.Obama Administration Approves Partial Cuts to California Medicaid.
- Nelson, T.D. (1984) Ageism in Stereotyping and Prejudice Against Older Adults (Ed.). Cambridge, MA:MIT Press.
- Nursing Home Reform Act (1987) Code of Federal Regulations, Title 42- Public Health, 483, Requirements for States and Long –Term-Care Facilities.
- Pepper, C. & Okar, M.R. (1981) Elder Abuse: An Examination of a Hidden Problem. Report Issued to the Select Committee on Aging U.S. Congress. Comm. Pub No.97-277. Washington, D.C.: U.S. Government Printing Office.
- Pillemer, K. & Finkelhor, D. (1998)The Prevalence of Elder Abuse. The Gerontologist, 28, 51-57.
- Platt, A. M. (1969) The Child Savers. Chicago, IL. University of Chicago Press.
- Population Projections of the United States by Age, Sex, Race, Hispanic Origin, and Nativity: 1999-2100. Retrieved from http://ftp.census.gov/population/projections/nation /detail/np-d5-cd.txt.
- Quigley, T. (2004) Suspicions of Cullen Arose in 1993. The Express Times, May 30, 2004. Retrieved from http://www.nij.gov/journals/255/elder_abuse. html
- Reed, D. (2009). An Insider's Guide to Better Nursing Home Care, Amherst, NY: Prometheus Books.
- Rice, D.P., Fillit, H.M., Max, W., Kropman, D.S., Lloy, J.R., & Duttagupta, S. (2001) Prevalence Costs, and Treatment of Alzheimer's disease and Related Dementia. American Journal of Managed Care.7 (8)809-818.
- Sandell, D. & Hudson, L.(2000) Ending Elder Abuse, Fort Bragg, CA: Cypress House
- Steigerwalt, K. (2007) Resources 4 Nursing Home Abuse. Retrieved October 21, 2011, from http://www.legalchatonline.com.
- Stone, R.L (2000) Long-Term Care for Elders with Disabilities. Retrieved from http://www.milbank.org/0008stone/
- United States Office of Health and Human Services (2011) Retrieved from http://www.hhs.gov.
- United States Social Security Administration (2011) Retrieved from http://www.ssa.gov.
- Volderheide, B. (2008) Action Agenda For Nursing Home Reform In Kentucky. Retrieved October, 21, 2012, from http://www.kynursinghomereform.org.
- Wasik, J.F. (2000) The Fleecing of America's Elderly. Consumer's Digest. March/April.
- Whitton, L.S., (2007) Durable Powers as an Alternative to Guardianship: Lessons We have Learned. Stetson Law Review, 37, 7.
- Wolf, R.S. (1986). Major Findings From the Three Model Projects on Elder Abuse. In Pillemer, K.A. & Wolfe, R.S., (ED.) Elder Conflict in the Family. (218-238). Dover, MA, Auburn House

ELDERLY ABUSE IN AMERICA: PREVALENCE, ETIOLOGY AND PREVENTION

Final Examination Questions

Select the best answer for each question questions 1 through 10 and mark them on the answer sheet found on page 84 or complete your test online at **SocialWork.EliteCME.com.**.

1. The lack of a "gold standard "definition for abuse may lead to which of the following problems?
   a. Adult protective services agencies and physicians are not trained to distinguish between injuries caused by mistreatment and those that are the result of accident, illness or aging.
   b. Abuse cannot be determined in all cases.
   c. Offenders are difficult to prosecute.
   d. There is no accurate way to detect abuse.

2. Psychological conditions may indicate which of the following?
   a. The elder may not be abused just confused.
   b. Psychological conditions may indicate that neglect or abuse has taken place.
   c. There is no correlation with physical abuse.
   d. All abuse is psychological.

3. The National Center on Elderly Abuse (NCEA) defines elderly abuse as_____.
   a. Intentional or neglectful acts by a caregiver or trusted individual that leads to harm of a vulnerable, elderly individual.
   b. Forensic evidence that physical abuse took place by a caregiver on an elderly person.
   c. Physical and psychological harm to a person over 65.
   d. Any harmful act by a family member or caregiver.

4. Self–neglect is considered to be _____.
   a. Not a form of elder abuse.
   b. A form of elder abuse.
   c. A part of dementia
   d. A normal occurrence among the elderly.

5. The term caregiver refers to _____.
   a. Anyone paid to care for someone.
   b. Anyone who routinely helps others who are limited by chronic conditions.
   c. Anyone who has contact with elderly persons.
   d. Staff who are working with the elderly in nursing homes.

6. Medication control is a problem for elderly persons. Which of the following may add to this problem?
   a. Long-term care facilities can add to this problem by encouraging residents to take "as-needed" medications, such as sedatives, relaxants and sleeping medications, on their own.
   b. Families add to the problem by over medicating elderly family members to sedate them.
   c. Pharmacists often give the wrong dosages.
   d. Long-term facilities never give enough medication for fear of liability.

7. According to NCEA data, which of the following is accurate?
   a. 95 percent of all reported elder abuse occurs in nursing homes.
   b. The majority of elder abuse cases happen in residential, long-term facilities.
   c. In 90 percent of all reported elder abuse cases, the abuser is a family member.
   d. 75 percent of elder abuse cases happen in the home.

8. Nutritional documentation includes which of the following?
   a. There must be no more than 14 hours between a substantial evening meal and breakfast the following day.
   b. Patients must have at least 2 meals a day since many elderly patients do not require as much food.
   c. Patients requests for foods that dictate the diet they will receive.
   d. Guidelines that forbid outside foods that may not be nutritious.

9. The facility must provide what type of environment for the elderly residents?
   a. The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belonging to the extent possible.
   b. The facility must provide a safe, medically supportive environment.
   c. The environment must meet the needs of the majority of elderly residents.
   d. Each facility provides a different type of environment dictated by the state statutes only.

10. A common thread among elder advocates and researchers is that the prevention of elder abuse will require one of the following?
    a. Better medical care.
    b. Improved regulation and monitoring.
    c. Eradication of ageism in our society and a culture of respect for our older adults.
    d. Better treatment for all forms of dementia.

SWCO05EAE15

Chapter 2: Ethics and Boundaries

3 CE Hours

By: Rene' Ledford, MSW, LCSW, BCBA and Kathryn Brohl, MA, LMFT

Learning objectives

- Understand the importance of professional values and ethics in mental health practice.
- Identify the role and the impact of law in mental health practice.
- Recognize and distinguish between problematic and non-problematic boundary issues in mental health practice.
- Describe ways mental health practitioners can prevent unethical or illegal behaviors in daily practice.
- Identify elements and conditions of informed consent.
- Understand the basic requirement of HIPAA and the Privacy Rule as it relates to practice.
- Understand the impact of technology on mental health practice and the unique responsibilities that are included.
- Identify a protocol for ethical decision-making.

INTRODUCTION

Ethics and mental health practice

Ethical issues are common in any profession. But mental health work, which relies heavily on relationship building and which can directly impact the health and welfare of its clients, poses even greater responsibilities and challenges.

Mental health practitioners must rely on internal guides of character and integrity and external guides such as laws and ethical codes of conduct. Consider these two examples:

- **Mary,** a mental health counselor, provided counseling services at a community mental health center. Most of her clients did not have insurance nor could afford to pay privately anywhere else. After several years of postgraduate full-time practice, Mary felt competent providing services for most issues.

  After three sessions with one of her clients, her client confessed that he wanted a sex-change operation and would need Mary's support through the process. Mary had taken few graduate level courses in human sexuality and had no other specialized training in this specialized area. If there was another clinician available who specialized in gender reassignment issues, her client could not afford it. Given her strong belief in client self-determination, the client's belief in her ability to assist, and her willingness to read the literature and consult the Internet on protocol, Mary agreed to revise their plan of treatment and proceed.
- **Joaquin,** a licensed clinical social worker, and his client, a young man with schizophrenia, have successfully worked together to achieve stability in symptom management and independent living. Joaquin and his client are close in age, have many interests in common and consequently have achieved a strong rapport and mutual trust. Now Joaquin is transferring to a supervisory position, which will effectively end his professional relationship with the client. His client wishes to continue their relationship as friends, and Joaquin is tempted to do so.

In these two examples, each mental health practitioner demonstrates both a compassion for and commitment to their respective clients. They are at a crossroads in their relationship with their clients. What they decide to do next must consider various issues that include what is in the best interest of the client and the client's right to self-determination.

The primary reason for action

What is easiest, most comfortable, and/or desired by these mental health practitioners should never be the primary reason for action. If the needs of the client versus mental health therapist were the only considerations, decision-making would be easy. However, the mental health worker must also consider the ethical guidelines established by various government agencies and national mental health professional associations, as well as the law.

In the first scenario, Mary must balance both her and her client's desire to continue what appears to be a comfortable and trusting therapeutic relationship, with the need to provide the most effective service for the client. Clearly Mary is not qualified to provide the service this client needs. Is her plan for a crash course in transgendered treatment adequate? Should she make a referral to a more competent therapist? Should she work with the client to overcome the financial barriers he is facing?

If Mary makes the wrong decision, she might either violate ethical guidelines or the law, or both. She may be committing a medical error and putting her client at risk of harm. Her actions may also result in Mary being sued and/or censured.

Joaquin must ask himself the question, "Am I considering crossing the boundaries of our professional relationship for my own needs or for those of my client?" Clearly both Joaquin and his client value a friendship but what potential harmful impact could this have on one or both of them?

Ethical decision-making is a complex process, requiring mental health practitioners to look at not just the immediate impact, but also the long-term and future consequences of their actions.

Defining ethics

The word "ethics" is derived from both the Greek word "ethos," which means character, and the Latin word "mores," meaning customs. Ethics defines what is good for both society and the individual. Though closely related, law and ethics do not necessarily have a reciprocal relationship. While the origins of law can often be based upon ethical principles, law does not prohibit many unethical behaviors. Likewise, adherence to certain ethical principles may challenge a mental health practitioner's ability to uphold the law.

For example, documenting that a service has occurred when it hasn't may be unethical, but not subject to prosecution. Unfortunately, it may take high-profile adverse consequences of unethical behavior, such as the discovery that a child under protective custody has been missing for months, to create new laws that support ethical standards of behavior. For instance, in a well-publicized case, the state of Florida made the falsification of documentation, e.g., visitations that never took place, illegal for people employed as child welfare workers.

Implications for practice

Ethical standards are, according to Reamer (Ethical Standards in Social Work, 1998), "created to help professionals identify ethical issues in practice and provide guidelines to determine what is ethically acceptable and unacceptable behavior." What makes mental health work unique is its focus on the person as well as its commitment to the well-being of society as a whole.

The social work profession adopted the first code of ethics for the profession in 1947. In 1960, following the formation of the National Association of Social Work, another code of ethics was drafted, with multiple revisions in the following years. Ethics have been developed for other national mental health licensing associations and boards that include among others, The American Association for Marriage and Family Therapy, The American Counseling Association, and The American Mental Health Association.

The American Association for Marriage and Family Therapy "strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as professional expectations" that are enforced by its own ethics committee. The American Counseling Association "promotes ethical counseling practice in service to the public." The primary mission of the National Association for Social Workers is to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty."

Being part of a professional association not only brings a wealth of knowledge and expertise but also certain rights and privileges for its members. But those benefits must not overshadow the professional's commitment to promote ethical behavior on behalf of clients.

When an individual identifies with a mental health profession, he or she is pledging to practice in an ethical and responsible manner. In addition to allegiance to the professional ethics and standards of practice it promotes, the individual also has a duty to support the values, rules, laws, and customs of the society with which they remain a part.

The law and mental health

Here is one scenario that illustrates how law can interface with mental health practice:

> A licensed mental health practitioner believes a foster teen's allegations of abuse toward her foster father merely represent countercoercive behavior related to her adjustment within a more stable, rule-enforced environment and chooses not to report it. He rationalized that this family had successfully helped many children before without incident.

As pointed out earlier, criminal law and professional and ethical guidelines are not one and the same – they may complement each other or be in opposition of one another depending on the issue and on the state. For example, a minor legal offense may result in a small fine but could then lead to loss of a professional license. Licensed mental health practitioners have not just an ethical responsibility but also a legal responsibility to learn and follow any and all regulations in the jurisdiction within which they practice.

In the case described above, federal and state laws about mandatory reporting leave little choice for a professional but to report the allegations of abuse. Sometimes we can be too sure of our abilities or too fearful (in this case, potentially losing a foster parent), and in doing so ignore the very real consequences of violating the law. Or, in less obvious circumstances, we may just not know.

With the advent of technology-based practice, such as e-therapy, the mental health practitioner's scope of responsibility is even larger; some jurisdictions identify the location of practice, and thus the applicable laws and rules, as that of the client's. We will explore more about technology-based and other practice implications later in this course.

Impact of law on practice

Currently the United States, including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and other countries regulate some form of mental health practice. Many typically regulate practice through statutes, i.e., practice acts that stipulate who may practice and/or call themselves mental health practitioners (Saltzman and Furman, 1998). State oversight boards give authority to practice to qualified individuals, typically defined by three competencies:

- Education.
- Experience.
- Passing score on an examination.

Failure to abide by these regulations can have serious and negative legal and financial consequences. For example, mental health professionals need to understand that they may not be covered by their insurance policy if they were not practicing legally at the time of a questionable ethical occurrence; i.e., were not licensed as required by law.

There are also laws that impose legal obligations to abide by practices that further serve to protect the consumer, such as federal and state statutes requiring mandatory child abuse reporting, practices that ensure client confidentiality, or competence to perform certain services.

Unlike regulation under the law, adherence to regulations set forth by private credentialing bodies is voluntary. However, the regulations and codes of ethics are universally respected. Mental health professionals also practice in accordance to the professional standards of care established by private professional association organizations such as ACA, NASW, or AAMFT.

Establishing ethical codes of conduct

In addition to professional affiliation code of ethics, (such as established within national professional associations), state licensing laws and licensing board regulations identify basic competencies for mental health practice. Failure to follow the ethical codes of one's profession may result in expulsion from the profession, sanctions, fines, and can result, if sued, in a judgment against the practitioner.

For example, Strom-Gottfried (2000) reviewed 894 ethics cases filed with NASW between July 1, 1986, and December 31, 1997. About 48 percent of the cases resulted in hearings and of those, 62 percent concluded that violations had occurred for a total of 781 different violations.

The study clustered those violations into 10 categories:
1. Violating boundaries.
2. Poor practice.
3. Competence.
4. Record keeping.
5. Honesty.
6. Confidentiality.
7. Informed consent.
8. Collegial actions.
9. Reimbursement.
10. Conflicts of interest.

Of the 267 individuals found to have violated ethical standards, 26 percent were found to have violated only one ethics category, while 74 percent had violated more than one. Most of the cases (55 percent) involved boundary violations, such as those involving sexual relationships and dual relationships. Given the frequency that these violations occur, (and remember, this study only examined reported violations) we will be exploring these two violation types in more depth later. The findings reflected a variety of inappropriate behaviors that blurred the helping process and exploited clients including:
- The use of physical contact in treatment.
- The pursuit of sexual activity with clients, either during or immediately after treatment.
- Social relationships.
- Business relationships.
- Bartering.

Unintended actions

Some mental health professionals may argue that an action is ethical as long as you are not intending harm and/or are not knowingly violating an ethical standard or law. Or, what about those unique situations that don't readily lend themselves to a reference in law or codes of conduct? What defines prudent practice? Grappling with questions about what is unethical and what isn't ethical is a situation faced by any person in the helping professions.

Pope and Vasquez (1998) discuss the tendency to rationalize that an action is acceptable, as it relates to the practice of psychotherapy and counseling.

This rationalization encompasses two principles:
1. Specific ignorance.
2. Specific literalization.

Specific ignorance
The principle (or rationalization) of specific ignorance states that even if there is a law prohibiting an action, what you do is not illegal as long as you are unaware of the law.

Literalization
The principle (or rationalization) of literalization states that if we cannot find a specific mention of a particular incident anywhere in legal, ethical, or professional standards, it must be ethical.

Assisting mental health practitioners in resolving ethical dilemmas that may arise in practice is just one of several purposes for establishing ethical codes of conduct.

Ethical standards of practice for mental health generally benefit both the practitioner and the public and include:
1. Identifying core values.
2. Establishing a set of specific ethical standards that should be used to guide mental health practice.
3. Identifying relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. Providing ethical standards to which the general public can hold mental health professionals accountable.
5. Providing mental health ethical practice and standards orientation to practitioners new to the mental health field.
6. Articulating formal procedures to adjudicate ethics complaints filed against mental health practitioners.

Core values and ethical principles

The core values espoused by mental health ethics codes incorporate a wide range of overlapping morals, values, and ethical principles that lay the foundation for the profession's unique duties. They generally include:
- Service.
- Autonomy – Allowing for freedom of choice and action.
- Responsibility to clients.
- Responsibility to the profession.
- Responsibility to social justice.
- Responsibility for doing no harm.
- Dignity and worth of the person.
- Confidentiality.
- Importance of human relationships.
- Do good and be proactive.
- Professional competence.
- Integrity.
- Engagement with appropriate informational activities.
- Treating people in accordance with their relevant differences.
- Responsibility to students and supervisees.
- Fidelity.
- Responsibility to research participants.
- Financial arrangements conform to accepted professional practices.

Depending on a particular professional association's Code of Ethics, ethical professional practice can include:
- Helping people in need.
- Challenging social injustice.
- Respecting the inherent dignity and worth of the person.
- Recognizing the central importance of human relationships.
- Behaving in a trustworthy manner.
- Practicing within areas of competence and developing and enhancing professional expertise.

The intent of some of the principles, such as responsibility to students and supervisees, are what mental health practitioners can aspire to, while others are much more prescriptive, clearly identifying enforceable standards of conduct (Reamer, 1998).

Most ethics codes describe specific ethical standards relevant to six areas of professional functioning. These standards provide accepted

standards of behavior for all mental health clinicians concerning ethical responsibilities:

1. To clients.
2. To colleagues.
3. To practice settings.
4. As professionals.
5. To a particular mental health profession focus.
6. To the broader society.

This course will continue to look at issues around each of those areas.

Ethical responsibilities to clients

This illustration highlights the complexity of ethical responsibility to clients:

> **Example:** A depressed, 80-year-old client, suffering from the painful, debilitating effects of arthritis, asks Rene, his mental health therapist, for information on assisted suicide. He tells her that he only needs help downloading information from the Internet and then it is his right to weigh the options of proceeding. Rene believes the client's depression is directly related to the pain, because the client is otherwise of sound mind, and therefore has a right to determine his future.

Commitment

Client interests are primary. The example above epitomizes the difficulties often faced by mental health practitioners when the principles of law, personal belief, professional codes of ethics, client need, and cultural and societal norms intersect and at times contradict each other. The professional is then faced with a conundrum that offers a multitude of potential decisions, actions, and consequences. We will discuss more about how the worker can best weigh all these considerations to make the most ethical decision later in this course.

Self-determination

Another standard that strongly reflects the mental health practitioner's commitment to a client is that of self-determination. Professionals have an obligation to support and assist clients in accomplishing their goals, only deviating from this when a client's goal puts them or others imminently at risk.

Defining risk can be difficult – most mental health professionals cannot argue that suicide or homicide do not present a clear risk to the client or to others. Other client choices, such as staying in an abusive relationship or living in squalor or on the streets, may challenge a professional's personal values and sincere desire to protect, also known as "professional paternalism." (Reamer, 1998.) In the absence of clear and present harm, the client has a right to choose his or her own path and make his or her own decisions, whether we agree or disagree.

Suicide: The right to choose versus duty to protect

Sometimes a mental health practitioner may be faced with a choice between a client's right to choose suicide and the duty to protect his or her life. The request by the emotionally stable and rational terminally ill client is a good example of a situation that is not as "cut and dried" as that involving a severely depressed young woman contemplating suicide.

Would one client deserve individual consideration and thus not be assessed for possible hospitalization over the other? Most workers choose this profession because it supports respect for the strengths and abilities of clients, and thus their ability to learn, make good decisions, and be self-sufficient. But aside from laws prohibiting assisted suicides, workers also rely on intuition and judgment in determining whether to take action to protect a client from harm. This scenario blurs the line between respect for the client's wishes and society's obligation to protect. It also raises the issue of client autonomy versus the professional obligation to prevent discrimination. Thus, it is essential that mental health practitioners establish clear procedures that ensure impartial assessment while valuing client autonomy and individual treatment.

Since laws and professional codes of ethics are not always clear and do not always spell out our specific duties and responsibilities, it is recommended that workers not only do everything to assist clients in taking advantage of any options to alleviate their distress, but also rely on practice guidelines that call for:

- Careful evaluation, such as the client's ability to make rational choices based on the mental state and social situation.
- A good therapeutic alliance.
- Consultation.

Informed consent

Informed consent services should only be provided when valid informed consent can be obtained. Therefore, clients must know the exceptions to self-determination before consenting to treatment or other services. Mental health professionals working in child welfare or forensic practice settings are faced with additional challenges. In their article about informed consent in court-ordered practice, Regehr and Antle (1997) state:

> Informed consent is a legal construct that is intended to ensure that individuals entering a process of investigation or treatment have adequate information to fully assess whether they wish to participate. This concept of informed consent is closely linked with the value of self-determination.

Generally, potential threats and factors to be considered in ensuring the validity of informed consent are:

- Language and comprehension.
- Capacity for decision making.
- Limits of service refusal by involuntary clients (including court-mandated clients).
- Limitations and risks associated with electronic media services.
- Audio and videotaping.

Competence (or professional and ethical competence)

Another section that relates to informed consent, competence, is mental health professionals' responsibility to represent themselves and to practice only within the boundaries of their education, experience, training, license or certification, and level of supervisory or consultant support. For example, poor practice, or the failure of a worker to provide services within accepted standards, was the second most common form of violation found in Strom-Gottfried's study of code violation allegations resulting in social work practice (2000).

The study also revealed findings of incompetence, in conjunction with other forms of unethical behavior, in 21 percent of the cases. In these cases, reasons why a social worker was not competent to deliver services included:

- Personal impairments.
- Lack of adequate knowledge or preparation.
- Lack of needed supervision.

Conflicts of interest

One of the most difficult areas of responsibility to clients is conflict of interest. Workers need to avoid conflicts of interest that interfere with the exercise of:

- Professional discretion.
- Impartial judgment.

The issue of informed consent should include both prescribing the need to inform clients of potential or actual conflicts, and taking reasonable steps to resolve the conflict in a way that protects the client's needs and interests.

Dual or multiple relationships

Dual or multiple relationships occur when mental health professionals relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.

Dual or multiple relationships with current or former clients should be avoided whenever possible, and the exploitation of clients for personal, religious, political, or business interests should never occur.

Further, workers should not engage in dual or multiple relationships with clients or former clients where there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries.

Recognizing that there are many contexts within which mental health work is practiced, dual relationships are not always entirely banned by different professional association ethical codes. The word "should" in sections where dual or multiple roles are outlined within various codes of ethics, implies there is room for exceptions. However, what they are usually distinguishing is that dual relationships are not permitted when there is risk of exploitation or harm. In not banning all dual relationships, each worker bears the responsibility for both determining, and if needed, proving that the relationship was not harmful to the client.

Boundary violations

Conflicts of interest relate closely to other types of unprofessional behavior such as boundary violations, which more specifically identifies harmful dual relationships. Most mental health professionals can easily recognize and identify common boundary issues presented by their clients.

Likewise, most can identify examples of boundary violations around professional behavior, for example, sexual misconduct. While not exclusive to the clinical role, there are certain situations that are more challenging than others, especially for workers vulnerable to committing boundary violations.

Boundary issues involve circumstances in which there are actual or potential conflicts between their professional duties and their social, sexual, religious or business relationships. These are some of the most challenging issues faced in the mental health profession and typically involve conflicts of interest that occur when a worker assumes a second role with one or more clients. Such conflicts of interest may involve relationships with:

- Current clients.
- Former clients.
- Colleagues.
- Supervisees and students.

With that in mind, the following would be examples of inappropriate boundary violations, and thus unethical, in that they involved a dual relationship that is exploitive, manipulative, deceptive, or coercive in nature.

- Buying property from a disaster client at far below its market level.
- Falsely testifying to support fraudulent actions of clients.
- Imposing religious beliefs on a client.
- Suggesting that a hospice client make you executor of his/her will.
- Referring a client to your brother-in-law, the stockbroker.
- Friendship with the spouse of a client you are treating for marital issues.

Five conceptual categories with regard to boundary violations generally occur around five central themes:

1. **Intimate relationships** – These relationships include physical contact, sexual relations, and gestures such as gift giving, friendship, and affectionate communication.
2. **Pursuit of personal benefit** – The various forms this may take include monetary gain, receiving goods and services, useful information.
3. **Emotional and dependency needs** – The continuum of boundary violations ranges from subtle to glaring and arise from social workers' need to satisfy their emotional needs.
4. **Altruistically motivated gestures** – These arise out of a mental health practitioner's desire to be helpful.
5. **Responses to unanticipated circumstances** – Unplanned situations over which the social worker has little to no control.

Intimate relationships

As discussed earlier, boundary issues involving intimate relationships are the most common violations. Those involving sexual misconduct are clearly prohibited and will be further explored.

While most professionals might agree that having other nonsexual relationships, such as a friendship, with a current clinical client is inappropriate, the rules are not as clear regarding ex-clients and even less so for those clients in case management, community action, or other non-clinical relationships.

When a dual relationship results in personal benefit to the practitioner it also undermines the trusting relationship. Some of the scenarios mentioned earlier (getting property below market value, becoming the executor of the client's will, and referring clients to a relative) are all examples.

There are very respectful, sound and appropriate reasons for encouraging clients to share what they know and to listen to their strengths. Benefiting from information the client has (e.g., stock tips and leads on jobs) is another matter. It is important to remember that

this can apply both ways, i.e., the mental health professional needs to avoid offering assistance in areas outside his or her role.

"Your usefulness to your patients lies in your clinical skills and separation of your professional role from other roles which would be better filled elsewhere in their lives. Do not suggest, recommend, or even inform the patient about such things as investments, and be cautious about giving direct advice on such topics as employment and relationships. There is a difference between eliciting thoughts and feelings to encouraging good decision making and inappropriately influencing those decisions." (Reid, W. 1999)

Another tricky area involves bartering arrangements, particularly involving the exchange of services. These should be considered carefully, and according to Reamer (2003), be limited to the following circumstances when they are:

- An accepted practice among community professionals.
- Essential to service provision.
- Negotiated without coercion.
- Entered into at the client's initiative.
- Done with the client's informed consent.

Again, the professional is in the unenviable position of determining whether an action presents the possibility of psychological harm to the client. Kissing on the cheek, for example, may be perfectly correct and clearly nonsexual in certain cultures and contexts, but may confuse or intimidate a client in other contexts.

Another area fraught with peril is when workers engage in behavior arising from their own emotional needs. Most mental health practitioners are more familiar with examples of intentional and even more egregious examples, such as the practitioner who uses undo influence to "convert" the client or takes sides in a custody case in order to foster a relationship with one of the spouses. Many times the boundaries are crossed unintentionally, as in a practitioner who becomes overly involved in a case with which she personally identifies. Or the worker may be experiencing life issues that make him or her more vulnerable to the attention of a client.

Mental health professionals have a responsibility to maintain competence in both the professional and emotional arenas. Regardless of the circumstances, the worker's first responsibility is always to the client.

There are also times when the intent of the professional is truly out of a desire to be helpful, such as buying merchandise from a client whose business is struggling or inviting a divorce recovery group client to a community function in order to help her broaden her social network. While some types of situations may not be considered unethical or illegal, the worker needs to carefully review his or her motivation and the potential consequences of each decision. Some helpful questions to ask are:

- Would I do this for all my clients?
- Am I doing this because I feel uncomfortable (e.g., saying no)?
- Am I feeling at a loss to help the client any other way and thus feeling, "I must do something" to feel competent?
- How might the client interpret my gesture?
- Am I doing this just for the client's interest or also for my own interest?
- What are all the potential negative outcomes?

There will be occasions when you incidentally come into contact with a client, such as finding your client's daughter is on the same soccer team as your child. Some practitioners go out of their way to live in a different community so the chances are minimal that this could happen. Others see that as over-managing a potential situation that is unlikely to lead to harm for the client or colleague (as in the case of supervisees).

The appropriateness of relationships with clients is often debated across the profession. The unique service settings and roles assumed by workers often contrast with the traditional clinical approach to human service. Applying strict rules around relationships can appear excessive and/or contradictory with sound mental health practice. A worker, for example, may work in a small, isolated community that would expect its community members to share in social customs such as family meals and weddings.

Ethical guidelines recommend giving students a copy of supervisees' guidelines to guarantee client protection instead of blanket advice to avoid dual relationships altogether. (Boland-Prom and Anderson, 2005.)

Freud and Krug (2002) also feel that "over-correcting a problem, as is a frequent tendency in our society, sometimes escalates the very transgressions against which the new rules are to protect us." While necessary and healthy debate continues, practitioners need to, no matter what their scope of practice, seek guidance and input from a variety of sources to make good decisions around boundary issues.

There are some areas where clear rules about dual relationships are essential and include:

1. **Protection of the therapeutic process** – In the context of current clinical practice, "even minor boundary trespasses can create unwarranted expectations." Transference and countertransference issues are present and cannot be underestimated. According to Freud and King (2002), "The mystique of the tightly boundaried, hierarchical therapeutic relationship heightens transference phenomena."
2. **Client protection from exploitation** – A clinician may be tempted to meet personal sexual, financial, or social needs with persons who may be particularly vulnerable to exploitation. Ethical guidelines serve to protect clients from exploitation.
3. **Protection from potential legal liability** – Workers are concerned about legal liability, and "careful adherence to the boundary specifications may protect clinicians from malpractice suits."

Ultimately, it is the mental health professional's responsibility to establish culturally appropriate and clear boundaries for clients because doing so often prevents issues from surfacing in the first place. The worker cannot underestimate the importance of expectations – respecting the client means together creating a safe relationship where boundaries and expectations are unambiguous and openly discussed.

To further minimize possible harm to all parties – the client, the worker, the employer, and so on – the following risk management protocols to address boundary issues are suggested:

1. Be alert to potential or actual conflicts of interest.
2. Inform clients and colleagues about potential or actual conflicts of interest; explore reasonable remedies.
3. Consult colleagues and supervisors, and relevant professional literature, regulations, policies, and ethical standards to identify pertinent boundary issues and constructive options.
4. Design a plan of action that addresses the boundary issues and protects the parties involved to the greatest extent possible.
5. Document all discussions, consultation, supervision, and other steps taken to address boundary issues.
6. Develop a strategy to monitor implementation of your action plan (clients, colleagues, supervisors, and lawyers.)

Sexual relationships, physical contact, sexual harassment, and derogatory language

Ethical mental health practice limits sexual relationships with clients, former clients, and others close to the client, physical contact where there is risk of harm to the client, sexual harassment, and the use of derogatory language in written and verbal communication to or about clients.

Sexual harassment

In 1980, the EEOC (Equal Employment Opportunity Commission), the agency that enforces Title VII, first defined sexual harassment as a form of sex-based discrimination and issued guidelines interpreting the law. These guidelines define unlawful sexual harassment as:

- Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, when:
  - Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment.
  - Submission to, or rejection of, such conduct by an individual is used as the basis for employment decisions affecting such individual.
  - Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

In mental health practice, sexual harassment can take many forms including offensive or derogatory comments, sexually oriented jokes, requests or demands for sexual favors, leering, visual displays depicting sexual imagery, innuendos, pinching, fondling, impeding someone's egress, etc. Workers should not sexually harass supervisees, students, trainees or colleagues.

Sexual misconduct

Some states also have laws making sexual misconduct subject to lawsuits and even arrest. Practitioners need to be sure about the rules that apply to them, as well as be aware of how their behavior may be perceived by others. For example, Reid points out that in most situations, consent will not be an effective defense against sexual misconduct allegations. The reasons Reid (1999) gives for a client's ability to consent being called into question are:

- The fiduciary trust between clinician and patient.
- Exploitation of transference feelings.
- The right of the patient to expect clinical needs to be the overriding priority.
- Exploitation of the patient's purported inability to resist the therapist's influence.
- The alleged "power differential" between any patient and his or her clinician.

Anyone working in mental health practice has experienced different relationships with clients. Sometimes it is nearly impossible not to form respect and even affection for clients. However, practitioners must work diligently to avoid problems, i.e., either crossing the boundaries of the professional relationship or even appearing to do so. In addition to other previously discussed actions designed to prevent harm to the client, workers can proactively address this issue by doing the following:

- Limit practice to those populations that do not cause your own needs to surface.
- Seek clinical supervision to effectively deal with personal feelings.
- Document surroundings and who was present during sessions and visits.
- Avoid seeing the client at late hours or in locations that are atypical for routine practice.

Reporting sexual misconduct by a colleague is an ethical responsibility of mental health practitioners. Many states have laws that require licensed professionals to report such misconduct as well as other ethical violations to their state boards. It is the responsibility of every professional to protect clients by reporting a reasonable knowledge or suspicion of misconduct between the client and colleague.

Professional boundaries self-assessment

Below are red flags that professional boundaries may be compromised. Some relate to you and some to clients. As you honestly answer the following questions yes or no, reflect on the potential for harm to your client.

1. Have you ever spent time with a client "off duty"?
2. Have you ever kept a secret with a client?
3. Have you ever adjusted your dress for a client?
4. Has a client ever changed a style of dress for you?
5. Have you ever received a gift from a client?
6. Have you shared personal information with a client?
7. Have you ever bent the rules for a client?
8. Have you ever given a client a gift?
9. Have you ever visited a client after case termination?
10. Have you ever called a client when "off duty"?
11. Have you ever felt sexually attracted to a client?
12. Have you ever reported only the positive or only the negative aspects of a client?
13. Have you ever felt that colleagues/family members are jealous of your client relationship?
14. Do you think you could ever become overinvolved with a client?
15. Have you ever felt possessive about a client?

Clients who lack decision-making capacity

The practitioner's responsibility is to safeguard the rights and interests of clients who lack decision-making capacity.

Payment of services

With regard to payment of services, it is most helpful to refer to your particular professional association's financial arrangement ethical standards. Professional association ethical guidelines, in general, call for fair and reasonable fees for services, prohibition or no prohibition of solicitation of fees for services entitled and rendered through the workers' employer, and avoidance of bartering arrangements. Other guidelines include no acceptance or offering of kickbacks, rebates, bonuses, or other remuneration for referrals. Clear disclosure and explanation of financial arrangements, reasonable notice to clients for intention to seek payment collection, third-party pay or fact disclosure, and no withholding of records because payment has not been received for past services, except otherwise provided by law, are also examples of ethical financial guidelines.

ETHICS IN PRACTICE SETTINGS

Administration

Mental health administrators should advocate within and outside their agencies for adequate resources, open and fair allocation procedures, and a work environment that is not only consistent with, but encourages compliance with ethical standards of practice.

Billing

Practitioners need to establish and maintain accurate billing practices that clearly identify the provider of services. Many agencies, associations and boards include these expectations in their own values and codes of ethics, commonly under the category of stewardship.

Client transfer

Mental health practitioners should consider the needs and best interests of clients being served by other professionals or agencies before agreeing to provide services, and discuss with the client the appropriateness of consulting with the previous service provider.

Informed consent is an important aspect of this issue, in that a practitioner must discuss all implications, including possible benefits and risks, of entering into a relationship with a new provider.

Client records

Maintaining records of service and storing them is not always easy. Aside from the potential negative legal fallout of not doing so, there are good reasons for keeping records including:

- Assisting both the practitioner and client in monitoring service progress and effectiveness.
- Ensuring continuity of care should the client transfer to another worker or service.
- Assisting clients in qualifying for benefits and other services.
- Ensuring continuity of care should the client return.

To facilitate the delivery and continuity of services, the practitioner, with respect to documentation and client records, must ensure that:

- Records are accurate and reflect the services provided.
- Documentation is sufficient and completed in a timely manner.
- Documentation reflects only information relevant to service delivery.
- Client privacy is maintained to the extent possible and appropriate.
- Records are stored for a sufficient period after termination.

Recordkeeping

State statutes, contracts with state agencies, accreditation bodies and other relevant stakeholders prescribe the minimum number of years records should be kept. For example, HIPAA has a requirement of six years for electronic records. The Council on Accreditation requires records be kept a minimum of seven years. The NASW Insurance Trust actually strongly recommends retaining clinical records indefinitely.

Again, professionals who are primary custodians of client records should refer to additional legal requirements, such as those established by state licensing boards, regarding care for client records in the event they retire and/or close their business or practice.

The Privacy Rule (HIPAA)

In 1996, the 104th Congress amended the Internal Revenue Code of 1986, and created Public Law 104-191, the Health Insurance Portability and Accountability Act. This established the first-ever national standards for the protection of certain health information. These standards, developed by the Department of Health and Human Services, took effect April 14, 2003. The Privacy Rule standards address who can use, look at, and receive individuals' health information (protected health information or PHI) by organizations (covered entities) subject to the rule. These organizations include:

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and other health care providers.
- Health insurance companies, HMOs, and most employer group health plans.
- Certain government programs that pay for health care, such as Medicare and Medicaid.

Key provisions of the standards include:

- **Access to medical records** – Patients may ask to see and get a copy of their health records and have corrections added to their health information.
- **Notice of privacy practices** – Patients must be given a notice that tells them how a covered entity may use and share their health information and how they can exercise their rights.
- **Limits on use of personal medical information** – The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information. Generally, health information cannot be given to the patient's employer or shared for any other purpose unless the patient signs an authorization form.
- **Prohibition of marketing** – Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before disclosing their patient information for marketing.
- **Stronger state laws** – As stated earlier, confidentiality protections are cumulative; any state law providing additional protections would continue to apply. However, should state law require a certain disclosure – such as reporting an infectious disease outbreak – the federal privacy regulations would not pre-empt the state law.
- **Confidential communications** – Patients have the right to expect covered entities to take reasonable steps to ensure communications with them are confidential. For example, a patient may want to be called on a work phone rather than home telephone.
- **Complaints** – Patients may file a formal complaint regarding privacy practices directly to the provider, health plan, or to the HHS Office for Civil Rights. Consumers can find out more information about filing a complaint at *http://www.hhs.gov/ocr/hipaa* or by calling 866-627-7748.

It is very important to know that professionals who work in the mental health field are responsible for following and enforcing the HIPAA Privacy Rule.

The American Recovery and Reinvestment Act of 2009 put new teeth into the laws and penalties for HIPAA violations when it implemented tiered penalties reflecting the circumstances surrounding the violation. These acknowledged whether the violator did not know about the violation, had reasonable cause, allowed the violation because of willful neglect but subsequently corrected it or allowed the violation because of willful neglect and did not correct it.

- For violations that the entity did not know about, minimum fines are $100 per violation; up to $50,000 may be imposed, with an annual maximum of $1.5 million.
- For violations that had reasonable cause and were not due to willful neglect, a minimum fine of $1,000 and up to $50,000 may be imposed, with an annual maximum of $1.5 million.
- For violations due to willful neglect that were corrected within the required time period, a minimum fine of $10,000 and up to $50,000 may be imposed, with an annual maximum of $1.5 million.
- For violations due to willful neglect that were not corrected, a minimum fine of $50,000 per violation may be imposed, with an annual maximum of $1.5 million.

However, courts in some cases have treated multiple violations as separate cases, allowing the maximum fines to be much higher that $1.5 million.

In addition, criminal penalties may apply in some cases. A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of $50,000 and up to one year of imprisonment. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and up to $250,000 and up to 10 years imprisonment if the wrongful conduct involves the sale, transfer or use of individually identifiable health information for commercial advantage, personal gain or malicious harm. Criminal sanctions are enforced by the Department of Justice.

This rule ensures protection for clients by limiting the way covered entities can use personal medical information. The regulations protect medical records and other individually identifiable health information (identifiers) whether it is transmitted in electronic, written, or verbal format. This, then, would include faxes, e-mail, online databases, voice mail, and video recordings, as well as conversations among practitioners. Examples of identifiable health information include:

- Name or address – including city, state, or ZIP code.
- Social Security numbers.
- Dates related to birth, death, admission, discharge.
- Telephone and fax numbers.
- E-mail or URL addresses.
- Medical record numbers, account numbers, health plan beneficiary numbers.
- Vehicle identifiers such as driver's license numbers and license plate numbers.
- Full face photographs distributed by the agency.
- Any other unique identifier, code, or characteristic used to identify clients is protected under HIPAA.

In addition to reasonable safeguards, covered entities are required to develop and implement policies and procedures that limit the sharing of protected health information and to implement them as appropriate for their practices. The policies must limit who has access to protected health information, specify the conditions under which it can be accessed and designate someone to be responsible for ensuring procedures are followed (privacy officer).

It may seem that the law only places limits on the sharing of information; however, it does allow the sharing of protected health information as long the mental health worker takes reasonable safeguards with the information. Some steps professionals can follow include:

- **Ensure that protected health information is kept out of sight.** This could mean keeping it in separate, locked files, covering or turning over any material on your desk, or setting your computer to "go blank" after a minute or two in case you walk away.
- **If you must discuss protected health information in a public area, such as a waiting room, hospital hallway, or courtroom, make sure you speak quietly so others cannot overhear your conversation.** If this cannot be assured, move to another area or schedule another time to discuss the information.
- **Use e-mail carefully.** Make sure you send the information only to the appropriate people. Watch the "CC" lines to make sure your e-mail is not copied to unauthorized parties. Use passwords and other security measures on computers.
- **If you send a fax, don't leave the material unattended.** Make sure that all of the pages go through and check the fax numbers carefully to make sure it is sent to the correct person. You should also add a disclaimer stating that the information in your fax is confidential.
- **Avoid using client names in hallways, elevators, restaurants, etc., unless absolutely necessary.**
- **Post signs and routinely review standards to remind employees to protect client privacy.**
- **Secure documents in locked offices and file cabinets.**

Note that there is another law that provides additional protections for clients receiving alcohol and drug treatment. Information is available at the Substance Abuse and Mental Health Services Agency website at *www.samhsa.gov.*

Supervision and consultation

Mental health supervision and management generally include three primary aspects of the supervisory role:

1. Administration.
2. Support.
3. Education. (Kadushin, 1992).

While the supervisor of mental health work is increasingly involved in the administrative and political realm, to get the work done, supervision, coaching, mentoring, and consultation remain key roles. Mental health practitioners need to be keenly aware of the role of a supervisor, because he/she is responsible for both the actions and omissions by a supervisee, aka, vicarious liability.

To provide competent supervision, supervisors, particularly those in clinical settings, should remember the following:

- They need to possess the necessary knowledge and skill, and do so only within their area of competence.
- They must set clear, appropriate, and culturally sensitive boundaries that would include confidentiality, sexual appropriateness and others outlined earlier in this training.
- They should not engage in dual or multiple relationships with supervisees when there is risk of exploitation or potential harm.
- They should fairly and respectfully evaluate supervisee performance.
- They should avoid accepting supervisees when there has been a prior or an existing relationship that might compromise the supervisor's objectivity.
- They should take measures to assure that the supervisee's work is professional.
- They should not provide therapy to current students or supervisees.

Supervisors should consult their particular professional association guidelines regarding supervision, human resource policy, and other applicable resources. Effective and ethical supervisory practices not only benefit the supervisees and their clients but the supervisor as well. Supervisors can manage their vicarious liability in several ways through:

- Clearly defined policies and expectations.
- Awareness of high-risk areas.
- Provision of appropriate training and supervision.
- Understanding supervisee strengths and weaknesses as practitioners.
- Developing an adequate feedback system.
- Supervisors knowing their own responsibilities.

Commitment to employers

Several standards that address issues around loyalty and ethical responsibilities in one's capacity as an employee are formally or informally discussed in professional association ethical guidelines. Generally, mental health practitioners should:

- Adhere to commitments made to employers.
- Work to improve employing agencies' policies, procedures and effectiveness of service delivery.
- Take reasonable steps to educate employers about mental health workers' ethical obligations.
- Ensure that the employing organization's practices do not interfere with one's ability to practice consistent with one's mental health association professional ethical guidelines.
- Act to prevent and eliminate discrimination.

- Accept employment, or refer others to only organizations that exercise fair personnel practices.
- Be diligent stewards of agency resources.

In general, mental health practitioners should support their agency's mission, vision, and values and also its policies and practices; in essence, maintain loyalty to the organization or agency they are committed to. That is not to say one should disregard the profession's standards and ethical codes of conduct.

When an employer engages in unethical practices, whether knowingly or not, the worker still has an obligation to voice those concerns through proper channels and advocate for needed change while conducting oneself in a manner that minimizes disruption. But what does the worker do when faced with an ethical dilemma in the workplace that is not easily solved?

This issue has been discussed with regard to the practice of social work when Reamer (1998), in his review of the NASW Code of Ethics, discussed the challenge a social worker may have in deciding whether or not to continue honoring a commitment to the employer:

> "This broaches the broader subject of civil disobedience, that is, determining when active violation of laws, policies and regulations is justifiable on ethical grounds. Most social workers acknowledge that certain extraordinary circumstances require social disobedience."

He believes that it is possible to provide clear guidelines about when it is acceptable to break one's commitment to an employer. He poses several questions that must be explored before taking action:

- Is the cause a just one? Is the issue so unjust that civil disobedience is necessary?
- Is the civil disobedience the last resort?
- Does the act of civil disobedience have a reasonable expectation of success?
- Do the benefits likely to result clearly outweigh negative outcomes, such as intraorganizational discord and erosion of staff respect for authority?
- If warranted, does civil disobedience entail the least required to rectify the targeted injustice?

Labor-management disputes

Mental health practitioners are generally allowed to engage in organized action, including the formation and participation in labor unions, to improve services to clients and working conditions.

When involved in a dispute, job action, or strike, workers should carefully weigh the possible impact on clients and be guided by their profession's ethical values and principles prior to taking action.

Professional competence

The following guidelines discuss professional competence in mental health practice:

- Accept responsibilities or employment only if competent or there is a plan to acquire necessary skills.
- Routinely review emerging changes, trends, best practices in the mental health field and seek ongoing training and educational opportunities.
- Use empirically validated knowledge to guide practice/ interventions.
- Disclose potential conflicts of interest.
- Do not provide services that create a conflict of interest that may impair work performance or clinical judgment.

In addition to education and experience, mental health practitioners need to be cognizant of their personal behavior and functioning and its effects on practice:

- Refrain from private conduct that interferes with one's ability to practice professionally.
- Do not allow personal problems (e.g., emotional, legal, substance abuse) to impact one's ability to practice professionally, nor jeopardize the best interests of clients.
- Seek appropriate professional assistance for personal problems or conflicts that may impair work performance or critical judgment.
- Take responsible actions when personal problems interfere with professional judgment and performance.

Burnout and compassion fatigue

An area receiving increasing attention is that of burnout and compassion fatigue. The consequences of burnout and compassion fatigue (or any other form of professional impairment) include the risk of malpractice action. Results from the effects of day-to-day annoyances, overburdened workloads, crisis, and other stressors in the work place, burnout and compassion fatigue can be serious and considered similar in many ways to acute stress and post-traumatic stress disorder.

Burnout

Burnout is a "breakdown of psychological defenses that workers use to adapt and cope with intense job-related stressors and syndrome in which a worker feels emotionally exhausted or fatigued, withdrawn emotionally from clients, and where there is a perception of diminishment of achievements or accomplishments." Burnout occurs when gradual exposure to job strain leads to an erosion of idealism with little hope of resolving a situation. In other words, when mental health practitioners experience burnout:

- Their coping skills are weakened.
- They are emotionally and physically drained.
- They feel that what they do does not matter anymore.
- They feel a loss of control.
- They are overwhelmed.

Compassion fatigue

A newer definition of worker fatigue was introduced late in the last century by social researchers who studied workers who helped trauma survivors. This type of worker fatigue became known as compassion fatigue or secondary traumatic stress (STS.) Mental health practitioners acquire compassion fatigue or STS as a result of helping or wanting to help a suffering person in crisis. As a result, they often feel worthless and their thinking can become irrational. For example, they may begin to irrationally believe that they could have prevented someone from dying from a drug overdose.

Burnout is gradually acquired over time and recovery can be somewhat gradual. Compassion fatigue surfaces rapidly and diminishes more quickly. Both conditions can share symptoms such as emotional exhaustion, sleep disturbance, or irritability.

Dealing with burnout and compassion fatigue

A professional mental health practitioner can take steps to increase her or his ability to cope and achieve balance in life. Maintaining a healthy lifestyle balance and recognizing the signs of burnout and compassion fatigue are one thing: the responsible mental health clinician will also take action, such as a vacation break or change in schedule or job duties. Practitioners also need to not only be aware of the signs and symptoms of burnout and compassion fatigue, but more importantly,

the situations that may set the stage for their occurrence. Ongoing supervision is the mental health practitioner's best defense.

In addition, ongoing supervision and regular supportive contact with other practitioners to prevent isolation is recommended. Houston-Vega, Nuehring, and Daguio (1997), recommend the following measures to help prevent burnout or compassion fatigue:

- Listen to the concerns of colleagues, family, and friends.
- Conduct periodic self-assessments.
- Take needed "mental health days" and use stress-reduction techniques.
- Arrange for reassignment at work, take leave, and seek appropriate professional help as needed.

Related personal and professional integrity issues

Mental health practitioners must also address issues related to personal and professional integrity. They are:

- Dishonesty, fraud, and deception.
- Misrepresentation.
- Solicitations.
- Acknowledging credit.

Practitioners have an obligation to avoid actions that are dishonest, fraudulent, or deceptive. Such actions, or in some cases, lack of action, put the continued integrity of both the individual mental health worker and the profession at risk. Some examples include:

- Falsifying records, forging signatures, or documenting services not rendered.
- Embellishing one's education and experience history or qualifications (refer also to "misrepresentation").
- Lying to a client or their family to "protect" them from unpleasant information.
- Not sharing legitimate options to a client because they violate the professional's beliefs.
- Misleading potential donors or current funders with false outcome data.

Misrepresentation occurs when mental health professionals present opinions, claims, and statements that are either false or lead the listener to believe facts that are not accurate. Three actions must be taken to ensure that clients and the public receive accurate information:

1. Clearly distinguish between private statements and actions, and those as representative of an organization, employer, etc.
2. Accurately present the official and authorized positions of the organization they are representing and/or speaking on behalf of.
3. Ensure accurate information about, and correct any inaccuracies regarding professional qualifications/credentials, services offered and outcomes/results.

Client solicitation stems from a concern for clients who, due to their situation, may be vulnerable to exploitation or undue influence. Because of their circumstances, there is also the potential for manipulation and coercion. As such, mental health practitioners should refrain from doing the following:

1. Engage in uninvited solicitation.
2. Solicit testimonial endorsements from current clients or other potentially vulnerable persons.

Mental health practitioners also have an ethical responsibility to the contributions of others by acknowledging credit. They should:

1. Take responsibility and credit only for work they have actually performed and contributed to.
2. Honestly acknowledge the work and/or contributions of others.

Ethical responsibilities to colleagues

Licensed mental health practitioners should not only take responsibility for their own actions, but also take actions that ensure the safety and well-being of any clients served by others in the mental health profession. Thus, their responsibilities include:

- Duty to clients.
- Duty to colleagues.
- Indirectly, duty to the mental health profession.

In addition, they demonstrate further ethical responsibility by:

- Respecting and fairly representing the qualifications, views and obligations of colleagues.
- Respecting shared, confidential information.
- Promoting interdisciplinary collaboration.
- Not taking advantage of disputes between colleagues and employers or exploiting clients in disputes with colleagues.
- Seeking advice and counsel of colleagues who have demonstrated knowledge, expertise and competence so as to benefit the interests of clients.
- Referring clients, without payment for such, to qualified professionals and transferring responsibilities in an orderly fashion.
- Consulting and assisting impaired and/or incompetent colleagues; and addressing impairments through proper channels when they are unable to practice effectively (e.g., reporting to professional associations or licensing and regulatory bodies).
- Discouraging unethical conduct of colleagues; being knowledgeable about established procedures, and taking action as necessary through appropriate formal channels.
- Defending and assisting colleagues who are unjustly charged with unethical conduct.

Ethical responsibilities to the mental health profession

In general, national mental health professional associations discuss the responsibility to help maintain the integrity of their particular mental health focus, as well as issues related to mental health work evaluation and research. Maintaining the integrity of the profession is a responsibility of every licensed mental health professional and requires the active participation of each person whether it be collaborating on the creation of new standards, continuing to challenge mediocrity or complacency, or taking advantage of educational opportunities. Mental health professionals should demonstrate the following integrity safeguards:

- Maintain and promote high standards of practice.
- Uphold and advance the values, ethics, knowledge, and mission of the profession through study, research, active discussion and reasonable criticism.
- Contribute time and professional expertise to activities that promote respect for the value, integrity and competence of the profession.
- Contribute to the knowledge base and share with colleagues their knowledge related to practice, ethics, and research.
- Act to prevent unauthorized/unqualified practice of mental health work.

More about informed consent

The issue of informed consent relates closely to one of the most important values of ethical mental health practice: Self-determination. In order for informed consent to be valid, the following must be met:

1. Consent must be given voluntarily by a person of legal age.
2. The individual must be competent to refuse or to consent to treatment.
3. The client must be given thorough, accurate information about the service so she or he may weigh the benefits and risks of treatment.

One of the newest challenges for mental health practitioners is the issue of informed consent in e-therapy. Kanani and Regehr (2003) point out the following reasons for this:

1. Anonymity on the Internet makes it more difficult to determine the client's mental capacity and/or legal age.
2. Potential conditions, such as suicidal behaviors and eating disorders, may not be suitable for online therapy.
3. There is limited empirical research available, thus limiting both the practitioner and clients' understanding of the efficacy and the risks associated with e-therapy.
4. Internet identity issues place more burden on the practitioner to determine whether the client is legally and ethically able to consent.

Ethics for specialized practice areas

Responsible mental health practice can be found in a variety of settings and address multiple issues. As the world changes, practitioners are increasingly challenged to broaden their knowledge and adopt practices that meet the unique needs of their service populations and settings. Currently, most mental health associations provide additional guides or standards of practice that address areas including: substance abuse, health care, marriage and family issues, couples work, clinical social work, child welfare, palliative/end of life care, work with adolescents, and long-term care. They also publish standards that address issues such as technology.

It is helpful to review the relevant issue of technology and the impact on mental health practice.

Technology

While there are many individuals who are hesitant to embrace new technology that can enhance best practice, one cannot ignore its many benefits. Currently, mental health professionals can use technology, particularly the Internet, to conduct research, provide e-therapy when permitted, advertise their services, and communicate on a global scale with both clients and other professionals.

E-mail, though fraught with potential for security violations and miscommunication, has certainly increased the efficiency and speed with which people can communicate in another region. For example, a mental health researcher can conduct a search on the Internet to inquire about and then contact another professional in anther region to investigate innovative approaches to service delivery.

Software applications (e.g., basic word processing, financial management systems and documentation templates) assist practitioners with service planning, delivery, evaluation and reporting. And wireless technology allows better utilization of their time away from the office. Cell phones have greatly increased accessibility as well. Mental health practice would be different without technology.

National mental health associations, along with others, are continuing to develop and publish guidelines to assist practitioners in the appropriate use of technology, including those who provide virtual therapy services. Technology and practice are generally defined as any electronically mediated activity used in the conduct of competent and ethical delivery of services.

For example, a copy of the standards as developed by NASW and ASWB is available for both review and print at: *http://www.socialworkers.org/practice/default.asp* and is summarized as follows. Social workers shall:

- Act ethically, ensure professional competence, and uphold the values of the profession.
- Have access to, and ensure their clients have access to, technology and appropriate support systems.
- Select and develop culturally competent methods and ensure that they have the skills to work with persons considered vulnerable (e.g., persons with disabilities, for whom English is not their primary language).
- Increase their proficiency in using technology and tools that enhance practice.
- Abide by all regulations in all jurisdictions in which they practice.
- Represent themselves accurately and make attempts to confirm the identity of the client and their contact information.
- Protect client information in the electronic record.
- Provide services consistent with accepted standards of care, regardless of the medium used.
- Use available technology to both inform clients and mobilize individuals in communities so they may advocate for their interests.
- Advocate for technologies that are culturally sensitive, community specific, and available for all who can benefit from it.
- For those in administrative practice, keep themselves informed about technology that can advance quality practice and operations, invest in systems, and establish policies that ensure security and privacy.
- Conduct a thorough assessment, including evaluation of the appropriateness of potential clients for e-therapy. This includes the need for the social worker to fully understand the dynamics involved and the risks and benefits for the client.
- Evaluate the validity and reliability of research collected through electronic means and ensure the client is likewise informed.
- Continue to follow applicable standards and laws regarding supervision and consultation.
- Adhere to NASW standards for continuing professional education and applicable licensing laws regarding continuing education.

Virtual or e-therapy

Depending on their mental health focus and where they practice, many mental health practitioners offer online therapy services through real-time chats, e-mail, videoconferencing, telephone conferencing, and instant messaging. The benefits touted by supporters of online therapy, as described by Kanani and Regehr (2003), include the ability to:

- Serve millions of people who would otherwise not participate (e.g., people with certain conditions, such as agoraphobia, persons living in remote locations, or those concerned about the stigma of counseling).
- Decrease inhibitions clients may have about fully disclosing relevant information.
- Increase the thoughtfulness and clarity of communication as an unintended byproduct of written communication.

- Produce a permanent record that can be easily referred to and forwarded to clients or colleagues for review and consultation purposes.
- Substantially reduce overhead costs, thus reducing costs for the consumer.

As discussed earlier in this training, one of the major areas still under debate as a result of this new technology is that of jurisdiction. Here are some thought-provoking considerations.

- When the client lives in a different state, it is difficult to avoid violating licensure laws because it is still unclear as to which state's laws would be applicable.
- Is the origin or location of counseling in the client's community, the therapist's, or is it somewhere in cyberspace?
- What defines location, if a busy executive is involved in an online session while flying from Tucson to Bangkok?

This is clearly an ambiguous area that will undoubtedly continue to be debated.

Kanani and Regehr (2003) have summarized some of the other concerns raised by others regarding the use of e-therapy:

- E-therapy does not allow practitioners to observe and interpret facial expressions and body language.
- The Internet poses a serious risk to security, and thus, to confidentiality.
- Inappropriate counseling may occur due to therapist ignorance about location-specific factors related to the client (e.g., living conditions, culture).
- Clients cannot be sure as to the credentials, experience, or even identity of the person they are trusting to provide services.
- Clients may not have any legal recourse for malpractice, given unresolved questions about jurisdiction and standards of care.

Limiting risk in the practice of e-therapy

Matthew Robb recommends these points for those practicing e-therapy:

- **Full disclosure** – This relates to informed consent and the need to fully disclose the possible benefits and risks of distance counseling, including informing the client that this is a new area of practice, which has not had the benefit of long-term study.
- **Comprehensive assessment** – Provide clients with detailed and complete assessment tools and encourage full disclosure by client.
- **Confidentiality and disclosure of safeguards** – Take all precautions to safeguard the confidentiality of information and avoid misdirected e-mails, eavesdropping, hacking, etc. Alert the client to these potential risks as well.
- **Emergency contact** – Obtain information for an emergency contact and together develop a clear emergency plan.
- **Consult your association's code of ethics** – Review standards regarding informed consent, confidentiality, conflict of interest, misrepresentation, etc.
- **Consult state licensing provisions** – Research both the statutory regulations of your board, as well as those in the client's home state.
- **Consult a malpractice/risk management attorney** – Consider asking a legal specialist to review website materials to determine compliance with standards of care and potential malpractice issues.
- **Provide communication tips** – If communicating solely by text-based messaging, provide client with clear tips regarding communication.

Conclusion

Ethical dilemmas are varied, common and complex. Ethical decision-making can be difficult, as well as time-consuming, while sometimes, mental health practitioners are still left with a little ambivalence and uncertainty following their decision. Typically, there will be more than one person involved with the ethical decision-making process. It is always important to keep in mind the power of supervision and consultation regarding any mental health practice. With an ethical dilemma, this cannot be overstated.

This information is not intended to provide all of the details of the HIPAA Privacy Rule, or of any other laws or guidelines. This presentation also does not constitute legal advice. If there is any discrepancy between the provisions of the HIPAA Privacy Rule, other laws or regulations, and the material in this presentation, the terms of the laws, rules, professional guidelines and regulations will govern in all cases. This information is not intended to describe all of the national mental health associations' guidelines, but to ensure that learners are guided by their particular association's code of ethics and state licensing regulations in order to make the most appropriate ethical decisions.

Any case examples used within this course do not reflect actual individuals.

ETHICS AND BOUNDARIES

Final Examination Questions

Select the best answer for each question questions 11 through 20 and mark them on the answer sheet found on page 84 or complete your test online at **SocialWork.EliteCME.com.**.

11. Ethics defines:
    a. What is good for the individual while law defines what is good for society.
    b. What is good for both society and the individual.
    c. What law does not define.
    d. What is good for society and has no effect on the individual.

12. The principal of specific ignorance states:
    a. That if there is a law prohibiting an action, what you do is not illegal as long as you are unaware of the law.
    b. That if there is a law instituting action, what you do is legal if you have good intent.
    c. There are specific rules and regulations for ethical conduct.
    d. All of the above.

13. Most ethics codes describe specific ethical standards relevant to:
    a. Over 10 areas of professional functioning.
    b. Only one area of professional functioning.
    c. Nine areas of professional functioning.
    d. Six areas of professional functioning

14. Informed consent services:
    a. Can be provided regardless of whether valid informed consent can be obtained.
    b. Should only be provided when valid informed consent can be obtained.
    c. Do not apply to ethical conduct.
    d. Can be provided when a person is incapable of giving consent.

15. Buying property from a disaster client at far below market value:
    a. Would not be considered an inappropriate boundary violation.
    b. Is an inappropriate boundary violation.
    c. Is an appropriate and ethical action.
    d. Does not apply to ethical conduct.

16. As a mental health professional you are _____ ethically responsible for reporting sexual misconduct by colleague.
    a. Not.
    b. Sometimes.
    c. Always.
    d. None of the above.

17. Considering the transfer of a client from another provider includes issues of informed consent.
    a. True.
    b. False.

18. Burnout occurs:
    a. When gradual exposure to job strain leads to an erosion of idealism with little hope of resolving a situation.
    b. Employers are inpatient with their employees.
    c. Very seldom in work environments.
    d. From lack of sleep.

19. Informed consent must be given voluntarily by a person of legal age.
    a. True.
    b. False.

20. E-therapy may not be suitable for potential conditions such as:
    a. Agoraphobia.
    b. Depression.
    c. Adjustment disorders.
    d. Suicidal behaviors and eating disorders.

SWCO03ETE15

Chapter 3: Internet Addiction to Cybersex and Gambling: Etiology, Prevention and Treatment

8 CE Hours

By: Deborah Converse, MA, NBCT, Clinical Ed.

Learning objectives

This workshop is designed to help you:

- Discuss the behavioral and psychological impact of Internet addiction;
- Apply criteria necessary for a DSM-5 diagnosis of gambling disorder;
- Analyze similarities between Internet addiction and obsessive/compulsive disorders;
- Identify factors that may lead to the development of an Internet addiction;
- Explain examples of inappropriate thought patterns that may lead to Internet sexual and gambling addictions;
- Discuss pharmacological and psychotherapy treatments that have proven effective for treating Internet sexual and gambling addictions;
- Assess negative aspects of social networking;
- Identify prevalence rates of Internet addiction by age, gender and socioeconomic variables;
- Discuss biological, social and environmental factors that may predispose an individual to an Internet sexual addiction;
- Explain biological, social and environmental influences on the development of an Internet gambling addiction;
- Analyze unique factors of Internet sexual addictions as compared to other forms of addiction;
- Discuss federal laws and sanctions on Internet child pornography; and
- Apply prevention strategies for Internet addiction.

Introduction

Many individuals today are drawn by the power of the Internet to expand their world. The Internet can be a positive tool in business, education, research and communication, and has revolutionized opportunities to establish social networks worldwide. However, this unlimited access can also lead to self-destructive behaviors and addictions in many areas. Some individuals like to escape into novel experiences, and they develop alternative personalities that are more aggressive, less inhibited, more sensual, and more likely to take risks.

The Internet may lead to dramatic changes in behavior and identity in some individuals. Excessive use of the Internet can lead to addiction with characteristics similar to obsessive-compulsive disorders and the same type of euphoria reported during impulse control disorders.

Internet addiction is a relatively new phenomenon, and research studies into problematic Internet use are in the beginning stages. One study by Elias Aboujaoude (2011) reviewed Internet habits of more than 2,500 U.S. adults and found significant rates of online pathological behavior across all geographic, socioeconomic, age and gender groups.

The data from this study indicated that Internet use often interfered with the individual's personal relationships, career goals and family responsibilities, and altered the self-concepts and personalities of many individuals. This study showed that in the virtual world, individuals developed an exaggerated sense of their abilities, a superior attitude toward others, new moral codes, increased impulsive behavior, and a tendency to develop a totally different persona. These characteristics may lead individuals to indulge in activities online that they would never consider in real life.

The Internet has been described as a gateway drug, which has opened the door to many addictions. With the development of video games, smart phones, iPads, personal daily planners and wireless computers, some individuals spend more time and are more preoccupied with online experiences than real-world ones. Their communications and interactions in every aspect of life are linked to the online virtual world.

Described by some researchers as the "e-personality," many individuals find themselves in a daily battle between their virtual life and their real-life personalities. Reality may reinforce responsibilities, obligations, personal weaknesses and failures. By going online, these realities can quickly disappear into an exciting virtual life based on imagination, desires and grandiose thinking, all in the privacy of cyberspace.

Aboujaoude (2011) studied heavy Internet users and found that they experienced dissociation phenomenon as demonstrated by high scores on dissociation questionnaires. Other scientific studies noted biological changes that occurred in the brain during excessive online use.

PET scans have been used to measure the level of the neurotransmitter dopamine during excessive Internet use (Renshaw, 2007). Dopamine is released in the brain during pleasurable and rewarding experiences such as sex, eating or gambling, as well as during use of addictive substances like alcohol and drugs. The euphoric state that occurs during the use of cocaine and other addictive substances correlates with the level of dopamine released in several pleasure centers in the brain. Studies of the brain during online gambling or during sexual encounters have shown effects on the brain's reward system that is similar to those of substance abuse.

A study by Dr. John Suler (2004) identified dynamics of Internet use that enhance its appeal and may lead to addiction. These factors include disinhibition, anonymity, accessibility, the loss of balance or control, and the lack of any real hierarchy in cyberspace. Suler notes that "People have the opportunity to separate their actions online from their in-person lifestyle and identity; they feel less vulnerable about self disclosing and acting out."

Anonymity allows individuals to believe their online behavior is separate from who they really are and thus does not reflect on their character and absolves them of responsibility for their actions. These fallacies of thinking allow them to abandon moral and societal boundaries and behave in ways they would never have considered in real life.

The invisibility and anonymity online leads to disinhibition because the individual is able to be alone to engage in risky online activity without judgment or censorship. The person or activity they choose is easily accessible 24 hours a day and is often designed to the individual's specific requirements or desires.

Addition to cybersex and gambling from a diagnosis standpoint

Internet sex addiction is not listed in the latest DSM manual, the DSM-5 (APA, 2013) which is commonly used by psychiatrists in the United States and several other countries to provide diagnoses of mental health disorders that are recognized by the American Psychological Association. Therefore, it is not considered a mental health disorder by APA standards.

Gambling disorder is the only behavioral (non-substance related) addiction included in the category of Addictive Disorders of the DSM-5.

An important departure from past diagnostic manuals is that the substance-related disorders chapter has been expanded to include gambling disorder. This change reflects the increasing and consistent evidence that some behaviors, such as gambling, activate the brain reward system with effects similar to those of drugs of abuse and that gambling disorder symptoms resemble substance use disorders to a certain extent.

Previously, the DSM-IV listed pathological gambling but in a different chapter. This new term and its location in the new manual reflect research findings that gambling disorder is similar to substance-related disorders in clinical expression, brain origin, comorbidity, physiology, and treatment.

Recognition of these commonalities will help people with gambling disorder get the treatment and services they need, and others may better understand the challenges that individuals face in overcoming this disorder.

While gambling disorder is the only addictive disorder included in DSM-5 as a diagnosable condition, Internet gaming disorder is included in Section III of the manual. Disorders listed there require further research before their consideration as formal disorders. This condition is included to reflect the scientific literature on persistent and recurrent use of Internet games, and a preoccupation with them, can result in clinically significant impairment or distress.

Additionally, Internet Gaming Disorder is listed as a "Condition for Further Study" in the DSM-5 (APA 2013). This means that it is not an "official" disorder in the DSM, but one on which the American Psychiatric Association request additional research. Upon further research, the APA may or may not decide to make the disorder "official" in future editions of the DSM.

The DSM-5 states that Internet Gaming Disorder is most common in male adolescents 12 to 20 years of age. According to studies it is thought that Internet Gaming Disorder is more prevalent in Asian countries than in North America and Europe (APA, 2013).

"Internet-based gambling" is not included in the diagnostic criteria for Internet Gaming Disorder. This is because Internet-based gambling is already included in the Gambling Disorder diagnostic criteria.

The diagnostic criteria for Internet Gaming Disorder include:

1. Repetitive use of Internet-based games, often with other players, that leads to significant issues with functioning. Five of the following criteria must be met within one year:
    - Preoccupation or obsession with Internet games.
    - Withdrawal symptoms when not playing Internet games.
    - A build-up of tolerance–more time needs to be spent playing the games.
    - The person has tried to stop or curb playing Internet games, but has failed to do so.
    - The person has had a loss of interest in other life activities, such as hobbies.
    - A person has had continued overuse of Internet games even with the knowledge of how much they impact a person's life.
    - The person lied to others about his or her Internet game usage.
    - The person uses Internet games to relieve anxiety or guilt–it's a way to escape.
    - The person has lost or put at risk and opportunity or relationship because of Internet games.

Five psychological elements of addictive personalities

Aboujaoude (2011) has identified five psychological forces that also contribute to Internet addictive personalities:

- **Grandiosity,** or the feeling that one is more important, more impressive and more capable during activities online than in real life.
- **Narcissism,** because individuals can think of themselves as the center of their world on the Internet.
- **Darkness,** or the ability of the Internet to nurture the sinister, morbid side of their personality anonymously.
- **Regression,** or the marked immaturity that is sometimes seen in the behavior of individuals online.
- **Impulsivity,** the urge-driven lifestyle that may occur with excessive online use.

SOCIAL NETWORKING

The five psychological forces mentioned above can be found among the seemingly harmless pastime of social networking. As with any activity taken to extremes, excessive time on social network sites may cause problems in the everyday lives of the users.

The Digital Future Project is the annual identification and examination of the social impact of online technology conducted by the University of Southern California (2013).

The project found that after dropping slightly in a 2010 study, the amount of time that Americans who are Internet users spent online in 2012 grew to 20.4 hours per week, which is more than double the hours reported in 2000 and 2001.

The current Digital Future study found that 87 percent of Internet users said they check their email at least daily (defined as once a day or several times a day). Twenty-five percent said they send attachments with their email daily or more, and 20 percent send instant messages at least daily. However, the current study also found that large percentages of Internet users never post messages or comments on discussion boards (49 percent), use instant messaging (46 percent), update their online status (47 percent), or comment on blogs (43 percent).

Seventy-eight percent of users report going online at least weekly (defined as several times a day, daily, or weekly) to generally browse the Web (78 percent), and 58 percent do so to use online banking services. The next highest percentages were reported for those who visit social networking and video-sharing sites (51 percent), get product information (49 percent), play games (36 percent), download or watch videos (35 percent), download or listen to music (33 percent), pay bills (29 percent), listen to online radio stations (28 percent), and buy online (22 percent). Conversely, much smaller percentages of Internet users reported going online at least weekly to visit sites with sexual content (14 percent), visit religious or spiritual sites (11 percent), gamble (4.4 percent), make travel reservations (4.1 percent), or invest (3.6 percent).

Large percentages of Internet users go online regularly for news, as well as health and travel information, but smaller percentages seek job information, read blogs, or look for humorous content. Forty-eight percent of users go online to look for news daily or more, and 66 percent of users go online for news at least weekly. Modest numbers of users go online at least weekly to look for jokes or humorous

content (27 percent), to read blogs (25 percent), or to look for health information (24 percent). Looking for travel information is done at least monthly by slightly more than 42 percent of users. Looking for work online is never done by half of users.

The online personality

The Internet provides endless opportunities to reach out to old and new friends. For some users, a new identity develops as a result of the novel and diverse online interactions. The online personality may be very different when compared to what they thought was their personality. The result may be an e-personality that despite not being real, is full of life and vitality (Aboujaoude, 2011).

The ability to create and modify the e-personality can allow users to let go of inhibitions and forge new connections and friendships that would have been impossible otherwise. In many cases, the virtual personality compliments and is an extension of their offline self. They may be more efficient, and more likely to voice opinions. It could make standing up against injustice by instant messaging or voicing unpopular ideas over a social network site much easier. Even breaking off a relationship over the Internet can be quick, to the point, and avoids the unpleasantness of a face-to-face encounter.

But the e-personality, which can remain anonymous without the rules and boundaries of the offline world, may encourage the online user to be irresponsible and act in sinister or morbid ways without caution or control. Some may pursue unrealistic and unhealthy goals and be encouraged to behave in more selfish and reckless ways.

As exciting as this virtual experience may be, it can lead to real-life problems. Beyond changes in the brain dopamine levels and neurotransmitters that may lead to Internet addiction, online personality characteristics can be carried over into the offline interactions where boldness, feelings of power, narcissism, or need for adventure and excitement may interfere with family, school or work activities.

Narcissism and social networking

Whether the new self-image emerges unintentionally or by design, online users can exaggerate their most attractive characteristics and post them on Facebook with its more than 500 million subscribers. Certainly, the Internet allows people with narcissistic traits to reach a huge audience for their self-promotion.

Aboujaoude (2011) says the focus of the letter "i" on Internet URLs and electronic "apps" matches the rise of self-absorbed online narcissism. The "i" is everywhere in what is now called personal social media. From iTunes, iPod, iPad, iChat and iPhone, the cyberspace world revolves around the first-person singular pronoun.

Technology is constantly upgrading social networks to satisfy users' every desire and gives them a sense of control and creativity at lightening speed. Social networking sites provide the perfect media for narcissists because users can spend all day revising their profiles, posting flattering photographs, inflating biographies and "tweeting" with hundreds of people who have "friended" or "followed" them.

Twitter uses the term "followers," a more accurate description of social sites that have been extensively used by celebrities in pop culture to build their fan base. A large number of Web-based relationships and statements such as, "I have 1,000 friends on Facebook," set the standard for popularity on social networks. Facebook had to increase its 5,000-friend limit because people reached it so quickly. Now people can use the site to gather as many followers as possible and spend even more time soliciting new friends.

In a study by Buffardi and Campbell in 2008, 129 undergraduate Facebook users were interviewed, and their Facebook pages were analyzed. Researchers administered The Narcissistic Personality Inventory, or NPI, which is a 40-item personality test designed to measure narcissistic traits by asking the recipient to choose between two statements, for example, "I think I am as attractive as other people," or "I am more attractive than other people." In the sample pairs, the second statement is awarded one point and the first statement is awarded no points. A high total score on the NPI indicates a high degree of narcissism.

The study also included independent raters who did not know the undergraduate participants to analyze the students' Facebook pages using a number of subjective and objective criteria. The objective criteria were based on Facebook components, such as the number of friends listed, the number of virtual groups they belonged to, the number of lines of text in the "About Me" section, and the number of wall posts, which are messages posted on virtual bulletin boards. The hypothesis was that the participants with the greatest number of friends, virtual group connections, wall posts, and lines of self description were more likely to be narcissistic in life, as judged by their NPI scores.

The subjective criteria included the content of the "About Me" section, rated as self-absorbed, self-important, self-promoting or self-conscious. The type of clothing worn in the main photo was rated as attractive, self-promoting, sexy, vain or modest.

Scores of the objective and subjective measures of narcissism from the Facebook page were then totaled and compared to the participants' NPI profile scores. The results showed that users with high NPI scores were more narcissistic in real life and were seen as sexier and more self-promoting in their photograph. The independent raters were able to accurately detect the owner's level of narcissism based solely on the profile content. The higher scores on the NPI were linked to higher numbers of Facebook interactions and the more interactive, the more narcissistic.

Buffardi and Campbell concluded that because narcissists have more social contacts on Facebook than non-narcissists, the average user on Facebook will find social networks have a high representation of narcissism. The study also suggests that interaction with narcissistic individuals and self-promotion could become the norms for expression on social network sites. Members who want to keep up with their Facebook peers will have to increase their self-promotion, which could lead to more narcissism, to gather more friends and followers.

Mark Leary (2008), a Duke University psychologist, expressed similar concerns about the results of this study. He described Facebook's use of self-promotion as a "self presentational vehicle" that resembles advertising. Because ads are made to be self-promoting, it appears that the rules of advertising are applied to people when they use social network sites. Users select and highlight their most attractive characteristics, then advertise them on the network. Facebook and many online dating sites turn into virtual ads, often promoting false profiles that over time may translate into rising levels of narcissism and deception.

For example, it would be difficult to keep a positive self-image with only five Facebook friends when a friend at school or work has more than 500. To prevent feelings of inferiority, some users would have to enhance their online identity to seem more attractive to increase the number of their friends or followers. If Betty and Bob represent the normal, everyday, real life of the average person but feel their profiles are boring, they can reinvent themselves to have a captivating and stimulating virtual online life.

The Internet can provide a place for self-conscious or inhibited individuals to connect with each other and gain confidence. Unfortunately, it also can be difficult to tell whether people are presenting their real attributes and personality, which ultimately can result in disappointment or rejection.

Attention span

With instant messaging, texting and Twitter, speed and brevity are the most important factors. Twitter, the micro-blogging service, compacts conversations into 140 characters so no one has to read long messages or give long responses. Dictionary.com says the definition of Twitter is "to talk lightly and rapidly, especially of trivial matters." Twitter followers can send or receive thousands of micro-messages simultaneously, and like Facebook, the friend counter shows the number of followers for all to see. It is commonly accepted on the social network that the more followers you have, the more important, smarter, and popular you are because people want to read your tweets and interact with you online.

Because online encounters using Twitter are quick and to the point, this rapid-fire communication style can interfere with slower paced offline reading and writing and decrease attention span and increase distractibility when trying to focus on learning or completing tasks. College instructors have noted shorter attention spans among students who often skip class to post on Facebook.

Nicholas Carr (2008) writes about the problems with attention span on sites like Twitter, which highlight superficial social network communication. Carr noted difficulty concentrating among people who spent excessive time on Facebook activities. Many users reported feeling trapped by Facebook, unable to focus their attention elsewhere for any significant length of time. Martha Brockrenbrough writes about this worldwide cultural trend:

> *For many, the year passed in a blue-and-white blur of Facebook status updates, inane friend comparisons, and awkward "poking" situations with complete strangers. We spent hours throwing cupcakes at people we barely spoke to in high school. We compared our tastes in movies with our ex-boyfriends' new girlfriends. We let everybody know we were fans of Starbucks and "Battlestar Galactica," and pants. Worse, where we used to just send e-mail messages, now we send messages through Facebook so everyone can see what we have written.*
>
> *Then they send their replies to our Facebook accounts, which send us e-mails, which then prompt us to log back in.*

Children and teenagers often have difficulty understanding that facts in real life may be different from what they read on the Internet. The overabundance of content on the Internet, which includes facts and opinions, is difficult for young people to decipher. Information posted on health issues and drug use may be dangerous for young people who do not have the experience, knowledge and decision-making skills to sort fact from opinion.

The increasing problems with attention span and distractibility have researchers questioning whether excessive Internet use may be a factor in ADHD, which is the most commonly diagnosed behavioral disorder. Prescriptions for Ritalin, which is used to treat ADHD, have significantly increased over the last decade. This disorder leads to impairment at home, school and work, and is found in adults as well.

Several studies have shown a link between ADHD and excessive Internet use. The largest of the studies involved 752 elementary students in South Korea and found that 33 percent of those who suffered from ADHD were addicted to the Internet. A study of 216 college students in Taiwan compared the rate of ADHD in those who met criteria for Internet addiction to the rate of ADHD in those who were moderate users of the Internet. The results showed that 32 percent of Internet addicts had ADHD compared to only 8 percent of non-addicts.

These studies do not prove that Internet use is the cause of ADHD, but they do show a significant correlation between ADHD and excessive Internet use.

With the 140 key stroke-limit set by Twitter before reaching information overload, it is not surprising that youngsters who use this form of communication exclusively will have a short attention span for longer, more traditional texts and responses.

Just as someone might spend too much time at home working on the computer, studies have shown that many people spend too much time at work being distracted by social network sites, which is called "cyber loafing." This can have high costs for employers:

- A New Zealand security firm estimated personal Internet use at work to be as high as 25 percent of the total online time.
- According to a 2005 America Online study, 45 percent of 10,000 workers listed Internet use as the number one distraction at work.
- The Harris Interactive Web Sense study reported the cost to U.S. employers from cyber loafing at $178 billion dollars annually.

Privacy and security

There have been numerous accounts of tragedies that have occurred because of the lack of privacy on the Internet. Anyone can write and send almost anything they want, making it impossible to maintain privacy in cyberspace. This was shown recently when an 18-year-old freshman committed suicide by jumping from a bridge after his roommate posted a video of the freshman having sex with another man. He thought he was in the privacy of his dorm room and did not know that his roommate had a remotely activated webcam running and was streaming live video of him and sharing it with others. Two days later, the roommate sent his 148 Twitter followers another message that anyone with iChat should video chat him between 9:30 and midnight because the young man was having another visitor in his room that night, and the camera would be rolling.

The incident ended with a criminal trial, but the roommate received only probation because his actions were conducted through cyberspace and he could not be held accountable for the suicide.

Most online users are not driven to suicide, but detailed and permanent online records can ruin reputations and have devastating effects when embarrassing or incorrect information is posted online. Along with the loss of privacy, the security of all kinds of information on the Internet is also at risk.

Many people choose simple passwords and use them on many different sites. Even if a Facebook account is closed, it will not permanently remove archived user content that remains on the company's servers. Content delivery networks (CDN), which are used to manage data and distribution, copy the data to multiple intermediate devices to speed up access to files when millions of people are trying to access the service at the same time. Changes are not reflected across the content delivery network immediately and copies of files can still be found.

This was scientifically demonstrated in 2009 in a Cambridge University study where a group of computer scientists found that nearly half of 16 social networking sites they tested did not immediately remove pictures when a user requested they be deleted. During the experiment they uploaded photos to each of the sites then deleted them, recording the direct URL addresses to the pictures from the site's CDN. When they checked 30 days later, those links continued to work for seven of the sites, even though users would assume the pictures had been removed. If the pictures had gone beyond the boundaries of the social network site, they would be impossible to delete.

Online dating and sex

The Internet has revolutionized the dating world with numerous relationships sites and an unlimited number of subscribers. The six-month subscription to Match.com includes a warranty that if a person does not find someone special in six months, he or she will get an initial six months free.

Plentyofish.com is one of the fastest growing relationship sites on the Internet, and eHarmony advertises a compatibility matching system that claims to filter millions of potential matches to a specific group of singles who are compatible based on 29 characteristics of personality. According to eHarmony, the matches are based on scientifically determined characteristics of long-term relationships.

More than 15 million people are estimated to be subscribers to dating websites, and many people find themselves in dating relationships as a result of their participation. The Internet has changed social norms and all of the rules of traditional communication, romance and dating.

Many of the sites include pictures, although people still exaggerate their attributes and misrepresent every aspect of their profile in some cases. It is impossible to have success meeting someone online without including a picture, which points to the importance of physical appearance. On some dating sites, just the picture of the match comes up first with the idea that if the person's appearance is not acceptable, there is no need to read the profile. Helen A.S. Popkin (2009) wrote an article entitled "The Internet Makes Me Feel Fat," which includes the following passage:

> *In the Internet age with its endless playground for re-invention and resources for human understanding, it's painfully clear just how fond we are of appearances. Even in the world, especially in a world where computers control our illusions, nobody wants to feel like, let alone be seen as, anything less than an "8." That many people use enhanced cyberspace images is making many people more self-conscious than ever.*

Beyond increasing individuals' ability to socialize with like-minded people, the Internet may also facilitate casual and random sexual encounters and is especially harmful for youth who are not fully aware or capable of understanding the dangers online encounters may hold.

The Internet, with its false sense of security coupled with disinhibition, impulsivity, grandiosity and accessibility, can lead to increased risks of acting outside the bounds of normal behavior. The feeling of anonymity and false sense of control trump common sense, inhibition, judgment or fear. When individuals are struggling with self-concept, gender identity issues, loneliness, or just beginning to experiment with dating or sex, they are especially vulnerable.

The real-life dangers of Internet encounters can be life altering in a negative way. It is impossible for people to verify that the online profiles they have selected are real or truly represent the individual. One study led by Dr. Jeffrey Klausner (1999) revealed that 67 percent of patients surveyed with syphilis, compared to only 19 percent of healthy control subjects, said they found their sexual partners online. This shows one negative outcome of the online search for sex and off-line sexual behavior and sexually transmitted diseases.

Paige M. Padgett (2007), Ph.D, of the University of Texas School of Public Health, studied the effect of the Internet on the health and safety of women seeking men through online sites. The 740 women who completed the study survey included 568 women who reported having met in person with a man who had contacted them as a result of their online dating ads. Their ages ranged from 18 to 78 years of age, with an average age of 38. The results of the study showed:

- Women relied heavily on their online communication with men when considering safety and boundary issues, such as sexual preferences, STD history and condom use.
- 77 percent of the women did not use protection during their first sexual encounter with men they met online.
- Women in this study felt they knew the men quite well because they had an Internet relationship with them already and did not see the sexual encounter as a one-night stand.
- They relied heavily on instinct, intuition and feelings, and felt overly confident in their online opinion of the men.
- They believed they could sense whether it was safe to meet the men by analyzing how they communicated via e-mail.

This data points to the false sense of security the women had based on their online communication, which led them to engage in at-risk sexual behavior.

There are not many studies among teenage girls and young adults, but the young generation is growing up with different feelings about sexual encounters that were not seen prior to the Internet social networking craze. The 2008 survey of 1,280 participants, commissioned by the National Campaign to Prevent Teen and Unplanned Pregnancy, illustrates this point. According to the survey:

- Electronic exchange of sexual content, called sexting when using a cell phone, has become very common among teenagers and young adults.
- Of all teenage girls surveyed, 22 percent said they had posted online, e-mailed or sexted nude or semi-nude images of themselves.
- Of teen boys, 18 percent reported posting or sending such pictures of themselves.
- Young adults ages 20 to 26 are even more likely than teens to have sent nude or semi-nude images, with 36 percent of women and 31 percent of men reporting this behavior.
- Two-thirds of the teenage girls said it was fun or flirtatious to send these pictures to boys.
- 50 percent said it was a sexy present for their boyfriends.
- 40 percent said they sent the pictures as a joke.
- One-third of the teen boys and 40 percent of the young men said they have seen sexually suggestive images intended for someone else.
- One-fourth of the teenage girls and young women said they had seen sexual images intended for someone else.
- One-fourth of the teens admitted that technology makes them feel more forward and aggressive.
- More than one-third of the respondents agreed that exchanging sexual content makes real-life sex more likely.
- Nearly one-third of the girls believed that exchanging explicitly sexual content was expected to get a date.

Based on the research presented so far, it would seem that the digital age makes dating, long-term relationships and the pursuit of true love more difficult as people try to search on the constantly changing, dubious online social networks. With Twitter, as with online dating sites, users power-date with few words, which can complicate real romance and long-term relationships.

According to Charles M. Blow (2008), there seems to be a major change in the way teens view sex and dating, citing a report that noted more high school students said they have never dated than said they dated frequently. Blow writes, "Under the old model, you dated a few times and, if you liked the person, you might consider having sex. Under the new model, you 'hook up' a few times, and if you like each other, you might go on a date."

The rules people have followed for years have changed due in part to Facebook, online dating sites, Craigslist's sexually explicit personal ads, and easy access online to sexually explicit pornographic materials that are outside the boundaries of decency for adults who did not grow up experiencing dating and sexual experimentation online.

For many adults and youths, social networking on the Internet creates confusion and feelings of inadequacy because of the emphasis on appearance over honest interactions.

Case study: Rick

Pleasant and well mannered, Rick was a 25-year-old man with good looks and an engaging personality. He went to see a psychologist because of symptoms of depression that had occurred after a long-term relationship ended. He had become socially isolated from others and was spending excessive amounts of time looking for a romantic relationship on a popular classified website.

Rick became discouraged because he saw nothing but profiles of other men with perfect bodies, great incomes and graduate level degrees. Rick figured he was no match when it came to attracting women when compared to his competition online. He felt too inhibited to post a truthful ad about himself, let alone a made-up one. He felt that he would never have a chance to meet a match online and became more isolated and depressed.

His psychologist suggested that he should try to meet someone the traditional way at church or by joining a group with others of similar interests, but his lack of confidence prevented him from joining any social groups.

The online profiles were actually holding him back because of his lack of confidence in his ability to attract someone online. The psychologist told Rick that people often exaggerate or make up their characteristics and attributes, but eventually, they will have to come in contact with reality when they meet an individual. He told Rick that many online matches result in confrontations that will be damaging to both individuals depending on the amount of commitment, length of the online relationship, and the emotions of both parties.

Rick had to learn about the often false, self-promoting profiles on the Internet and how they had contributed to his feelings of inferiority, which were unwarranted, based on false social networks profiles. Along with his therapy sessions, he came across an article that explained in a humorous way the exaggerated terms used on social networks and what they often represent. That gave him the confidence to take some initial steps in more open, traditional venues for meeting others.

According to the University of Southern California 2008 Digital Future Project, as many 50 percent of Internet users believe most or all of the information online is reliable. Their research found that exaggerations like those listed in online personal ads, dating profiles and social network sites are likely to generate more interest than doubt or avoidance of the Internet.

Just as online advertising works, online self-promotion works, too, and people who live more online than off turn to the cyberspace for relationships. Cyberspace relationships work until the first contact with reality and often end negatively, which may cause more serious problems if the online users have underlying mental disorders.

Case study: Yvette

Yvette, a 45-year-old with a history of bipolar disorder, thought she had found her perfect love online after meeting a 38-year-old Frenchman named Pierre on a singles website. She did not mind the long-distance relationship, and that he appeared to live in southern France seemed exotic and romantic to Yvette as she fantasized about strolling along the sea, hand-in-hand with Pierre.

Neither of them had the money to travel overseas to meet, and one day during a manic episode, Yvette thought she remembered a conversation with Pierre the previous night in her bedroom. She noticed some scratches and believed that they, along with the exhaustion and night sweats she was having, were the result of many passionate, all-night lovemaking sessions with Pierre. She believed those physical symptoms were evidence that her online love affair with Pierre was real.

The sinister side of social networking

In addition to social networking designed to promote friendships and dating, many radical groups use social networks to recruit online. Neo-Nazis, Skinheads, Ku Klux Klan (KKK) and various extremist, racist, militia and gang organizations are growing in number from online networking and promotion. The number of such groups in the U.S. is on the rise, according to the Southern Poverty Law Center. The worldwide Jihadist movement Al Qaeda has networks in cyberspace called As-Sahab, Arabic for "the cloud." The website comes with instructional videos and text on building bombs, firing surface-to-air missiles, obtaining fake documentation, and directions on how to leave and enter the country unnoticed. Its terrorist members have grown from less than 100 in 2000 to more than 5,000 today.

In 2009, President Obama added a high-level cyber security position to coordinate the response to cybercrime by the Pentagon, The National Security Agency, and the Department of Homeland Security. The president said the goal would be to "detour, prevent, detect, and defend against cyber attacks." The Protecting Cyberspace as a National Asset Act proposes to give the president the power to "declare a cyberspace emergency and may order the disconnection of any federal government or United States critical infrastructure information system or network." It would give the president what has been called an "Internet kill switch" to go along with the nuclear defense activation switch.

Many statistics show the sinister side of the Internet, where engaging in objectionable material for sexual fantasies, identity theft, cyber fraud or other cybercrimes can enable the violent and criminal side of human personality and behavior. More than 20 million Americans were victims of online identity theft in which their personal information was stolen from a website transaction. Many companies fell victim to computer hacking and information theft, with trillions of dollars lost and extensive costs incurred to repair the cyber damage.

The U.S. government is not completely secure either, with more than 5,000 security breaches of government computers, including hackers breaching White House computers to intercept official e-mails as recently as June 2012. No individual or agency is safe from cybercrime, which occurs anywhere data is posted online.

Case study: Carl

Carl graduated from school and was excited about making money in his new online investment company. He proposed to focus on retirees on fixed incomes that he met on social networks or from lists he retrieved online from marketing sites. He encouraged the seniors to invest their savings in high-risk Internet stocks, including investing money in his new company.

The Internet makes it easier for some users to ignore rules of ethics that govern conduct and behavior in real life. Carl had always been well-respected in the community and was a member of a number of civic organizations that completed service projects for the betterment of the community. This well-mannered, sociable, respected member of the community was able to work outside of ethical or moral codes when it came to his Internet investment company. Protected

by anonymity and the lack of laws governing online trading and investments, he could run a company that violated community standards and ethics in the offline world.

There are many examples of deceptive and harmful behavior on the Internet every day. The online culture regularly reinforces the cruel side of the social networking. An example of that is the Megan Meier case. The 13-year-old Missouri girl was the victim of a hoax when she believed she had found an Internet boyfriend – who turned out to be the 49-year-old mother of a girl with whom Megan had argued.

Lori Drew, the mother of the other girl, had posed as the boy on MySpace, and for weeks told Megan she was beautiful and sexy and led her on, only to later began a vicious online attack with hurtful insults posted on Megan's site for all to see. One day, the "boy" told Megan he hated her, and that the world would be better off if she were dead. Later that day her mother found her hanging dead in her closet.

Drew was accused of cyberbullying and convicted of a misdemeanor for fraudulent use MySpace. Two years later, a federal judge threw out the conviction.

CYBERBULLYING

Children are often victims of cyberbullying on social networks, and the number of cyberbullies is increasing. According to Dr. Robin Kowalski, Clemson University psychologist and author of "Cyberbullying: Bullying in the Digital Age," cyberbullying occurs through e-mails, chat rooms, instant messages, social networking sites, digital images and messages sent via cell phones. It is different from traditional playground and school bullying, and data suggest higher victimization rates, as much as 50 percent of children.

Because of the anonymity of the Internet, more individuals are cyberbullies than schoolyard bullies. Not only is the number of cyberbullying cases increasing, but so is the severity of the threats and the aggressiveness and violence of the content, according to data from The National Institute on the Media and the Family.

Unlike traditional bullying, the identity of the cyberbully is unknown to at least half of the victims. This leads to higher levels of anxiety among the victims who do not know who the bully is, when and where they might strike, and who therefore cannot protect themselves.

The victims often become socially isolated, avoiding playgrounds, school buses and any area where they could be attacked. But cyberbullies can strike 24 hours a day, seven days a week through a social network. Children are often afraid to tell their parents about the behavior for fear the parents will take away their cell phones and Internet capability.

Kowalski also notes that when people tease or bully face-to-face, the victim can usually figure out the intent behind the behavior with verbal and nonverbal clues. Cyberbullies do not acknowledge the pain that they cause their victims because it's invisible to them, and the victims cannot tell whether their bullies are serious about their threats.

A number of negative consequences can occur from the bullying, including bad grades, school phobia, fear, social withdrawal, depression, suspicion, anxiety and suicide. Many families move or change schools to try to end the cyberbullying.

Most experts agree that bullying peaks in middle school, while children are making the transition from children to young adults. Although bullying certainly continues into high school – and even into adulthood, unfortunately – it does seem to subside with maturity. Even so, approximately 160,000 teens reportedly skip school every day because they are bullied, and 1 in 10 teens drops out of school due to repeated bullying.

- 83 percent of girls, and 79 percent of boys report being bullied either in school or online.
- 75 percent of school shootings have been linked to harassment and bullying against the shooter.
- Not shockingly, students who are bullies as young adults continue the trend of abuse and violence into adulthood. By the age of 30, approximately 40 percent of boys who were identified as bullies in middle- and high school had been arrested three or more times.

According to Hertz, Donato and Wright there is a strong correlation between bullying and suicide related behaviors. The relationship is often influenced by o factors like depression and delinquency. Those bullied by peers were more likely to think of suicide and even attempt it.

Middle school students report many different forms of bullying during the school years. About 44.2 percent of bullying is teasing which is often playing jokes and calling a child names. Over 43.3 percent of children have rumors and lies spread about them verbally or online. About 36.3 percent of children experience pushing and shoving in lines or class, 32.4 percent report hitting, shoving, and kicking by peers, and 29.2 percent have been left out or ignored by classmates.

About 28.5 percent of middle school students been threatened by peers and classmates and 27.4 report someone stealing their belongings as another type of bullying. Over 23.7 percent report sexual comments and gestures as another form of bullying.

Where does bullying occur many parents and teachers wonder about the location. Bullying takes place on school grounds and often on the bus. This is not the only place it occurs however, Cyber bullying occurs on cell phones and online on social networks, boards, and through email. A study of middle school students reported that they were bullied about 29.3 percent in classrooms, 29.0 percent in the school hallways or near lockers, and 23.4 percent in the cafeteria.

Other locations that school student were bullied were 19.5 percent of the time the gym or PE class, the bathroom 12.2 percent and the playground or recess 6.2 percent. This study shows that bullying occurs in many locations where children gather to study, play, or hang out. Only between 20 to 30 percent of students that are bullied tell an adult or teacher about the incident.

Regular bullying and cyber bullying in schools and elsewhere are believed to be linked to violence among youth, suicide and even murder. Over 77 percent of students have been bullied verbally, mentally, and physically. Each day about 160,000 students miss school because of bullying or because of their fear of being bullied. The sad fact is that every 7 minutes a child is bullied on the playground. Adult intervention is often 4 percent, peer or classmate intervention is 11 percent, and no intervention is 85 percent. This means that is more common for these incidents to be ignored.

The Bureau of Justice School Bullying and Cyber Bullying (2014) reports that bullying often leads to violence. About 87 percent of students say school shootings are motivated by the desire to get back at those who have hurt them. About 86 percent in this study cite bullying as the reason that kids turn to lethal violence. Some students believe that experiencing physical or emotional abuse at home can lead to similar behavior at school. About 61 percent linked school shootings with the perpetrator being physically abused at home.

Online violence

Ninety percent of U.S. children aged 8 to 16 play virtual video games or visit online sites that are classified as being appropriate for their age but contain violence. Amazingly, about 80 percent of underage children who try are able to purchase mature-rated material online. It could be logical to expect that these children will become more violent offline as well as online because of the violent, mature content of the online material easily accessible to them.

One of the largest studies to address this issue was led by psychologist Craig A. Anderson of the Center for the Study of Violence at Iowa State University. The study included three groups of young people ages 9 to 18 from the United States and Japan, totaling more than 1,500 participants. The study evaluated over time whether repeated exposure to violence online leads to an increase in physical aggression.

Results showed that children involved in violent online activity early in the school year were twice as likely to show aggressive behavior later in the year compared to those who were not accessing violent online sites. The difference was still there after researchers corrected for gender differences and differences in baseline aggressiveness.

The study offered two types of evidence to show a connection between aggression and excessive exposure to virtual online violence. The study supports the theory that increased aggression occurred in individualistic cultures with high societal levels of physical aggression and violence, like the United States, and in more mutualistic or collectivistic cultures with low levels of physical violence and aggression, like Japan. It also found that the power of virtual violence to affect children's development in an aggressive way is not altered by a culture that has a low overall tolerance for violence. Virtual violence seems to cause increased violence in cultures with very low baseline levels of aggression and different parenting practices.

The study also contradicts alternative hypothesis that only children with aggressive tendencies will have problems with aggression in the future, and it points to a need to use caution and develop preventative measures and restrictions to address the spread of violence online and off.

The studies of the dangers of online violence show greater impact on personality and behavior than violent TV shows, movies, graphic novels and violent music lyrics, which have been studied over the years. The interactive nature of virtual violence, the total immersion in the activity, the capacity to reward and punish others with violent acts, and the fact that the user is totally focused for long periods of time, makes online violence more powerful than other form of media and potentially more addictive.

Dr. Vladan Starcivic, a psychiatrist at the University of Sydney Australia writes:

> *In the virtual world, a violent player may kill or injure computer-generated characters or other online gamers without any consequence, including punishment. While many video games provide a story that primes the player to kill, there is very little room for moral consideration of killing, and to kill invariably benefits the player more than exercising restraint. The players are likely to be rewarded for killing, by means of points, more powerful weapons, or their own survival.*

His studies and others have found that the virtual world can desensitize users to violence and to what is immoral or indecent. Violent images no longer disgust individuals as they once did, and violence as entertainment adds to the desensitization. There are thousands of violent posts online, which gain instant notoriety and are watched around the world. Videos of tragic acts of God, painful, tragic accidents and unspeakable acts of cruelty and violence are shared online and through YouTube. Some view these sites out of curiosity, but others enjoy view them as entertainment.

It does not take much to progress from thinking virtual violence is entertaining to finding it sexual. The Philip Markoff case illustrates the online curiosity, attraction and correlation between sex and violence.

In 2009, Philip Markoff, a 23-year-old Boston medical student, became known as the first "Craigslist Killer." Markoff was charged with killing a masseuse and aspiring drug counselor, Julissa Brisman. Markoff allegedly had booked a "sexual release" massage with Brisman.

Four days before Brisman's slaying, Markoff had bound and robbed a Las Vegas hooker at the Boston hotel, police said, and robbed an exotic dancer in Rhode Island. In 2010 while in custody, Markoff committed suicide.

With his good looks, credentials, intelligence and status, Markoff did not fit the profile of someone who could hire prostitutes or commit murders and violence. He was described as well dressed, handsome, blond and intelligent with no criminal record. He was a student at Boston University Medical School and was engaged to a medical student he met while volunteering in a local emergency room.

Markoff had met all of the victims through Craigslist. According to attorneys general from 40 states, a section that was called "erotic services" on Craigslist violated anti-prostitution laws, but the site still lists "adult services." Markoff might have felt he could evade law enforcement and his crimes would be difficult to trace. The ads gave him easy access online to women who were desperate for money and in an environment that works outside of the law. The Internet had enabled him to assault, batter, rob and murder because he appeared to have the profile of a man with a bright future, anything but a serial killer.

Media coverage of the story revealed that Markoff also used Craigslist to meet men for sex, trading nude photos and e-mails that were sexually explicit and graphic. He described himself as "quite a catch" as an unattached medical student. No male victims came forward, but a number of men commented online that Markoff was sexy and hot, and that they would like to see the nude photographs and wished they had met him. One man even expressed regret that they had not gotten together because "he liked bad boys."

Elias Aboujaoude (2011) writes about the ordinary, everyday viciousness found on the Internet:

> *Less inhibition in the virtual world means that the threshold to act on violent impulses is lower, but so is the threshold to forgive others or ourselves for such actions. Desensitizing aggression, and turning it into entertainment, into something thrilling or even "hot," serves to make amoral or violent online manifestations lesser deals than they ought to be. So besides increasing someone's access to victims, online venues may also provide the person with a psychological out, convincing him that the extreme act will find an understanding audience online, one willing to absolve the perpetrator and pardon the offense.*

Case study: John Doe

The case of John Doe is a one example of a tragedy that occurred because of individuals who were desensitized to aggression, violence and the pain of others. John was a lonely, depressed, 19-year-old community college student who saw online chat rooms and social media as sources of support and substitutes for therapists, friends and family. Message boards are "like a family to me," he posted on his blog.

In November 2008, he wrote, "Ask a guy who is going to OD again tonight anything." Doe started a blog and linked it to a page with a live video streaming website. The cameras recorded his overdose on prescription pills with viewers urging him to go on, taunting him, name calling, saying, "Go ahead and do it," according to an investigator with the county medical examiner's office who read the online blog.

One viewer wrote to advise Doe that he didn't take enough pills to kill himself; another called his suicide "Internet Darwinism," while others called him derogatory and obscene names.

As Doe was dying on his bed, faced away from the camera, many hours passed. Some viewers mentioned he had not moved in a long time and questioned whether his body was being shown on a live webcam or was a fake still shot. Some believed the whole situation was a hoax. A viewer in Doe's online network found a cell phone number Doe had posted, and several people attempted to call him, but no one called an agency for help. Messages continued to be posted using anti-gay slurs and urging him to commit suicide.

Later one person did contact the police, and they tracked him down through his computer Internet protocol (IP) address. The police arrived, and on the live video stream, 181 viewers watched as police broke down the teen's bedroom door and attempted to revive him. They watched live and returned to view the video where Doe was pronounced dead 12 hours after he started his suicide blog and video.

The online tragic episode shows the high degree of desensitization and no regard for the pain of others. The power of online voyeurism and violence captivated viewers for 12 hours. Unconcerned about Doe's online suffering, viewers found it exciting to participate in the suicide, forwarding it to others online and returning to watch it again.

Another frightening aspect of social media today is the writing of suicide packs among a number of strangers who "friend" one another online for the purpose of dying together. Suicide pacts have led to death and near-death and have been documented around the world. One case from the Suicide Chat Room for Young People in 2005 found depressed participants as young as 12 who were matched up with people who had access to lethal methods for a mass suicide plan involving 32 individuals. Information from the IP address led police to arrest a man believed to be the leader.

Psychologist Irving Janis (1972) has discussed "a mode of thinking that people engage in when they are deeply involved in a cohesive in-group and when members' strivings for unanimity override their motivation to realistically appraise alternative courses of action. This group thinking seems to inhibit dissent and the option to counter the interest of the group and their single agenda." This is the online form of the crowd mentality that has been studied and documented.

Brown University psychiatrist Patricia R. Recuperto and her research team reported on the type of information a desperate person might find through a simple Internet suicide search. Their goal was to assess online suicide resources using five popular search engines and four common suicide-related key word searches. The results found more than 50 pro-suicide websites that described methods of suicide that are not known to the general public.

Before Internet access, only medical or scientific professionals would have had this information, and someone would have to search in medical/scientific libraries to find methods of suicide. The study described several individuals who committed suicide with unusual methods they learned online or in chat rooms, which could be traced to their computers. These studies and others suggest that mental health practitioners should question clients about their Internet searches for suicide, especially if they are depressed or have discussed suicide.

Whether it is a suicide chat room, cyberbullying, hate group recruitment, fabricated online dating profiles, cybercrime, or the urge to post and view violent material, cyberspace seems to bring out aggression, violence and anti-social behavior in some individuals. The Internet has infiltrated every aspect of life, and has the potential to be more dangerous than any other form of media. With its interactive qualities, lightning speed and unlimited access, it is easy to understand why Internet addiction is becoming more prevalent.

Many dangerous and criminal activities occur online that cause serious and sometimes deadly results. In 2009, the White House made the decision to expand cyber security beyond governmental agencies and appointed a cyber security czar to address online financial scams, illegal gambling, child pornography rings, cyberbullying, stalking, identity theft, and illegal spyware that affects the public.

Online gambling and child pornography are two of the most serious activities that are influenced by the anonymity, accessibility, affordability, disinhibition and grandiose thinking that someone can control, win or experience whatever they desire on the Internet. It was estimated that:

- More than $100 million was wagered daily through online poker sites (Walters, 2005) and that online poker revenues grew from $82.7 million in 2001 to $2.4 billion in 2005 (Newsweek, 2005).
- The regulation of online sexual content and child pornography is a major area of concern; more than 10 percent of all web pages, 25 percent of all searches, and 35 percent of all downloads are pornographic in nature (Family Safe Media, 2006).
- When the subject is a child, the online activity becomes criminal behavior, and one report found that one in five youths has been sexually solicited online (Office of Victims and Crimes). The growing Internet addiction problems of pornography and gambling will be covered in detail in the following sections.

INTERNET ADDICTION

The debate over whether Internet addiction is an independent disorder that deserves to be included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or simply a new manifestation of other mental disorders has been an ongoing debated topic in the mental health community. Some questions that must be answered are what constitutes a legitimate pathology when it comes to the Internet, what level of Internet use is excessive, and what negative real-life consequences result.

In 2013, The American Psychological Association determined that Internet addiction is not a mental disorder that merits inclusion in the DSM-5. However, many individuals continue to advocate for its future inclusion and professionals continue to utilize other existing diagnoses to identify and treat behavioral and mental health conditions related to internet addiction.

The proposed diagnosis of Internet addiction falls in the compulsive-impulsive spectrum disorder that involves online and offline computer usage and consists of at least three subtypes:

- Excessive gambling.
- Sexual preoccupation.
- E-mail/text messaging.

These subtypes show the following four components:

- Excessive use, often associated with the loss of sense of time, or neglect of basic drives.
- Withdrawal, which includes feelings of anger, tension and depression, when the computer is inaccessible.
- Tolerance, including the need for better computer equipment, more software and more hours of use.
- Negative repercussions, including arguments, lying, poor achievement, social interaction and fatigue.

Some of the most interesting research on Internet addiction has been published in South Korea, where rates of online use are much higher than those in the United States (Choi, 2007). After a series of 10 cardiopulmonary-related deaths in Internet cafés and a video game-related murder, South Korea considers Internet addiction one of its most serious public health issues. In one case, a 28-year-old boiler repairman suffered a cardiac arrest following a 50-hour Internet gaming binge during which he did not eat, sleep or take a break. His death prompted an investigation into the problem of Internet addiction in Korea, where current estimates are that 4 percent of children suffer from the disorder.

Using data from 2006, the South Korean government estimates:

- Approximately 210,000 South Korean children ages 6 to 19 are afflicted and require treatment.
- About 80 percent of those needing treatment may need psychotropic medications.
- An estimated 20 to 24 percent require hospitalization.
- The average South Korean high school student spends about 23 hours each week on online gaming.
- Another 1.2 million are believed to be at risk for addiction and require basic counseling (Ahn, 2007).

- In addition, therapists worry about the increasing numbers of individuals dropping out of school or work to spend time on computers.
- As of June 2007, South Korea had trained 1,043 counselors in the treatment of Internet addiction and enlisted over 190 hospitals and treatment centers (Ahn, 2007).
- Preventive measures are now being introduced into schools.

Prevalence

In China, 13.7 percent of adolescent Internet users – about 10 million teenagers – meet Internet addiction diagnostic criteria. In 2007, China began restricting computer game use, and current laws discourage more than three hours of game use per day (Peoples Daily Online, 2007).

Online use by adolescents in European countries ranges from 1 to 9 percent; Middle Eastern countries between 1 and 12 percent; and Asian countries between 2 and 18 percent (NIH, 2010).

United States estimates of the prevalence of Internet addiction are not consistent. Unlike in Asia, where Internet cafés are frequently used, in the United States games and virtual sex are accessed from home. Attempts to measure the phenomenon are hampered by shame, denial and diminished reporting by recipients.

The issue is further complicated by co-morbidity. About 86 percent of Internet addiction cases have some other mental health disorder diagnosis present. In the United States, unless the therapist is specifically looking for Internet addiction, it is unlikely to be detected. In Asia, however, therapists are trained to screen for excessive Internet use.

Etiology

Most researchers currently model Internet addiction criteria on Internet gambling addiction. Key components of Internet addiction include:

- Preoccupation with the specific content or behavior.
- Repeated unsuccessful attempts to reduce or control Internet use.
- Mood disturbances from attempts to reduce use.
- More Internet use than anticipated or desired.
- Problems with employment, relationships or education caused by excessive use.
- Hiding or lying about Internet use.

There are significant differences between Internet addiction, substance addiction and gambling addiction. Behaviors or substances that often lead to addiction, such as alcohol, gambling, tobacco or drugs, have structured legal sanctions governing their use. Drinking alcohol or using drugs while driving, at work or school are examples.

But excessive time searching the Web does not fall under any specific legal sanctions unless child pornography or other illegal activity is involved. Using the Internet at work and social networking at home is a routine and accepted activity. The same cannot be said for gambling or child pornography.

With the current understanding of genetic predisposition as well as biological and environmental components to behavioral addictions, a number of different factors may influence the development of Internet addictions in some people. Existing research on Internet addiction has revealed specific subpopulations that are at increased risk, including those with other psychological co-morbidities including obsessive-compulsive disorder (OCD), attention-deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), impulse control disorders, anxiety, and depression.

In a study completed by Aboujaoude (2011), a telephone survey was conducted with 2,513 adults from all 50 states. Subjects were selected using a percentage of the population and demographics of each state. Though not included in the DSM-5, diagnostic criteria for this study was taken from well-established psychiatric conditions that share similar features with Internet addiction, including OCD, pathological gambling and substance addiction as previously outlined in the DSM-IV.

The sample was developed using random-digit telephone calls of listed and unlisted residential numbers so that the populations within each state had an equal chance of being called. Cell phone numbers were not included to avoid costs to the recipients of the survey. In addition, telephone numbers were called 15 times before being disconnected.

Fifty percent of the people contacted participated in the survey, which is considered a significant return for a health-related telephone survey. Individuals responding to the survey were 18 years of age or older with the average age of 48, and 51 percent of the respondents fell in the middle-class socioeconomic level.

An analysis of the data revealed that 14 percent of the general population shows indicators of problematic Internet use. The survey resulted in the following data:

- Four percent responded they were preoccupied with the Internet when they were offline.
- Six percent felt their personal relationships had suffered as a consequence of Internet use.
- Six percent regularly went online to escape negative thoughts and feelings.
- Nine percent felt they had to hide their Internet use from others.
- Eleven percent regularly stayed online longer than they intended.
- Fourteen percent had difficulties staying offline for several days in a row.
- There were no significant differences attributed to geographic locations or ages among the participants.

Genetic studies have indicated a possible predisposition to Internet addiction linked to genes that are known to be involved in the transmission of dopamine. In a 2007 study led by a Harvard psychiatrist, teenage boys engaged in excessive online video game play, an average of 2.3 hours per day, were studied against a control group who were online for only 0.8 hours a day (Renshaw, 2007). By analyzing DNA samples from both groups, the genes involved in dopamine transmission were studied. The results show that the group who engaged in excessive Internet use did have versions of the two genes that are known to be present in individuals with alcohol and nicotine dependence.

The study suggests that the brain's neuron pathways and what activates the neurotransmitters might predispose some individuals to Internet obsession leading to addiction. Scientific studies indicate identifiable changes that occur in brain chemistry as individuals become more involved in the online world.

Signs and symptoms of Internet addiction

Researchers have been trying to define the set of symptoms that constitute an Internet addiction. Psychologist Kimberly S. Young from the Center for Online Addiction classifies people as Internet-dependent if they meet the criteria listed below:

- Do you feel preoccupied with the Internet or online services and think about it while offline?
- Do you feel a need to spend increasingly more time online to achieve satisfaction?

- Are you unable to control your online use?
- Do you feel restless or anxious when trying to reduce or stop your online use?
- Do you go online to escape problems or feelings such as depression, guilt, anxiety or depression, or boredom?
- Do you lie to family, friends, or coworkers to conceal how often and how long you stay online?
- Do you risk the loss of a significant relationship, job, and educational or career opportunity because of excessive online use?
- Do you keep returning to the Internet even after spending too much money on online fees?
- Do you go through feelings of withdrawal when offline, such as increased depression, anxiety, moodiness, or irritability?

Case study: Bill

A patient named Bill was a man in his 20s, with flat affect and a history of treatment anxiety. He went to see a psychologist at the urging of his fiancée. Bill had secretly joined an online community that promoted dropping out of real life and living in whatever virtual reality or alternate state one wished to design.

For the first time, Bill was free to develop any socioeconomic, psychological or physical profile he wanted. Bill suffered from social anxiety, so he designed the most attractive, gregarious and successful online personality he could. On this new life website the user can pick and choose characteristics to make him- or herself a fantasy individual, and Bill developed a new persona as a handsome, former NFL star player now in his mid-30s. He changed his virtual career to become the wealthy CEO of a high-tech company and boasted about living in a waterfront condo with great views from his penthouse.

As time went on, Bill did not just pretend to have the life he'd always dreamed of, he became obsessed and told his psychologist he preferred to live in his virtual life. He spent most of his time online, and when talking about his virtual life, he showed enthusiasm and confidence.

Before long, Bill's online obsession had become all-consuming, and he begin to doubt the value of his real life compared to the one he had created in his virtual world. The everyday life he had always known, with its problems and anxiety, was now second to his virtual life.

He would check online at least once an hour and often ignored responsibilities at work and home. Bill passed on extra work assignments with overtime pay and only did the bare minimum required. On one occasion, he had a choice to go to a party with his fiancée or to go online to his virtual penthouse. Because his priorities were now held by his virtual life, he skipped the party with his fiancée.

Bill became increasingly more agitated when he was not online, and his fiancée grew increasingly hurt and angered by his virtual life and hoped that it was a phase he would outgrow. When Bill introduced her to another virtual resident who had become his virtual girlfriend, she demanded that he seek treatment. He was in a sexually interactive relationship with this new online girlfriend who had all the features and characteristics he had always desired.

He later told the psychologist that his real world had become overrated, and his real-life girlfriend had become too demanding and the relationship was full of problems. Bill had perfected himself and his life online, so he made the decision to leave his fiancée and discontinued therapy sessions.

Bill told the psychologist that even though he knew he had crossed into a fantasy world, he did not see that as something bad. He did say that he would try to live more in the real world even though he found it dull and uninteresting. He never wanted to completely withdraw from his virtual life, and Bill did not return to therapy.

Bill was addicted to his online world and met all of Young's online addiction criteria listed above. Not only was Bill addicted to his cyberspace world, but the person behind the virtual girlfriend also fell for the fabricated athletic, wealthy, CEO persona without questioning his real identity or perhaps just simply enjoyed engaging in the fantasy.

Bill felt fulfilled enough in the virtual relationship to justify breaking off with his fiancée. His virtual life was more satisfying and less complicated than his offline relationships. It never occurred to him that his perfect new girlfriend in real life might be a 49-year-old housewife with a husband and four children looking for her own fantasy. People like Bill and his online girlfriend are excited by the virtual world that gives them all the feelings of living in a thrilling fantasy world. They fall prey to the online life they can never have in reality.

Lynn Roberts, who has researched cyber psychology, describes some of the possible physiological correlates of heavy Internet usage:

- A conditioned response, including increased pulse and blood pressure as the modem connects.
- An altered state of consciousness during long periods of interaction, including total focus and concentration on the screen, similar to a meditation or trance state.
- Dreams that appear in scrolling text.
- Extreme irritability when interrupted by people or events in real life while engaged in cyberspace activities.

Psychologists often identity patterns that are common to all forms of addiction, and these can be applied to Internet addiction (Suler, 2004). These patterns are:

- Are you neglecting important things in your life because of this behavior?
- Is this behavior disrupting your relationships with important people in your life?
- Do important people in your life get annoyed or disappointed with you because of this behavior?
- Do you get defensive or irritable when people criticize your online behavior?
- Do you feel guilty or anxious about what you are doing?
- Have you ever found yourself being secretive and trying to conceal this behavior?
- Have your attempts to try to curb your Internet use failed?
- If you are honest with yourself, do you feel there is another hidden need or problem that drives this behavior?

People who are addicted to the Internet become disassociated from the reality of life and preoccupied with their Internet cyberspace life (Kihlstom, 2005). They may act out pathologically in cyberspace because they are dissociated from real life. Their Internet activity becomes a new, separate world, and they may feel too embarrassed, guilty or ashamed to share it with people in real life. Their Internet activity becomes an isolated, secretive, alternative life, providing an escape from real-life problems. In their cyberspace world, fantasies are acted out without the constraints or consequences of the real world.

Diagnosing Internet addiction

Powerful social, sexual, and gambling activities can be readily accessed through the Internet. Dr. Michael Craig Miller of the Harvard Mental Health Letter summarized this position in a 2007 editorial:

> *"The Internet is the equivalent of an electronic needle, a potent and efficient delivery system that provides ready access to a wide range of rewards and pleasures. Shopping, gambling, and pornography can be infused directly and in the high doses from the Internet, anywhere and any time."*

Many mental health professionals, including the APA members who revise the DSM, agree that Internet addiction should meet the DSM's definition of a mental disorder as a "clinically significant behavioral or psychological syndrome that is associated with present distress or with a significant increased risk of suffering death, pain, disability, or an important loss of freedom."

Internet addiction does have similarities with other established mental disorders, such as OCD, ADHD, substance addiction and impulse control disorders. Internet addicts, like individuals with OCD, have uncontrolled urges to use the Internet, which is the obsessive component. While on the Internet and engaged in their activity of choice, they follow repetitive, ritualistic behaviors, returning to their Internet sites in predetermined patterns, which is the compulsive component. Despite negative consequences, they return to the same patterns of behavior, which increase in frequency and level of intensity, on their favorite Internet sites. However, as stated previously, efforts to include Internet addiction as an official diagnosis as part of the DSM-5 were unsuccessful.

Comparisons of Internet sexual and gambling addiction to other forms of addiction are based on the development of the two states of tolerance and withdrawal:

- Individuals addicted to alcohol and drugs and those in Internet addiction progress through states of tolerance and withdrawal. Tolerance refers to a condition of needing higher doses of the experience or substance, whether it's OxyContin, online pornography or gambling, to produce the same effects achieved during initial use, including the same level of euphoria. Tolerance to the Internet occurs when the activity takes more frequent online visits, greater amounts of time, and the individual finds it increasingly more difficult to disconnect from the Internet.
- Likewise, physical dependency, an adaptive physiological state that occurs with chronic use, can result in withdrawal symptoms when online use is limited or abruptly stopped. The individual experiences significant feelings of heightened anxiety, agitation and physiological responses similar to substance abusers when they try to cut back or quit.

Internet addiction has a strong similarity to impulse control disorders as listed in the DSM. Some common components between the two are:

- An impulse or urge that is difficult or impossible to resist. Impulsivity is defined by the Clinical Manual of Impulse Control Disorders (2006) as "The failure to resist an impulse, drive, or temptation that is potentially harmful to themselves or others."
- It is characterized by "carelessness; reduced sense of harm; impatience, including inability to delay gratification; and a tendency toward risk- taking, pleasure and sensation-seeking behavior."
- Performing these behaviors is highly rewarding in the moment but often leads to long-term negative consequences.
- Some individuals report that a series of short-lived online thrills were followed by increased online activity, which led to relationship conflicts, depression and financial difficulties that are similar to individuals who have impulse control disorders.
- The impulse control disorders, whether online sexual compulsions or pathological online gambling, share basic characteristics. The person feels a repetitive, anxiety-ridden urge to perform an act in the moment that leads to long-term dysfunction and guilt (Chamberlain and Sahrawian, 2007).

Based on the similarities among impulse control disorders, substance abuse, OCD and Internet addiction, researchers have developed screening questionnaires using criteria from these conditions adapted from the DSM. The most commonly used screening tool was developed, as previously mentioned, by Kimberly S. Young (2007).

Young developed the Internet addiction test to screen for what she viewed as a new clinical disorder. The test, available online and adapted with scoring instructions, includes questions that are rated on a scale from 1 to 5. A total score of 80 or above is consistent with what Young terms Internet addiction. Excerpts from the test are found at the end of this course.

Legal issues

The media and research focused on Internet addiction has contributed to a new crop of legal cases in which patients are suing to reverse negative consequences, especially termination from work, that are brought about by their Internet addiction.

In one of the most publicized cases, IBM fired a 59-year-old man for visiting adult chat rooms at work despite being reprimanded about the behavior. In response, he sued IBM for $5 million, claiming he was an Internet addict and the Americans with Disabilities Act protected his diagnosis. He attributed his Internet addiction to seeing his best friend die in Vietnam in 1969, which left him with severe post-traumatic stress disorder. He said that the only relief he found was through visiting a pornographic online chat room. He stated, "I felt I needed the interactive engagement of the chat room talk to divert my attention from my thoughts of Vietnam and death."

He felt that IBM should have offered him support and treatment instead of firing him, and noted that IBM workers who have substance problems are referred to specialized treatment programs for rehabilitation. As a decorated Vietnam veteran suffering from a double disorder of PTSD and Internet addiction, he felt he deserved at least that much support from IBM. The case is ongoing, and the judgment could affect how employers regulate nonwork-related Internet use and treatment of addiction.

The appeal of sex and gambling is recorded in ancient history, but the Internet adds a new, powerful dimension to these behaviors. By providing feelings of total control and the possibility of personalized sex or gambling, the Internet provides limitless activity, which can lead to addiction.

INTERNET CYBERSEX ADDICTION

Anonymous, affordable, private and accessible 24 hours a day, the Internet offers worldwide access for those with compulsive sexual behavior. Internet sexual addiction often results in destroyed marriages and careers, families torn apart, and lives ruined.

For some individuals, the power of cybersex, like substance abuse, is impossible to resist and control. Men and women find themselves in a daily struggle with online sexual behavior that has taken priority over all relationships. They become isolated and too embarrassed or guilty to seek help, and often do not know where to find treatment.

Individuals with online sexual addictions often fall into some or all of the following patterns (Carnes, Delmonico, and Griffin, 2001):

- Keeps sexual activity on the Internet a secret from family members.
- Carries out sexual activities on the Internet at work.
- Frequently erases computer files in an effort to hide online sexual activity.
- Feels ashamed and afraid that a loved one might discover the sexual activity on the Internet.
- Time on the Internet takes away from or prevents the person from doing other tasks and activities.

- Spends hours captivated in an online sexual experience, losing all concept of time.
- Frequently visits chat rooms that are focused on sexual conversation.
- Looks forward to sexual activities and feels frustrated and anxious if he or she cannot get to them when planned.
- Masturbates while on the Internet,
- Sexual chat room friends have become more important then real-life family and friends.
- Downloads favorite pornography.
- Frequently views favorite porn sites.
- Visits fetish porn sites or child pornography online.

Prevalence

Though populations are diverse and vary worldwide, Internet addiction rates range from 0.3 percent in the U.S. to nearly 38 percent among Hong Kong teenagers and young adults. Other prevalence rates from the Family Safe Media (2010) report are:

- The average Internet user spends 15 minutes a day viewing pornography online.
- One in five men view pornography online at work.
- A quarter of all search engine requests are pornographic.
- More than a third of Internet users report unwanted exposure to sexual material online.
- Twenty-five percent of all Web searches are pornographic in nature.
- Thirty-five percent of all downloads are pornographic in nature.
- Seventy percent of men ages 18 to 38 visit porn sites.
- Twenty percent of those sites involved children.
- The average age of the men viewing pornography on the Internet was 38.
- Twenty-eight percent of those men were diagnosed as depressed.
- Six percent of the population has viewed pornography on the Internet, and for every three men, there is one woman.
- Two-thirds of junior high school students have looked at pornography on the Internet.
- Thirty-four percent of those students are at risk for developing compulsive sexual behavior on the Internet.
- Eighty-seven percent of university students have virtual sex using Instant Messenger, webcams and cell phones.
- Thirty-two million individuals have visited a porn site; 22.8 million – or 71 percent – were male, and 9.4 million, or 29 percent, were female.
- Two in five Internet users have visited an adult site.
- 63.4 million separate visitors used adult websites reaching 37.2 percent of the Internet audience.
- 8.9 million people in the U.S. need intervention to break their addiction to cybersex.
- 14.8 million who currently use cybersex moderately are showing the beginning signs of sexually compulsive behavior on the Internet.

Other statistics on Internet sex

- 87 percent of university students polled have virtual sex mainly using Instant Messenger, webcam, and telephone ("CampusKiss and Tell" University and College Sex Survey. Released on February 14, 2006. CampusKiss.com. February 17, 2006)
- There were 63.4 million unique visitors to adult websites in December of 2005, reaching 37.2 percent of the Internet audience (comScore Media Metrix, 2008)
- According to the Florida Family Association (2008), PornCrawler, their specialized software program, identified 20 U.S. companies that accounted for more than 70 percent of 297 million porn links on the Internet.
- By the end of 2004, there were 420 million pages of pornography, and it is believed that the majority of these websites are owned by less than 50 companies (LaRue, 2005).
- The Internet pornography industry generates $12 billion dollars in annual revenue – larger than the combined annual revenues of ABC, NBC, and CBS (Family Safe Media, 2006)
- The largest group of viewers of Internet porn is children between ages 12 and 17 (Family Safe Media, 2005)
- 71.9 million people visited adult sites in August 2005, reaching 42.7 percent of the Internet audience (comScore Media Metrix, 2008).
- Internet users viewed over 15 billion pages of adult content in August 2005 (comScore Media Metrix, 2008).
- Internet users spent an average of 14.6 minutes per day viewing adult content online (comScore Media Metrix, 2008).
- More than 32 million unique individuals visited a porn site in Sept. of 2003. Nearly 22.8 million of them were male (71 percent), while 9.4 million adult site visitors were female (29 percent). (Nielsen/Net Ratings, Sept. 2003).
- The cybersex industry generates approximately $1 billion annually and is expected to grow to $5-7 billion over the next 5 years, barring unforeseen change (National Research Council Report, 2002).
- The total porn industry - estimates from $4 billion to $10 billion (National Research Council Report, 2002).
- The two largest individual buyers of bandwidth are U.S. firms in the adult online industry (National Research Council Report, 3-1, 2002).
- Commercial pornography sites:
  - 74 percent display free teaser porn images on the homepage, often porn banner ads.
  - 66 percent did not include a warning of adult content.
  - 11 percent included such a warning but did not have sexually explicit content on the homepage.
  - 25 percent prevented users from exiting the site (mousetrapping).
  - Only 3 percent required adult verification. (Child-Proofing on the World Wide Web: A Survey of Adult Webservers, 2001, Jurimetrics. National Research Council Report, 2002).

A Stanford/Duquesne study (2000) noted that cybersex is a public health hazard that is exploding because very few health organizations recognize it as a danger or take it seriously. The study found that at least 200,000 Internet users are addicted to pornography sites, X-rated chat rooms, and other online sexual materials. The study completed in 2000 found:

- Men prefer visual erotica twice as much as women.
- Women favor sexual chat rooms twice as much as men.
- Women have a slightly lower rate of sexually compulsive behavior.
- Seventy percent kept their cybersex habit a secret.
- Twenty-five million visit cybersex sites between 1-10 hours a week.
- Another 4.7 million visit cybersex sites in excess of 11 hours per week.
- Students were most at risk for cybersex compulsion because of a combination of increased access to computers, casual attitudes toward cybersex, more private leisure time, and their developmental stage, which is characterized by increased sexual curiosity, experimentation and risk-taking behavior.

Categories of cybersex

Dr. Robert Weiss of the Sexual Recovery Institute describes cybersex as the "crack cocaine" of sexual addiction and states that cybersex reinforces and normalizes all forms of sexual disorders. Internet sex can be accessed and experienced in many ways, and each has the potential to cause serious problematic behavior leading to risky or dangerous situations.

The term cybersex has become a catch phrase to address a variety of sexually related behaviors on the computer, which fall into three general categories:

1. **Accessing online pornography** – Pornography can be found in various forms, including visual, auditory and text stories. Access is much greater online because many of the sexual content and activity laws that exist in the United States are difficult to enforce or do not apply in other countries. Online pornography can be easily accessed worldwide on personal and commercial WebPages; it can be exchanged by e-mail, discussion chat rooms or newsgroups.

   These forms allow participants to use their e-mail to post stories, ideas, photographs or software related to the topic of the group. These messages can be stored for other groups to retrieve. Thousands of sex-related newsgroups exist on the Internet and can handle high volumes of traffic.
2. **In real time with a fantasy partner** – This form of cybersex takes place in what is known as real time, and the experience is designed to act out sexual fantasies. Internet chat rooms give people the ability to hear and discuss sexual topics on the Internet. There are typically 10,000-20,000 channels available to join. Federal Communications Commission laws limit the type of communication that can take place over the airwaves, but many of the laws do not apply to international cyberspace, so sexual conversations frequently occur.

   Cybersex can become part of a person's arousal pattern, and many people find eroticism in Internet chat rooms. These can be exciting, particularly for women, because they provide opportunities for romantic intrigue, manipulation, seduction and power. Advanced computer technology enables the exchange of images and files online during live conversations. These can occur in many virtual locations, so a person can engage in online chatting with others and share voice and video images via the Internet. Live video feed technology makes it possible to chat online while viewing pornography. These virtual video booths are increasing in number and allow cybersex users to have control over the subject and sexual activity. With a credit card number, users can view live video cameras that transmit images of men and women performing everything from everyday routines to explicit sexual acts.

   Some men and women want to create someone who matches their idea of perfection, and the Internet provides this opportunity. Live feed video sites and interactive sex sites allow someone to log on and described the woman or man they want to see and what sexual act they want to experience and it appears on the screen. This provides the individual with the ability to create and engage in personal fantasies. For a small fee, the individual can link to X-rated video feeds or, with CuSeeMe software and camera, watch others masturbate or engage in sexual activities while they watch the individual do the same. Though most sites have a fee, some Internet sites can be accessed for free.
3. **Multimedia software** – This category of cybersex does not originate online but is accessed there. On the new multimedia systems, people can see X-rated movies, play sexual games and view the latest issues of erotic magazines on their computer or other electronic device. Compact disc read-only memory (CD-ROM) technology allows companies to release software titles with sound and video.

The Internet has become the method of choice for those seeking sexual experiences. Carnes et al., identified five factors that led to the popularity and increase in online cybersex:

- **Accessibility** – Sites are available seven days a week, 24 hours a day and available anywhere there is a computer or other electronic device to access the Internet. The variety of experiences is limitless and available whenever convenient in the privacy of the home or office.
- **Isolation** – The Internet gives users the ability to engage in any behavior they desire without actual contact with others, eliminating the risk of sexually transmitted disease or any responsibilities or entanglements of real world interactions.
- **Anonymity** – The Internet provides a way to interact anonymously, minimizing the risks of recognition, judgment, legal sanctions or consequences of sexual exploits in public.
- **Affordability** – Cybersex provides a low-cost way to obtain sexual satisfaction.
- **Fantasy** – Cybersex sites allow the user to choose the type of partner or sexual activity that fulfills the individual's fancy.

Cooper, Delmonico, and Berg (2000) conducted a survey of 9,265 Internet users and identified three categories of people who use the Internet for sexual pursuits:

1. Recreational users who access online sexual material more out of curiosity or for entertainment and are not seen as having problems associated with their online sexual behaviors.
2. At-risk users who might never develop a problem with online sexual interaction if not for the availability of the Internet. These individuals use the Internet a moderate amount of time for sexual release, but if their type of use or time online increases, it could progress to a sexual compulsion.
3. Sexually compulsive users have reached the level of pathological sexual behavior, and they excessively use the Internet for their sexual activities. For people in this group, the power of isolation, fantasy, anonymity, accessibility and affordability interacts with certain underlying personality factors to increase their Internet use for sexual activities. At this level, cybersex use has reached the point where it becomes difficult if not impossible to control. The sexual compulsion meets the criteria of an addictive disorder similar to those of substance abuse and other forms of addiction.

Indicators of cybersex addiction

Three criteria are often used to indicate cybersex addiction. They are compulsivity, continued use despite negative often dangerous consequences, and obsession.

The loss of ability to choose whether to stop or continue a behavior indicates a compulsion, which is totally different from normal daily activities or routine habits. The out-of-control behavior is marked by deeply held rituals interfering with all aspects of real life, with no regard for other relationships, activities or negative consequences. They cannot stop obsessing about sexual activity online, and those impulses require most of their mental and physical energy. No matter what is going on at the time, the individual is thinking about the next sexual encounter and how to create the time and secret location for cybersex.

The individual addicted to cybersex lives in three states of mind (Schneider, 1994):

1. Continually planning the next visit to the online sex site.
2. Engaging in online sexual activity.
3. Coming down from the euphoria of the cybersex activity.

Diagnosis

As with diagnosis of other forms of addiction, there are Internet sex screening inventories that use 10 criteria for problematic online sexual behavior (Delmonico, 1999). No set of criteria or test is an absolute measure or predictor of cybersex addiction because they do not address individual differences in behaviors, every type of Internet sexual behavior, or co-occurring mental disorders. Ratings range on a scale from harmless to those that are impulsive or addictive and result in serious health, relationship and legal risks.

The 10 criteria are:

1. Preoccupation with cybersex.
2. Frequently engaging in cybersex for longer periods of time than intended.
3. Repeated unsuccessful attempts to control, limit or stop engaging in cybersex.
4. Restlessness of irritability when attempting to limit or stop engaging in cybersex.
5. Using sex on the Internet as a way of escaping problems or relieving feelings, such as helplessness, guilt, anxiety or depression.
6. Returning to cybersex on a daily basis in search of a more intense or higher-risk sexual experience.
7. Lying to family, friends, therapists or others to conceal involvement with cybersex.
8. Committing illegal sexual acts online, such as sending or downloading child pornography or soliciting illegal sex acts online.
9. Jeopardizing or losing significant relationships, jobs, educational or career opportunities because of online sexual behavior.
10. Incurring significant financial consequences as a result of engaging in cybersex.

In summary, these activities are diagnosed as problematic because the online behavior involves excessive time, and the behavior is uncontrollable and distressing as well as the source of familial, social, professional, educational and financial difficulties. Diagnosis is based on a comprehensive interview with a physician or therapist, and no other psychiatric disorder can be found to account for the subject's Internet sexual addiction symptoms (APA, 2000).

Carnes, Delmonico, and Griffin (2001) have reviewed and researched types of problematic online sexual behavior. They divided those who are engaged in sexual behavior on the Internet into five groups, which include:

- Recreational cybersex users, who fall into the categories of:
  - Appropriate recreational use.
  - Inappropriate recreational use.

The next three groups identified have problematic sexual behaviors on the Internet and fall into one of three groups:

- **Discovery group** – Those who have no previous problem with online sex or any history of problematic sexual behavior.
- **Predisposed group** – Those who have had their first out-of-control sexual behavior on the Internet after years of obsessing over unfulfilled sexual fantasies and impulses.
- **Lifelong sexually compulsive group** – Their out-of-control sexual behavior on the Internet is part of an ongoing and severe sexual behavior problem.

These researchers found that people in the discovery, predisposed and lifelong sexually compulsive categories often progress through the stages to addiction once they discover the availability, accessibility, variety, and extent of sexual experiences on the Internet.

Faulty thought patterns

The addicts' belief systems contain errors, untruths, delusions and faulty thought patterns that support their beliefs and reinforce the problematic sexual behavior that leads to Internet addiction (Carnes et al., 2001). These four core beliefs include:

- I am a bad person and not worthy of anyone's love.
- I will never be accepted for what or who I am.
- I cannot trust or count on anyone to meet my needs.
- My most important need is sex.

Core beliefs are formed as individuals grow and develop within their families and community. In a functional, healthy family, children are taught values and receive love and support to grow and develop a positive self-concept. They know they are valued in the family because their basic needs are met and they are able to form close bonds with others.

In dysfunctional families, children are often ignored, neglected and abused. They grow up without the love and support that leads to a negative self-image. In this negative and often painful family dynamic, children believe that they are not worthy of acceptance, affection or love and they are often unable to form healthy attachments to others.

These beliefs and thought patterns undermine real feelings and connections with others, and such young people feel isolated. They often are responsible for meeting their own basic needs, and many of them struggle to survive.

To meet their sexual needs, they take control, and sex may be the only form of satisfaction and comfort they experience. They view sex as their most important need and a substitute for relationships with others to fill their feelings of loneliness and isolation. They often confuse sex for intimacy and connections with others.

People involved in dangerous or illegal activity will develop suspicion and paranoia, which will further isolate them from others. The Internet provides a way to interact with others while keeping a barrier between them and the outside world. People who cannot communicate with others or trust others may seek anonymity on the Internet.

Sex in real life, no matter how impersonal or unfulfilling, still involves physical contact. Cybersex provides sexual satisfaction without a relationship or connection to anyone and allows people to remain unattached while fulfilling sexual needs.

Faulty belief patterns distort the individual's view of reality. This results in denial, such as ignoring the problem, blaming others, and minimizing inappropriate behavior as part of their defensive coping strategies. They do not see their sexual activities as the cause of negative consequences, such as broken families, lost jobs, damaged relationships, criminal activity and arrests; instead, they blame other factors. Blaming others for their problems is a way to refocus attention and avoid judgment. They often blame outside factors to justify their addictive behavior so those things are responsible for their actions.

Each of these faulty thought processes of denial, rationalization, delusion, paranoia and blame block contact with reality, which leads to further escape into cybersex.

Online these people become more isolated from the real world, which gives free reign to the cybersex addiction cycle. The addictive cycle has four steps that intensify with each repetition (Carnes, et al., 2001):

- **Preoccupation** – The trance or mood where the person's mind is totally focused and absorbed with thoughts of sex, which creates obsessive urges.
- **Ritualization** – The individual creates routines and rituals that intensify the preoccupation and increases arousal and excitement.
- **Compulsive sexual behavior** – The actual sex act is the end goal of the preoccupation and ritualization. The individual cannot control or stop the sexual behavior at this point.
- **Unmanageability and despair** – The person feels complete hopelessness and powerlessness to control his or her sexual behavior.

The addictive cycle starts with a belief system containing faulty assumptions, myths and distorted values that support impaired thought patterns. The resulting delusional thought process leads to a cycle that is completely removed from reality. The four-phase addictive cycle repeats itself and consumes the addict's life. Other support systems, including relationships, family, work, finances, health and safety rules, are totally abandoned.

Faulty beliefs are reinforced through continued negative consequences and failures, which cause further withdrawal from reality. The online sexual experience is the only goal in life, and finding sexual pleasure becomes the primary motivation for the addict. Sexual experiences are the source of all energy, pleasure and excitement without the negative consequences of other high-risk sexual encounters.

Family and friends of cybersex addicts may observe the out-of-control behavior, self-degradation, and loss of goals, morals and values. They may believe that it would be easy to control addictive online behavior by just avoiding the Internet altogether or at least limiting use. But cybersex addicts who may spend up to 11 hours a day online and another four hours obsessing about online sexual activities cannot modify or control the behavior.

At this point, the addiction has evolved into an altered state of consciousness in which nothing can compare to the euphoria, release and escape obtained through online sexual behavior. Cybersex can significantly affect the emotions, sexual arousal and neuro-chemical reactions in the brain, and the Internet allows people to quickly access sexual experiences that stimulate emotions in new and powerful ways. Cybersex can capture people's imagination and draw them into their fantasy world. It becomes more intense and captivating because they can create and select their own fantasy experience with the click of a mouse. These experiences are virtual, but they affect individuals emotionally and physically and allow for unlimited sexual activities that they never imagined were possible. Addicts can create and repeat novel sexual fantasies whenever they want and for as long as they want, intensifying the arousal and fulfillment.

There are many examples of erotic experiences that do not involve sexual acts. Voyeurs and exhibitionists can experience erotic moments on the Internet through an endless supply of erotic pictures taken through windows or by small hidden cameras in locker rooms or department dressing rooms.

Many cybersex users talk about the excitement of finding a sex site that has particular images they find arousing, and for others, the erotic moment starts when the photos slowly download onto their screen. Some cybersex addicts lose control once they enter the cybersex world after many years of denying or hiding their fantasies and sexuality. Through the Internet, sexual stimulation occurs in ways that have nothing to do with previous sexual norms, arousal or sexual experiences.

Before the Internet, sex was confined to a relatively small range of activities influenced by cultural, religious or social background, and sexual practices were restricted by morals, values, norms and taboos. Cybersex instantly gives a worldwide view of sexual practices.

Individuals can find others who have similar sexual desires and arousal patterns, so they can share new and unusual methods of gratification. Finding someone who has similar desires or fantasies without shame or guilt can change negative feelings about sexuality and help develop a positive self-image. When the activities are illegal or unhealthy, the Internet makes it possible for individuals to reinforce undesirable behavior and strengthen an unhealthy addictive sexual behavior.

INTERNET CHILD PORNOGRAPHY

Child pornography is rampant on the Internet with an active and sophisticated black market that law enforcement agencies have found difficult to infiltrate and control.

The National Center for Missing and Exploited Children (2005) says:

- Of those arrested for child pornography possession, 40 percent had sexually victimized children as well. These individuals are known as dual offenders, and both crimes are often discovered in the same investigation.
- Another 15 percent of dual offenders had tried to victimize children by soliciting undercover investigators who posed as minors online.
- Overall, 36 percent of dual offenders showed or gave child pornography to undercover investigators posing as minors online.
- Of those arrested in the United States for possession of child pornography, 83 percent had images involving children between the ages of 6 and 12; 39 percent had images involving children between 3 and 5; and 19 percent had images of infants and toddlers under age 3.
- According to The National Children's Home Report, the number of Internet child pornography images has increased 1,500 percent since 1988.
- Approximately 20 percent of all Internet pornography involves children.
- Child pornography has become a $3 billion dollar annual industry.
- More than 20,000 images of child pornography are posted on the Internet every week, and demand for more babies and toddlers is increasing.
- Child pornography is more torturous and sadistic than ever before, according to investigators.
- In the year 2001 alone, over a five-month period there was a 345 percent increase in child pornography sites.
- More than half of all illegal child pornography sites reported to the Internet Watch Foundation are hosted in the United States.
- Illegal sites in Russia have more than doubled from 286 to 706. Demand for pornographic images of babies and toddlers is rapidly increasing there as well.
- Approximately 20 new children appear on pornography sites every month, with many kidnapped or sold into sex.
- In the last couple years, Toronto police have seen younger children in regular seizures of child pornography, including babies, 2-, 3- and 4-year-olds.
- The U.S. Customs service estimates that there are more than 100,000 websites offering child pornography, which is illegal, worldwide.
- Revenue estimates for the child porn industry range from about $200 million to more than $1 billion dollars per year. These illegal online sexual images can be purchased easily. Subscribers typically use credit cards to pay a monthly fee of between $30 and $50 to download photos and videos, or a one-time fee of a few dollars for single images.

ONLINE SEXUAL PREDATORS

Statistics

- Internet pedophiles are using counterintelligence techniques to protect themselves from being traced.
- Of people charged with child pornography, 40 percent also sexually abused children, according to police. It is difficult to find the predators and identify the victims.
- One in five children who use computer chat rooms has been approached over the Internet by pedophiles.
- Thirteen million youths use instant messages, and one in five has received sexual solicitations.
- One out of 33 children who received aggressive sexual solicitations was asked to meet the person, called by phone, and sent mail, money and gifts.

- Twenty-five percent of youth who received sexual solicitations told a parent.
- One in four children participated in real-time chats when solicited online.
- Twenty-six popular children's online characters revealed thousands of links to porn sites, and 30 percent were hard-core porn sites.
- Pedophiles disguise their sites with common brand names, including Disney, Barbie and ESPN to entice children.
- Children are reported missing at the rate of 750,000 per year, or 62,500 per month, 14,423 per week, 2,054 per day, 85 per hour, or three children every two minutes.

(Source: National Center for Missing and Exploited Children, National Juvenile Online Victimization Study, 2005.)

Paraphilia

Paraphilia is a disorder that is characterized by recurrent intense sexual urges and sexually arousing fantasies generally involving nonhuman objects, the suffering or humiliation of one's self or one's partner, animals, children or other nonconsenting persons (APA, 2013). Pedophilia is the paraphilia that involves an abnormal interest in children. It is a psychosexual disorder in which the fantasy or act of engaging in sexual activity with pre-pubescent children is the preferred or exclusive means of achieving sexual excitement and gratification (Fleming, 2007). Mental health professionals define pedophilia as a mental disorder, but the American legal system defines acting on pedophilia urges as a criminal act.

In the Diagnostic and Statistical Manual of Mental Disorders (DSM), paraphilic disorders are often misunderstood as a catch-all definition for any unusual sexual behavior. In the fifth edition of the book, DSM-5, the Sexual and Gender Identity Disorders Work Group sought to draw a line between atypical human behavior and behavior that causes mental distress to a person or makes the person a serious threat to the psychological and physical well-being of other individuals. While legal implications of paraphilic disorders were considered seriously in revising diagnostic criteria, the goal was to update the disorders in this category based on the latest science and effective clinical practice.

Through careful consideration of the research as well as of the collective clinical knowledge of experts in the field, several important changes were made to the criteria of paraphilic disorders, or paraphilias as they have been called in previous editions of the manual.

Characteristics of paraphilic disorders
Most people with atypical sexual interests do not have a mental disorder. To be diagnosed with a paraphilic disorder, DSM-5 requires that people with these interests:

- Feel personal distress about their interest, not merely distress resulting from society's disapproval; or
- Have a sexual desire or behavior that involves another person's psychological distress, injury, or death, or a desire for sexual behaviors involving unwilling persons or persons unable to give legal consent.

To further define the line between an atypical sexual interest and disorder, the Work Group revised the names of these disorders to differentiate between the behavior itself and the disorder stemming from that behavior (i.e., Sexual Masochism in DSM-IV which is now titled Sexual Masochism Disorder in DSM-5).

It is a subtle but crucial difference that makes it possible for an individual to engage in consensual atypical sexual behavior without inappropriately being labeled with a mental disorder. With this revision, DSM-5 clearly distinguishes between atypical sexual interests and mental disorders involving these desires or behaviors.

The chapter on paraphilic disorders includes eight conditions: exhibitionistic disorder, fetishistic disorder, frotteuristic disorder, pedophilic disorder, sexual masochism disorder, sexual sadism disorder, transvestic disorder, and voyeuristic disorder.

Additional changes to paraphilic disorders
Other changes to diagnostic criteria for two DSM-5 paraphilic disorders also should be noted.

The first concerns transvestic disorder, which identifies people who are sexually aroused by dressing as the opposite sex but who experience significant distress or impairment in their lives—socially or occupationally—because of their behavior. DSM-IV limited this behavior to heterosexual males; DSM-5 has no such restriction, opening the diagnosis to women or gay men who have this sexual interest. While the change could increase the number of people diagnosed with transvestic disorder, the requirement remains that individuals must experience significant distress or impairment because of their behavior.

Pedophilia

The focus of pedophilia is sexual activity with a child. Many courts interpret this reference to mean children under the age of 18. Most mental health professionals, however, use the definition of pedophilia as sexual activity with pre-pubescent children, who are generally ages 13 or younger.

The sexual behaviors in pedophilia cover a range of activities from online child pornography and solicitation to actual contact and may or may not involve the use of force. Some pedophiles limit their behavior to online contact in chat rooms, exposing themselves or masturbating in front of the child. Others are compelled to meet the child to participate in oral or genital intercourse. There is no typical pedophile; they may be young, old, male or female, although the vast majority are males.

The American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) has recently been published after a comprehensive multi-year research and review of all of its diagnostic categories.

In the case of pedophilic disorder, the diagnostic criteria essentially remained the same as in DSM-IV-TR. Only the disorder name was changed from "pedophilia" to "pedophilic disorder" to maintain consistency with the chapter's other disorder listings.

APA (2013) addressed an error made within the DSM-5 in a special memo, stating that "sexual orientation" is not a term used in the diagnostic criteria for pedophilic disorder and its use in the DSM-5 text discussion is an error and should read "sexual interest." In fact, APA considers pedophilic disorder a "paraphilia," not a "sexual orientation." APA indicated that this error will be corrected in the electronic version of DSM-5 and the next printing of the manual.

Etiology

A variety of different theories exist on the cause of pedophilia. A few researchers attribute pedophilia to biology (Wilson, 2002). They hold that testosterone, one of the sexual male hormones, predisposes men to develop a deviant sexual desire. However, no researchers have claimed to have discovered or mapped a gene for pedophilia.

Most experts believe pedophilia results from psychosocial factors rather than biological characteristics (Fleming, 2007). They attribute

pedophilia to the result of having been sexually abused as a child or from the person's interactions with parents or guardians during their early years of life.

Some researchers attribute pedophilia to incomplete emotional development, which explains the pedophile's attraction to children because he or she has never matured psychologically (Money, 1989). Others view pedophilia as a result of distorted needs to dominate a sexual partner, and because children are smaller and weaker than adults, they are regarded as nonthreatening potential partners (Carnes, 1999). This drive for domination is sometimes thought to explain why most pedophiles are males.

Symptoms

Pedophiles often have good interpersonal skills with children and can easily gain the child's trust. They may volunteer with athletic teams, scout troops, schools, religious or civic organizations that serve youth. In some cases, pedophiles are attracted to children within their extended family, so they offer to babysit for their relatives or neighbors.

Some pedophiles offer rationalizations or excuses that enable them to avoid responsibility for their actions. They may blame the children for being too attractive or sexually provocative. They may maintain that they are teaching the child about the facts of life, sex or love. This rationalization is frequently offered by pedophiles who have molested children related to them.

All of these rationalizations may be found in online child pornography with pedophilic themes. Pedophilia is one of the more common paraphilias, and the large worldwide market for child pornography suggests it is more frequent in the general population than statistics indicate. Together with voyeurism and exhibitionism, pedophilia is one of the three paraphilias most often leading to arrests by police.

The onset of pedophilia usually occurs during adolescence. Occasionally pedophiles begin their activities during middle age, but this late onset is uncommon. In the United States, about 50 percent of men arrested for pedophilia are married.

The frequency of behavior associated with pedophilia varies with psychosocial stress. As the pedophile's stress level increases, so does the frequency of his sexual urges and behavior. Little research has been conducted about the incidence of pedophilia in different racial or ethnic groups. Pedophiles' first contact with children often begins online, where they befriend children and eventually try to solicit them for sex.

According to the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, the following criteria must be met to establish a diagnosis of pedophilia (APA, 2000):

- Over a period of at least six months, the affected person experiences recurrent, intense and sexually arousing fantasies, sexual urges or actual behaviors involving sexual activity with prepubescent children ages 13 or younger.
- The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational or other important areas of daily functioning.
- The person must be at least age 16 and be at least five years older than the child or children who are the objects or targets of attention for sexual activity.

To establish a diagnosis of pedophilia, the doctor or therapist must determine whether the pedophilia is exclusive or nonexclusive; that is, whether the patient is attracted only to children or to adults as well as to children.

One difficulty with the diagnosis of the disorder is that persons with pedophilia rarely seek help voluntarily from mental health professionals. Instead, counseling and treatment is often the result of a court order. An interview that establishes the criteria for diagnosis listed above may be enough to diagnose the condition, or surveillance or Internet records obtained through the criminal investigation may also be used (O'Donahue, Regev, and Hagstrom, 2000).

An additional complication with diagnosis is that paraphilia has a high rate of co-morbidity with major depression, anxiety disorders, and substance abuse disorders. A person diagnosed with pedophilia may also meet the criteria for exhibitionism, substance abuse or mood disorder (O'Donahue et al., 2000).

Again, this criteria went unchanged when the DSM-5 was released in 2013.

Treatment of pedophilia

Cognitive behavioral therapy (CBT) is often used to treat pedophilia as well as other addictions. It works to change faulty thought processes, which leads to behavioral change. CBT will be covered in the treatment section of this course. Berlin (2000) noted that pedophilia may also be treated with medications, and the three classes of drugs most often used are:

- Female hormones, particularly medroxyprogesterone acetate (MPA).
- Luteinizing hormone-releasing hormones (LHRH) agonists, which include such drugs as triptorelin (Trelstar), leuprolide acetate and goserelin acetate.
- Anti-androgens, which block the uptake and metabolism of testosterone as well as reduce blood levels of this hormone.

Most clinical studies of these drugs have been done in Germany, where the legal system has allowed medication use for treating repeat sexual offenders since the 1970s. The anti-androgens in particular have been shown to be effective in reducing the rate of recidivism. Surgical or chemical castration is sometimes offered as a treatment to pedophiles who are repeat offenders or who have pleaded guilty to rape.

Increasingly, pedophiles are being prosecuted under criminal statutes and being sentenced to prison terms. Imprisonment removes them from society for a period of time but does not usually remove their pedophilic tendencies. Many states have begun to publish the names and addresses of persons being released from prison after serving time for pedophilia. Many states also restrict whom they may contact, and where they can live, work and travel. Legal challenges to these practices are pending in some states.

Prognosis

The prognosis for successfully treating pedophilia is not a positive one, and there is a high rate of recidivism because pedophiles tend to repeat their acts over time. The rate of recidivism for pedophiles with a preference for male children is approximately twice that of those who prefer females.

Historically, the arousal patterns found in pedophilia have been viewed as quite rigid and fixed. Pedophiles who were severely abused as children developed rigid and narrow arousal patterns that were significantly different from normal behavior. It is extremely difficult for these individuals to make changes in their patterns of arousal because the damage they suffered is so deep and began so early in life. Their behavior is a set pattern and reinforced often for a very long time (Carnes et al., 2001).

The rate of prosecution of pedophiles by the criminal justice system has increased in recent years because of changes in the law and stiffer penalties. Pedophiles are at high risk of being beaten or killed by other prison inmates, and for this reason they often are kept isolated from other members of the prison population. Knowledge of the likelihood of abuse by prison personnel and inmates is not an effective deterrent for most pedophiles (National Center for Missing and Exploited Children, 2012).

Prevention

Other than therapy that works to change thought patterns and medication to help control the pedophile's sexual compulsions, the main method for preventing pedophilia is avoiding situations that may enable these acts. Part of an individual's therapy would include stress management, avoidance and prevention strategies to use if the sexual impulse occurs.

Families, schools and any organizations that serve children must also be involved in prevention:

- Children should never be allowed in one-on-one situations with any adult other than their parents or trustworthy family members.
- Having another youth or adult as an observer can provide some security for all concerned.
- Children should be taught and given chances to practice strategies to use if approached online or in person.
- Children should be taught to yell or run when faced with an uncomfortable situation, and that it is acceptable to scream or call for help anywhere.
- They must be taught to avoid situations that make them vulnerable to pedophiles.
- Children must tell a parent or trusted adult about any unusual or threatening contact from an adult or older teen.
- Parents and guardians must instruct children on Internet dangers and monitor their online use at all times.
- Rules should be established that govern the amount of access and the online sites they can visit.
- Internet blocks can be installed, but they cannot restrict all dangerous material and should not replace careful monitoring.

Likewise, adults who work with youths must be taught to avoid situations that may be construed as pedophilia. Most states have adopted legislation that requires periodic background investigations of any adults who work with children. This includes individuals who may be paid, such as teachers, as well as volunteers in any organization serving youth.

Laws on obscene visual representations of the sexual abuse of children

The National Center for Prosecution of Child Abuse outlines the federal laws that govern any visual representation of child sexual abuse, which includes Internet representations. The federal law states that:

- Any person who knowingly produces, distributes, receives, or possesses with intent to distribute a visual depiction of any kind, including a drawing, cartoon, sculpture, or painting that depicts a minor engaging in sexually explicit conduct, is obscene and illegal.
- This includes any visual representation that depicts an image that is, or appears to be, of a minor engaged in graphic bestiality, sadistic or masochistic abuse, or sexual intercourse including genital to genital, oral to genital, anal to genital, or oral to anal whether between persons of the same sex or opposite sex, is illegal.
- Any communication or visual depiction involving a minor made in the furtherance of these offenses communicated or transported by mail or through interstate or foreign commerce by any means including by computer, or that has been shipped or transported by any means including by computer, committed in the special maritime and territorial jurisdiction of the United States, or in any territory or possession of the United States, is considered to be obscene and therefore illegal.

Definitions in the law

The term visual depiction includes:

- Undeveloped film and videotape, data stored on a computer disk or by electronic means which is capable of conversion into a visual image, and also includes any photograph, film, video, picture, digital image or picture, computer image or picture, or computer-generated image or picture whether made or produced by electronic, mechanical, or other means.

- The term minor means any person under the age of 18.
  - The child may be recognizable as an actual person by the person's face, likeness, or other distinguishing characteristics such as a unique birthmark, or other recognizable feature, and shall not be construed to require proof of the actual identity of the minor.
- The term sexually explicit contact means actual or simulated sexual intercourse including genital-genital, oral-genital, anal-genital, oral-anal, whether between persons of the same sex or opposite sex, sadistic or masochistic abuse, or lascivious exhibition of the genitals or pubic area of any person. Online dialog that uses sexually explicit terms or shows the attempt to solicit sex with a minor is also illegal.
- Child pornography is any visual depiction, including any photograph, film, video, picture, or computer, or computer-generated image or picture, whether made or produced by electronic, mechanical, or any other means of sexually explicit contact where the production of such visual depiction involves the use of a minor engaging in sexually explicit contact.
- Federal sanctions include but are not limited to the following:
  - If a person violates, attempts, or conspires to violate laws governing the material constituting or containing child pornography, they will be fined under this title and imprisoned not less than five years and not more than 20 years.
  - If such a person has a prior conviction under this chapter section or under the laws of any state relating to aggravated sexual abuse, sexual abuse, or abusive sexual contact involving a minor or ward, or the production, possession, receipt, mailing, sale, distribution, shipment, or transportation of child pornography shall be fined under this title and imprisoned for not less than 10 years nor more than 20 years.

Sexual exploitation of children – Any person who employs, uses, persuades, induces, entices, or coerces any minor to engage in, or has the minor assist any other person to engage in, or who transports any minor in, or affecting interstate or foreign commerce, or any territory or position in the United States, with the intent that the minor will engage in any sexually explicit conduct for the purpose of producing any visual depiction of such conduct, or for the purpose of transmitting a live, visual depiction of such conduct, shall be fined under this title and imprisoned not less than 15 years no more than 30 years.

- If a person has one prior conviction under this chapter they shall be fined under this title and imprisoned for no less than 25 years nor more than 50 years.
- If a person has two or more prior convictions under this chapter, they shall be fined under the title and imprisoned not less than 35 years nor more than life.
- If in the course of an offense under this section, the person engages in conduct that resulted in the death of a person, they shall be punished by death or imprisoned for not less than 30 years or for life.

Few treatment options are available that have been scientifically proven to be effective. Doctors and therapists often adapt treatments used to address OCD, substance abuse and impulse control disorders because of the similarities among these disorders and Internet addiction.

Pharmacological treatments are often used to increase serotonin levels in the brain, which has proven effective in treating impulsive and compulsive disorders. Twelve-step programs such as Alcoholic Anonymous and Narcotics Anonymous are effective in some cases, but scientific studies have not been able to prove the effectiveness of the 12-step programs with Internet addictions. Today computers are an integral part of everyday work and social life, so it is unreasonable and impossible for individuals to maintain complete abstinence from Internet access as required in 12-step programs.

Medication and cognitive behavioral therapy combined is often the treatment of choice.

Treatment with medication is often applied to problematic Internet use, including pornography and gambling. Prozac-like medications were effective in some patients with problematic Internet use.

Internet addiction is more complex than an obsessive-compulsive disorder that often responds favorably to serotonin-enhancing drugs. Beyond the rituals that doctors see in patients with OCD, Internet addictions are also about an interaction with a computer that engages the individual's personality, frustrations, arousal patterns and need for stimulation.

The availability of novel activities on the Internet combined with the characteristics of obsessive-compulsive disorder make the Internet addiction more complex and difficult to treat then the ritual of excessive hand washing that might be found in an OCD patient for example (Carnes et al, 2001).

Cognitive behavioral therapy

Cognitive behavioral therapy (CBT) has proven effective in bringing about behavioral change in people dealing with many types of addiction. CBT addresses the feelings of dissociation that are often present and the fallacies in thinking that are critical components for treating Internet-addicted individuals.

CBT focuses on correcting faulty thought patterns that reinforce inappropriate behaviors. For example, gambling addicts often share the belief that they have the knowledge and skills to beat the online gaming programs; Internet sexual addicts believe they can use cybersex as an escape and a perfect substitute for real-life relationships. As patients begin to review their thought patterns, behaviors and the negative consequences that result, they gradually learn to address the underlying problems that led to the Internet addiction and learn to replace problematic Internet behavior with real-life experiences.

According to Aboujaoude (2011), CBT is the only form of psychotherapy to have been scientifically examined to treat Internet addiction, although only a limited number of studies have been conducted and published. CBT for Internet addiction involves bringing the patient to awareness of the time spent on the Internet by keeping a detailed log of the time spent in cyberspace and the type of activity, frequency, duration and predisposing conditions or antecedents that led to excessive Internet use.

Weekly meetings are held to discuss the journals and develop more effective coping skills and ways to manage time more effectively. Patients are also asked to review their excuses, justifications, or rationalizations that they use to explain their Internet use. This helps them identify the faulty thought patterns they have used to justify their addiction and the negative consequences of their online addiction.

Dr. Kimberly Young (2004) who, as previously mentioned, has conducted some of the largest scientific studies examining Internet addiction, reported that CBT was effective in treating Internet addiction symptoms by the eighth session of the program, and that the gains made were in place for at least six months following treatment.

Carnes, Delmonico and Griffin (2001) discuss external boundaries that need to be set for individuals who have a cybersex addiction. Once people have acknowledged their problem, they need to set boundaries, such as:

- Keeping their computer on the main floor of the house rather than in a more private home office.
- Choosing a nonsexual screen name.
- Using the computer only when at work for work activities.
- Not logging on to sexual websites.
- Giving the computer password to a spouse or partner who can check computer usage or history files.

Setting boundaries may be the beginning step to gaining control of cybersex addiction. The motivation to begin the process often comes from family friends, therapists or the courts at first. At this point, users must acknowledge their addiction and accept that they are unable to control it and that they need support through medication, therapy or a combination to bring about behavioral change and personal growth. They must recognize and acknowledge that their cybersex behavior is causing negative consequences in their life and the lives of those around them.

Once individuals have taken the first step, Carnes et al., note that there are eight rationalizations that interfere with recovery and should be addressed as the individual begins to develop a new belief system. Most addicts will find that they have used one or more rationalizations in the past and need to understand them as they develop new thought processes that are inconsistent with cybersex use.

- **Rationalization 1:** It is not real. There are no real people, no rules, so I can indulge in cybersex without worrying. I'm not going to a strip club, seeing a prostitute, or exposing myself to a real person. I'm not being unfaithful because I haven't really done anything.
- **Rationalization 2:** Cybersex doesn't hurt others. I'm not having skin-to-skin contact, so it's not sex and not affecting anyone else. No one can get a disease, and I can't hurt anyone. Even when I'm in a chat room, it is all make-believe.
- **Rationalization 3:** Cybersex doesn't hurt me, I'm just on the computer, so what's the big deal? It's no different than using other kinds of websites on the Internet. There are no consequences, and I'm not hurting myself at all.
- **Rationalization 4:** I can stop anytime I want by just turning off the computer and everything goes away.
- **Rationalization 5:** I've already done a recovery program in the past, so why should I go to do another one?
- **Rationalization 6:** Cybersex doesn't have any consequences. I'm not going to destroy my marriage. No one has my real name, phone number, my mailing address, or knows where I live. I use the computer in private, and no one knows my passwords. When I'm online at work, that's no different from taking a short coffee break.
- **Rationalization 7:** It's just a game; that's why it's called virtual reality. It's fun entertainment, and who would ever take this seriously? I don't really mean anything by this, and it's not really different from a video game.
- **Rationalization 8:** I just use it occasionally; it doesn't interfere with things in my life. I'm not on the computer all the time, I just go on when I feel like it and need something to do. I'm still in a good relationship with my partner, have a good job, and spend time with my family and friends, so it's no big deal.

At this point in the process, individuals must complete a self-assessment inventory including the following:

- Begin by listing examples that show their inability to stop their Internet sexual behavior. The list should provide specific details and examples of behavior and frequency so that the user can see a pattern.
- After reviewing their inventories, individuals should write examples that show how unmanageable their lives are because of their cybersex behavior.
- The next step is to list the negative consequences that have been the result of their behavior. This section should show how their behavior affects family, friends and co-workers. The list should address the effects of their addiction on their social life, health, economic status, career, educational goals, emotions, and family and personal relationships. The information from this self-assessment should be shared with everyone involved in the individual's recovery.
- After the inventory is complete, individuals should be prepared to accept that they are powerless to control their behavior, which is a compulsive or obsessive disorder, and that they need help through treatment to overcome their addiction.

A number of changes must be made in order to strengthen the external boundaries to limit and control their online addictive behaviors (Watzlawick, Weakland, and Fisch, 1988). These include:

- Reduced Internet access.
- Move the computer to a high traffic area.
- Don't go online except when others are at home.
- Set limits on when, where and how long to use the computer.
- Use electronic limits to reduce access, such as running software protection such as Net Nanny, Cyber Sitter, Cyber Patrol, or Guard Dog, which will prevent anyone from getting into sexual websites.
- Switch to a safe Internet service provider. A number of family oriented Internet service providers carefully screen out sexual sites and provide better protection than software alone. Service providers that are family oriented can be found through Internet search engines such as Google or Yahoo.
- If the work site is a temptation, leave the office door open when using the computer and place the monitor so that others can see it as they walk by the room.
- Avoid any chat rooms that are at all sexual in nature.
- Reduce anonymity by using e-mail addresses and screen names that actually identify the individual so there can be no more hiding under fictitious names.
- Share with at least two other people that they have an Internet addiction.
- Reduce objectification by using various reminders that recipients of the Internet communication are real people who can be affected by the sexual interactions.
- Build accountability by allowing a trusted friend, sponsor or therapist to monitor online behavior and access. Give this person access to all computer history. Individuals should be accountable to this person for the time they spend online and what sites they visit.
- Develop healthy online habits so that users can access the computer and Internet. They will need to learn to use the Internet for only healthy, positive purposes, which include accessing supportive recovery online resources.
- Find an online sponsor and develop e-mail buddies who are recovering from problematic online sexual behavior.
- Find and use websites that can support recovery rather than enable inappropriate behavior.
- Find and visit online support groups.

Gold and Edwards (2010) advise that in some cases, inpatient or residential treatment may be necessary for several weeks. Treatment may involve interpersonal therapy or group therapy. Interpersonal therapy can deal with factors such as mood disorders, anxiety and depression. Group therapy may work on issues such as denial and rationalization.

Use of medications such as naltrexone and SSRIs have been effective to address mood disorders and reduce excessive behavior and can be combined with psychotherapy to enhance the effectiveness. Gold and Edwards note that 30- to 90-day residential programs are sometimes not effective, and it may take as much as three to five years or 175 hours of therapy to achieve a positive and lasting outcome.

Stages of change

In their book "Changing for Good," authors James Prochaska, John Norcross and Carlos Di Clemente (1995) state that there are six steps, or stages, that everyone goes through when making changes in their lives, regardless of their goals. These can be used effectively with Internet addictions.

Each of the steps is predictable, well defined, and takes place over a period of time. Each step includes a series of tasks that must be completed before moving onto the next stage. It is possible to stay in one stage longer than another, and by understanding the stages, individuals can gain control over the cycle of change and move through it more quickly and effectively. The stages are:

- **Stage I: Precontemplation** – People at this stage usually have no intention of changing their behavior and often deny even having a problem. Their families, friends, neighbors, doctors or coworkers see the problem clearly, but the addicted individual in this stage does not. Individuals at this stage resist change, lack information, and are often in denial. They do not take responsibility for their problems and blame their genetic makeup, family, society, or any other outside influence they can name. They often don't want to talk or think about their problem because they feel the situation is hopeless. Individual may have to hit rock bottom, suffering serious consequences, before they are able to progress from this stage.
- **Stage II: Contemplation** – At this stage, individuals acknowledge that they have a problem and begin to think seriously about solving it. They are still struggling to understand the negative consequences of cybersex, its causes, or possible solutions. Many have indefinite plans in the near future to take action. At this stage, these individuals are aware that life as they know it is not working, and problems are beginning to worsen. They are not quite sure how to solve their problems and not quite ready to get started. When contemplating, they begin to transition to the next stage where they can think more clearly and begin to focus on a solution rather than the problem. Their orientation is more to the future than to the past.
- **Stage III: Preparation** – Most people in the preparation stage are planning to take action soon, often within the next month, and are making final decisions before they begin the change process. At this stage, they may still need to convince themselves that this is what's best for them and their family. They're uncomfortable with the way things are and want to take action to relieve their anxiety.
- **Stage IV: Taking action** – At this stage, people want to change their behavior after years of avoiding their problems. They are working to modify their behavior while at the same time changing their level of awareness, emotions, self-image and thought patterns.
- **Stage V: Maintenance** – At this stage, they are working to strengthen the gains they have made during previous stages and are struggling to prevent lapse or relapse. This is a dynamic stage because ongoing effort is needed to maintain the change on a day-to-day basis.

Preventing relapse

The recovery process is complex and often includes setbacks and relapses. As people work through the change process, they may lapse and return to an earlier stage before getting back on track. Prochaska and other researchers note that relapse is a normal part of the change process. They have found that the average successful individual relapses several times.

Relapse is never easy, and those who do may feel like a failure, embarrassed, ashamed and guilty and may believe that their hard work was for nothing. They may want to give up entirely on the change process, or they slip back into previous stages and feel as if they're going in a circle. Prochaska advises that individuals should think of the change cycle not as a circle but as an upward spiral.

Relapses are often the combination of a chain of events that starts days, weeks or even months in advance of their actual occurrence when individuals engage in rationalization, denial or both. These two distorted ways of thinking can combine to influence certain choices or decisions as part of a chain of events that lead to a relapse.

One of the main relapse prevention goals is to become aware of the behavior chains that can lead to a lapse or relapse. If people can recognize the antecedents or triggers to those behaviors and their consequences, they can take action long before they get to the point of relapse.

They will be able to plan positive strategies that are incompatible with inappropriate Internet use. Just as people participate in emergency drills, they can have a relapse drill as part of their prevention plan, and practice skills and strategies ahead of time. Examples of behavior chains and specific details are included in the next section on Internet gambling addiction.

Carnes, Delmonico and Griffin (2001) identify five problematic attitudes that they refer to as "relapse traps":

1. **Entitlement** – In the entitlement phase, individuals who are in a struggle to maintain abstinence may feel self-pity and believe they are entitled to some kind of reward for their progress.
2. **Resentment** – During the recovery process, feelings of anger and resentment may come to the surface, and it is important to acknowledge and address these feelings with the therapist. If these feelings remain unresolved, they can lead to stronger feelings of self-pity and entitlement, which may lead to relapse.
3. **Self-reliance** – Once people have progressed in recovery, they may reach a point where they feel they can handle the situation and are in control. This trap is really an attempt to find ways to participate in the addictive behavior without totally losing the gains they have made.
4. **Deprivation** – Simply stopping problematic or addictive behaviors does not signal recovery. Feelings of deprivation and entitlement may occur, and individuals might start other compulsive behaviors, such as drinking or gambling. Until the underlying causes are resolved, recovery will not happen.
5. **Stress** – Higher-than-normal stress levels can quickly increase the risk of relapse. Stress can occur from negative and positive situations, and strategies must be developed to handle stress, such as:
    - Stress management skills.
    - Relaxation training.
    - Meditation or yoga.
    - Therapy groups.
    - Contacting support facilitators.
    - Preplanned activities or hobbies.

Individuals in recovery must always stay alert for antecedents or triggers, such as social pressures, internal challenges and special situation that may arise. The following strategies can be used for maintaining commitment and recovery:

- List barriers they may encounter. For each barrier listed, strategies should be developed to address that barrier.
- Take credit for accomplishments, avoid self-pity and self-criticism, and accept responsibility for the positive changes made.
- Acknowledge progress month by month, week by week, or day by day.
- Realize there will be temptations and situations that will make maintenance challenging. Avoid people, places, or activities that could trigger a relapse.
- Keep an emergency card in a wallet or purse with a list of negative consequences, strategies to follow, and support people with phone numbers to call if the urge to relapse occurs.
- Substitute a positive, distracting activity, and list the benefits of resisting the Internet.
- Seek help and support from support groups, therapist, partner, spouse and friends.
- Once control is regained, review the incident with a therapist or support person to find ways to avoid that situation, or review and develop new strategies.

The next step

This generation of youth is moving toward a totally "paperless" society, so Internet safeguards and laws must be developed to protect them against Internet addiction and abuse, which take many electronic forms. There also is a need for more scientific understanding of Internet addiction, which is limited to a few large-scale studies.

Online fee-based subscription material profits from designs that will encourage continued online activity. Effective prevention strategies need to be developed, tested and implemented for the unique needs of children, adolescents and adults. Internet materials are designed especially for those populations, but prevention and treatment is not. Limits on Internet access and close monitoring are important for children, though they are increasingly difficult to enforce at home, libraries and schools.

A targeted prevention approach, identifying children who may be at risk for addiction, is also important. Children with pre-existing psychological, social or familial conditions may be at risk. Internet use by children should be carefully regulated by parents, guardians and teachers.

As indicated by the following statistics, adults are often unaware that children are spending great amounts of time visiting social networks, chat rooms, blogs and online sites that expose them to danger:

- Parents rely mostly on personal observation and setting guidelines for their children's Internet use.
- One in two parents does not use any blocking or filtering software.
- Sixty-two percent of parents of teens are unaware that their children have accessed objectionable websites.
- Twenty-nine percent of children ages 7 to 17 would give out their name and home address if asked.
- Fourteen percent would give out their e-mail address if asked.
- Seventy percent of teens 15-17 have accidently accessed pornography online.
- Fifty-five percent of those exposed to pornography said they were not too upset by it, or not at all upset by it.
- One in four children participate in real-time chat.
- Only 34 percent of adults who have children participating in real time chat rooms use technology to monitor where the children chat.
- One in five children who use chat rooms has been approached over the Internet by a pedophile.
- Twenty-five percent of youth who received sexual solicitation told a parent.

- Fifty-eight percent of teens say they have accessed objectionable websites.
- Forty-four percent of children visited X-rated sites or sites with sexual content.
- Forty-three percent of children say they do not have rules about Internet use in their home.

INTERNET GAMBLING ADDICTION

Definition

Internet gambling addiction is commonly described as on-line gambling behavior that causes disruption in any major area of life, psychological, physical, social or vocational.

The term gambling addiction includes the condition known as pathological or compulsive gambling.

A progressive gambling addiction is characterized by:
- Increasing preoccupation with gambling.
- A need to bet more money frequently.
- Restlessness or irritability when attempting to stop.
- "Chasing" losses.
- Loss of control manifested by continuation of the gambling behavior in spite of mounting serious, negative consequences.

"Internet-based gambling" is not included in the diagnostic criteria for Internet Gaming Disorder. This is because Internet-based gambling is already included in the Gambling Disorder diagnostic criteria.

The diagnostic criteria for Internet Gaming Disorder include:
- Repetitive use of Internet-based games, often with other players, that leads to significant issues with functioning. Five of the following criteria must be met within one year:
  - Preoccupation or obsession with Internet games.
  - Withdrawal symptoms when not playing Internet games.
  - A build-up of tolerance–more time needs to be spent playing the games.
  - The person has tried to stop or curb playing Internet games, but has failed to do so.
  - The person has had a loss of interest in other life activities, such as hobbies.
  - A person has had continued overuse of Internet games even with the knowledge of how much they impact a person's life.
  - The person lied to others about his or her Internet game usage.
  - The person uses Internet games to relieve anxiety or guilt–it's a way to escape.
  - The person has lost or put at risk and opportunity or relationship because of Internet games.

There is a certain shame attached to confessing a gambling addiction, in some cases even more than being an alcoholic or cocaine addict. Many still believe that people gamble excessively because of a lack of willpower or because they are simply immoral. These beliefs are beginning to change, as doctors, scientists and researchers are concluding that pathological gambling is a behavioral addiction that affects the brain in much the same way as substance dependency. Research suggests that about one in two problem gamblers suffer other types of addictions (Goudriaan et al., 2006).

Beginning in 1980, modern psychiatry redefined gambling addiction. The publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–III) marked the first time pathological gambling was included (APA, 2010).

This resulted in a major shift in how gambling addiction was seen by those in a wide range of fields, from doctors to judges, social workers and religious leaders. The condition was accepted by many as a medical disorder, as opposed to a moral failing or sinful transgressions that stemmed from personal weakness. The DSM listing changed gambling addictions from vice to disease.

In the DSM-IV, pathological gambling (PG) was classified under the section titled, "Impulse Control Disorders Not Elsewhere Classified," along with Compulsive Hair Pulling (Trichotillomania); Intermittent Explosive Disorder; Kleptomania; and Pyromania. The DSM-5 successfully moved PG to the category Substance-Related and Addictive Disorders under the title Gambling Disorder; eliminating the official diagnosis of pathological gambling.

The rationale for this change is that the growing scientific literature on PG reveals common elements with substance use disorders. Many scientists and clinicians have long believed that problem gamblers closely resemble alcoholics and drug addicts, not only from the external consequences of problem finances and destruction of relationships, but, increasingly, on the inside as well. According to Dr. Charles O'Brien, chair of the Substance-Related Disorders Work Group for DSM-5, brain imaging studies and neurochemical tests have made a "strong case that [gambling] activates the reward system in much the same way that a drug does." Pathological gamblers report cravings and highs in response to their stimulus of choice; it also runs in families, often alongside other addictions. Neuroscience and genetics research has played a key role in these determinations.

Internet addiction was considered for this category, but work group members decided there was insufficient research data for it to be included.

Officially changing the name to "Gambling Disorder" is a welcome revision for many researchers and clinicians who have expressed concern that the label "pathological" is a pejorative term that only reinforces the social stigma of being a problem gambler.

One major change in the DSM-5's clinical description of gambling disorders is the elimination of the criterion "has committed illegal acts such as forgery, fraud theft or embezzlement to finance gambling." The rationale for this change is the low prevalence of this behavior among individuals with gambling disorder. In other words, no studies have found that assessing criminal behavior helps distinguish between people with a gambling disorder and those without one. Studies suggest that its elimination will have little or no effect on prevalence rates and little effect on diagnosis. However, although committing illegal acts will no longer be a stand-alone criterion for diagnosis, the text will state that illegal acts are associated with the disorder. In particular, the criterion related to lying to others to cover up the extent of gambling will be described to include specific mention of illegal activities as one potential form of lying.

Other changes in the criteria are as follows:
1. "Is preoccupied with gambling" was changed to "Is often preoccupied with gambling" to clarify that one need not be obsessed with gambling all of the time to meet this diagnostic criteria.
2. "Gambles as a way to escape from problems" was changed to "Gambles when feeling distressed."
3. In the text accompanying the criteria, "chasing one's losses" is clarified as the frequent, and often long-term, "chase" that is characteristic of gambling disorder, not short-term chasing.

The DSM-5 work group observed that several empirical studies have supported lowering the threshold for a more accurate diagnosis of a gambling disorder from five to four criterion. For example, Stinchfield found that a cutoff score of four made modest improvements in classification accuracy and, most importantly, reduced the rate of false

negatives. Another recent study conducted in France found that the DSM-5 criteria (the DSM-IV criteria without the illegal acts criterion and with a cutoff of four symptoms) performed better than the DSM-IV criteria alone, the DSM-IV criteria without the illegal acts criterion and a new instrument based on the DSM criteria for substance abuse.

Finally, to diagnose a gambling disorder, the criteria that are displayed among the individual must occur within a 12-month period, unlike the DSM-IV which did not provide a time period for symptoms. In other words, if the person had two symptoms years ago and two symptoms in the past year, he or she would not qualify for a diagnosis.

Prevalence

Online wagering has turned into the biggest worldwide gambling trend. Virtual gambling began in 1995, and since then has grown to more than 2,000 Internet gambling sites. Internet gambling addiction is increasing in alarming proportions and results in various dysfunctional behaviors if not treated correctly.

Internet gambling has been described as the nation's foremost "silent addiction." As one college counselor pointed out, "pathological gamblers don't have track marks on their arms, their speech is not slurred, and they are not staggering down the street. But on the inside, the emotional churn going on is equally as great as in the substance abuser. (Henry, 2003).

The venue of choice for individuals with Internet gambling addiction varies as well. While many prefer gambling online at home, the increasing numbers of Internet cafes contribute to the rates of Internet gambling addiction that continues to increase as follows:

- According to recent research, about 2.5 million adults in America are pathological gamblers, and another 3 million adults are considered problem gamblers.
- Fifteen million adults are at risk of problem gambling, and about 148 million are low-risk gamblers.
- Gambling addiction statistics show that more than 80 percent of American adults report having gambled at some point in their lives.
- Gambling addiction statistics reveal that more than $500 billion is spent on annual wagers.
- The statistics show that during any year, 2.9 percent of U.S. gamblers are considered to either be pathological or problem gamblers.
- Gambling addiction statistics on co-occurrence of gambling and alcohol dependence revealed problem drinkers are more likely to have a gambling addiction (Skolnik, 2011), (Shaffer, 2010.) and (Rosenthal 2010).

The rate of online gambling addiction continues to increase:

- Ten million Americans play poker online for money as opposed to the free, not-for-money games.
- The United States has the highest number of online gamblers in the world.
- The country that came closest to the U.S. in the 2009 survey was the United Kingdom, with 1.9 million players.
- A survey completed in 2010 estimated that American gamblers would bet $5.7 billion dollars online by the end of 2010. This is down slightly from the $6 billion wagered in 2009.
- Americans comprise 17.2 percent of the worldwide online gambling market.

Analysts predict that online gambling in the United States will rapidly increase if the Unlawful Internet Gambling Enforcement Act (UIGEA) is repealed. This act makes it illegal to transfer funds from financial institutions to online gambling sites. Two U.S. representatives from Massachusetts and Washington have bills on the table for repeal, as well as state lawmakers from across the country. If the law is repealed and online gambling becomes legal across the country, it would result in $67 billion for the U.S. economy over the first five years, according to the British consulting group H2 Gambling Capitol. Revenue from gambling would add $30 billion in new federal taxes and generate 125,000 jobs, the group predicts.

According to online proponents, the U.S. should follow Europe's lead, where many countries have legalized online gambling. From Denmark to Greece, European governments have legalized and deregulated the online gambling business by allowing private companies to compete with state-sponsored online gambling sites. Some officials noting the correlation between online gambling and high addiction rates have claimed that legalization is needed because government controls can aid in protecting problem gamblers. But many in the U.S. are concerned that legalization and the reliance on gambling revenues, including from addicted gamblers, is distorting the more appropriate role of government and creating dependencies. H2 Gambling Capital explains, "they regulate a little bit, then they deregulate more. The government gets more addicted to the tax than the players to the online games."

Young people, especially college students and recent graduates, are at risk for developing online gambling problems. Today young people use the Internet as their primary source of communication and entertainment. Compared to drugs and alcohol, which have been around colleges for decades, the addiction to online gambling is a relatively new addiction on campuses.

It is one of the most widespread and serious concerns affecting students today, and online gambling networks in a school can be disguised as a group of students socializing together. In this Internet age, bets can be made online or via cell phones, and the addiction can involve an entire school and be undetected. Because money is something most students need, online gambling seems like a harmless way to make cash quickly and easily.

Being physically and psychologically linked to a campus, college students are interested in the outcomes of sporting events, and when combined with easy access to alcohol and high-speed Internet, many post-secondary institutions find their students engaging in online sports gambling at much higher rates than the general population (Henry, 2003).

The University of Kansas director of counseling services noted that gambling allows students to feel intimately involved in the game (Aire, 2000). The gambling recovery counselor stated, "The more someone knows about a given sport, the more they believe their decision-making gives them a significant advantage." This develops a level of "emotional invincibility in the addiction" (Henry, 2003).

With easy access to online gambling and a need to feel part of the larger organization, pathological Internet gambling associated with betting on sporting events has risen significantly in the past 10 years (Jordan, 2009).

According to the Annenberg Public Policy Center's 2005 National Center of Youth:

- There are 2.9 million Americans ages 14 to 22 who gamble online once a week.
- About 50.4 percent of male college students gamble online once a month.
- 26.6 percent of female college students gamble online at least once a month.
- This is half of the entire male student body and a quarter of the female student body.
- Gambling is particularly tempting to college students because risk-taking behaviors are common.
- The legal age for gambling is 18 years old in many states, making it a socially permissible behavior.

In one extreme case, a student at the University of Wisconsin murdered three roommates because he owed them thousands in gambling debts. The trio had helped him place bets with an online offshore gambling company. He had lost $15,000 through gambling and withdrawn $72,000 from his bank account to support his habit before he committed the murders (Wexler and Isenberg, 2002).

Online gamblers are connected to one another and can "chat" with written posts, but most are sitting alone in a private place while gambling online. The ability of online gamblers to play considerably faster than they could at a casino can lead to higher rates of addiction.

The National Gambling Impact Study Commission warned of potential Internet gambling problems in a 1999 report, issued when the online industry was in the beginning stages and much smaller than today. The commission said, "In addition to their accessibility, the high-speed instant gratification of online Internet games and the high level of privacy they offer may increase the problem and lead to pathological gambling." Since then, the warning has materialized over the last decade.

Researchers have found pathological online gambling is related to poor physical and mental health even more than other forms of gambling. Internet gambling is very different from the experience of social gambling, according to Les Bernal, executive director of the group Stop Predatory Gambling, and he explains the difference. "The speed of the game, the frequency of play, the intensity of the high people get when they play, and the enormous amount of money people lose, all of which goes down 24 hours a day, seven days a week – It is the equivalent of putting a Las Vegas casino in every house, apartment and dorm room."

Robert L. Custer, M.D., cites the four phases of gambling and has developed an Adolescent Chart of Compulsive Gambling that can apply to adults as well:

- **The first phase: Winning:**
  The attraction of compulsive Internet gambling is the immediate gratification. During the winning phase:
  - Gamblers likely win more than they lose.
  - The wins reinforce the person's love of the game.
  - Gamblers may develop the illusion that they are skilled at the game.
- **The second phase: Losing:**
  Gamblers' luck does not run forever, and after a while, they start losing more money. Ironically, a losing phase does not discourage them. During the losing phase:
  - They feel tempted to gamble more and with larger amounts of money.
  - They are convinced that they are simply on a losing streak and just need one win to get back momentum.
  - They invest on the "long shots," which, while having low odds of winning, will pay big, according to their faulty thought processes.
  - They may engage in a behavior called "chasing losses," meaning they will increase their gambling with larger bets, hoping to win back the losses. In the phase of chasing losses, the lies begin, and gamblers lie to maintain the appearance that they are winning.
  - Gamblers want to seem financially viable and competent at the game. They continue to boast about their gambling skills – part of the narcissism often seen among Internet addictions. They talk about winning, but not about losses.
  - When they suffer a major setback that causes financial trouble, gamblers make up a lie to get a loan. Because they have been able to hide their online Internet gambling, their deception to get a loan is much easier.
  - They consider the bailout a win, again because of faulty thought patterns, and they resume gambling even more aggressively than before. In this phase, there is more losing than winning, time on the Internet increases, and life becomes unmanageable.
  - They find it is impossible to persuade others to provide a loan, and relationships with family and friends are rapidly deteriorating.
  - The obsession increases, they cannot stop, debts mount, irritability and depression may occur, and they drop out of social, work, and school activities. (These are characteristics listed in both Internet and gambling addiction as noted in the DSM.)
- **The third phase: Desperation:**
  This is the point when gamblers become obsessed with Internet gambling and feel compelled to carry it through, despite knowing they will lose:
  - Life becomes completely out of control, and when others don't believe their lies, they become angry, blaming others for their problems.
  - They need to find money to gamble at all costs, and illegal activity may occur through embezzling and stealing money or objects to sell or pawn.
  - They consider the illegal activity a loan, which they will pay back from the big win they believe will happen soon.
  - Still convinced that everyone believes the lies they have told, these gamblers become furious if questioned by others.
  - Gamblers outwardly blame everyone else but themselves for the unfortunate circumstances now occurring. Inwardly, they are in severe anguish, truly loves their families, and want things to be like they used to be.
  - They want to correct the problems they have caused, but are compelled to gamble, although they do not know why.
  - To pay debts, they sell family valuables, commit crimes, feel shame, guilt and panic, and are totally out of control.
- **The fourth phase: Hopelessness:**
  Until recently, only three phases of pathological gambling have been noted. Many clinicians and experts who treat pathological Internet gambling now say a fourth phase exists for both action-seeking and escape gamblers (Parhami, 2010). Once gamblers have been through the desperation phase, it would seem that everything bad had occurred. However, in the hopeless phase, pathological gamblers have given up:
  - They believe nothing can help and many do not care if they live or die.
  - Many believe suicide is the only way out, and they consider that during this phase.
  - Most will commit actions that could place them in jail or prison.
  - They believe no one cares, and no hope is available.
  - The hopeless phase is the time when the pathological gambler either gets help or turns to substance abuse or suicide.

Etiology

As with other mental health issues, compulsive online gambling may result from a combination of biological, genetic, social and environmental factors. Compulsive gambling affects both men and women and cuts across cultural and socioeconomic lines.

Risk factors for gambling addiction

Although most people who gamble never develop a gambling addiction, certain risk factors are often associated with gambling disorders; elements that increase the likelihood that the individual will develop a gambling addiction. Risk factors for developing a gambling disorder include schizophrenia, mood problems, antisocial behavior, personality disorder, bipolar disorder, and alcohol or cocaine addiction as described below (Mayo, 2011):

- **Behavior or mood disorders:** People who gamble compulsively often have mood disorders, such as anxiety and depression, as well as attention-deficit/hyperactivity disorders:
  - 37.9 percent of pathological gamblers were also diagnosed with mood disorders.
  - 37.4 percent of pathological gamblers were diagnosed with anxiety disorders (Rosenthal et al., 2010).

- **Family influences:** If a parent had a gambling problem, chances are greater that children in the family will develop gambling problems. Dysfunction in the family and childhood trauma and abuse are also factors.
- **Personality characteristics:** Highly competitive, narcissistic, restless or easily bored individuals have an increased risk of developing an Internet gambling problem.
- **A diagnosis of bipolar disorder:** Exorbitant spending in the form of compulsive Internet gambling may be a symptom.
- **Parkinson's disease or restless leg syndrome:** Medications used to treat these disorders have been observed to develop compulsive gambling in some individuals.
- **Alcohol and cocaine addiction** are risk factors for pathological gambling.
- **Biochemical factors:** In some addictive individuals, compulsive behaviors can be connected to increased activity of the chemical messenger dopamine in the brain or low serotonin levels.

For the last decade, researchers have studied how biochemical substances such as dopamine work in gamblers' brains. Neurotransmitters help the brain learn about pleasure, including predicting when the sensation may return (Goudriaan, et al).

Addicted Internet gamblers are different from nonaddicted ones in the ways their dopamine systems function. Individuals who have a low level of serotonin in the brain are at higher risk for developing pathological Internet gambling. Some researchers believe that during the first gambling experience, for some pathological gamblers, a huge dopamine rush can occur that gets planted in their memory. When that happens, the addicted gamblers, like cocaine addicts, develop reward systems that respond to pleasing stimuli differently than nonaddicts.

An increasingly high level of reward has to be given for many addicted gamblers to continue to feel pleasure, leading to tolerance, dependence and addiction (APA, 2010). Studies have noted that gamblers crave the rush, the high or euphoria they feel when they make a bet or when they anticipate making the bet.

People who suffer from compulsive gambling addiction and Internet addiction often have a tendency to be novelty seekers. Combining the two forces of gambling and the Internet only adds to the excitement. And the speed of the Internet only increases the frequency of this rush.

Physiological changes include a surge of blood to the face and a dry mouth. Concentration narrows, as time seems to slow. The high is short-lived but is repeated as soon a gambler makes the next bet – which can happen immediately online. The feeling exists whether the bet is won or lost, but can spike, especially if it is more than expected. The rush experience has been compared to snorting a line of cocaine (Skolnik, 2011).

The Internet has provided unprecedented access to online gambling so that rush gamblers can get satisfaction in the privacy of their homes at any time. Currently, there are more than 2,000 gambling websites that take in more than $4 billion annually (Aire, 2003).

Here is an example of online gambling as described by one college-aged compulsive gambler:

> *It's 2 a.m. I've got an economics exam very early in the morning. I can stay on for just one more online tournament. This time I can win, I can feel it. I need to make up for what I lost today. I absolutely have to. Maybe I can buy a new outfit for this weekend or put a little bit of money toward my credit card bill. I can feel it. This is the one. Come on. Aces, aces …*
>
> *I am an addict. I'm not alone. This is a new addiction, and my 2 a.m. pre-econ-exam, late-night binging is what I call the "gambling me." The reason I didn't connect this directly to myself is due to the fact that I never knew I was capable of an addiction. I've never smoked or used drugs and only drink socially. I was the last person in the entire world that I thought could be addicted to anything.*
>
> - Lauren Patrizi, Loyola University-2005, at a Gambler's Anonymous meeting (Jordan, 2009).

Using an MRI scanner, neurologists in Hamburg, Germany, measured the responses of 12 gambling addicts and 12 nonaddicts to a card-guessing game. When participants picked the correct card, they won a euro. The non-addicts picked the right card, which increased their blood flow to the ventral striatum, a portion of the brain with dopamine receptors that measures rewards. In comparison, the addicted gamblers' brains had far less blood flow to the area, indicating they needed a reward much larger than a single euro to become excited (Lewis, 2006).

Problem online gambling involves more than one symptom but less than the five symptoms required to qualify for the diagnosis of compulsive or pathological gambling. Binge gambling is a subtype of compulsive gambling that involves problem gambling, but only during discrete periods of time. That is different from an online gambling addiction, which tends to involve excessive gambling behavior on an ongoing basis and includes persistent thoughts or obsessing about gambling, even during times when the person is not engaged in gambling (UCLA, 2010)

TREATMENT OF ONLINE GAMBLING ADDICTION

Cognitive behavior therapy

Cognitive behavior therapy aims at replacing negative beliefs with healthy and positive ones as a form of gambling addiction treatment. This therapy focuses on changing unhealthy gambling behaviors and thoughts, such as rationalizations and false beliefs. It also teaches problem gamblers how to fight gambling urges, deal with uncomfortable emotions instead of seeking escape through gambling, and solve financial, work and relationship problems caused by the addiction.

The goal of treatment is to "rewire" the addicted brain to help the individual learn to think about gambling in a new way, according to the Department for the Mental Health Addiction Services (MHAS, 2011).

(Refer to the CBT section in the previous discussion on Internet sexual addiction.)

Principal errors in thinking among gamblers

One way to prevent and control online gambling addiction is to alleviate fallacies in thinking (Jordan, 2009). The faulty thought patterns of pathological Internet use were discussed in the previous section and are combined with the faulty gambling thought patterns listed below. Internet gamblers must evaluate their patterns of thinking to determine whether they are based on realistic odds.

The following are some faulty thought patterns commonly misunderstood by compulsive gamblers:

- **Independence of turns.**
  It is not unusual for gamblers to think in terms of winning streaks, which motivates them to continue gambling. They might say, "I will definitely win today, I am on a winning streak," or "I will not place a bet online today because I am on a losing streak." For example, when they get three wins in a row, they interpret that as

a strong likelihood that the next bet will win. This kind of thinking runs counter to the principle of the independence of turns.

Independence of turns means that events are independent of each other; each is considered as unique and has no links to previous and consequent events. Thus, there is no such thing as a lucky streak or catching up on previous losses. Each bet has a 50-50 chance of winning.

Independence of turns is an essential condition of games of chance. In order to be unpredictable and to obey the rules of chance, all gambling games are structured in a way that each turn is an independent event and in no way determined by the results of the previous turn. This independence of events, or absence of a link between events, makes predicting the next result impossible, so gamblers can never exert any control over the game.

- **Illusions of control.**
  The majority of gamblers believe that they accumulate experience and learn from their errors when gambling. This follows the patterns of control, narcissism and grandiosity, which are also characteristics of Internet addiction. This feeling of personal superiority leads gamblers to believe that their actions influence their chances of winning. They maintain the illusion that they will beat the online game by defying the negative odds to recoup their losses (Jordan, 2009).

  But because gambling activities are not games of skill, no mental or physical skills are necessary when it comes to betting. However the majority of gamblers believe that it is possible for them to acquire some form of mastery. Familiarity is an important factor in the illusion of control, but often when people familiarize themselves with a task determined by chance, the stronger they believe that they can control the situation.

  The amount of direct exposure to a situation increases the degree of perceived control. A number of studies have demonstrated that when individuals have the opportunity to aggrandize the degree of risk they take, as is the case with online gamblers, they take greater risks when they make their decisions alone. Wallech explained this increase in risk-taking as a group process in which the individuals share their risk-taking, and therefore, each feels reinforced by risk-taking behavior. As a result of the group sharing online, the tolerance for risk-taking is increased (Wallech, 2011).
- **Superstitions.**
  Another common error in thinking among gamblers is the belief in superstitions. Often superstitions support gamblers' illusions of control by making them think that a ritual can increase their chances of a win.

The next obvious step would be to address these principal errors in thinking through a form of therapy, such as cognitive behavioral therapy, that focuses on thought processes. This could lead addicted or potentially addicted online gamblers to identify fallacies in thinking, which are directly related to their views on winning.

Because these errors in thinking contain concepts commonly misunderstood by these gamblers, this may provide a cognitive basis to deal with the realities of gambling and change their thought patterns to develop appropriate strategies for prevention (Jordan, 2009).

Four steps program

A variation of cognitive behavioral therapy called the four steps program has been used in treatment of compulsive gambling. The goal is to change the thoughts and beliefs about gambling in four steps; relabel, reattribute, refocus and revalue. Dr. Jeffrey Schwartz outlines the four core steps to recovery from gambling addiction in his book, "Brain Lock."

These four core steps use a variety of psychotherapeutic methods to treat pathological gambling, including cognitive behavioral therapy and rational emotive severity approaches (Schwartz & Beyette, 1996).

Step 1: Relabel.
Recognize that the urge to gamble is nothing more than a symptom of the gambling addiction, which is a treatable medical condition. It is not a valid feeling that deserves attention.

Step 2: Reattribute.
Stop blaming and try to understand that the urge to gamble has a physical cause in the brain. People must learn they are separate from the disease of addiction and not passive bystanders. They must understand that with practice, they can learn to control the addiction.

Step 3: Refocus.
When the urge to gamble strikes, individuals must shift their attention to something more positive or constructive. They should plan to do something else, even if the compulsion to gamble is still strong.

Step 4: Revalue.
Over time, individuals learn to revalue flawed thoughts about gambling. Instead of taking thoughts and feelings at face value, they realize they have no inherent value or power. They are just "toxic waste from the brain" (Schwartz and Beyette, 1996).

Treatment helps these people develop tools and support for reframing their thoughts. They learn to change their lifestyles and make healthier choices by analyzing what is needed for online gambling to occur, work on removing these elements from their lives, and replace them with healthier choices (Fong, 2010).

Two elements of problem online gambling to address are:

1. **A decision** – Before gambling occurs, the decision to gamble has been made. If you have an urge to gamble, stop what you're doing and call someone, think about the consequences of your actions, tell yourself to stop thinking about gambling, and find something else to do immediately.
2. **Money** – Gambling cannot occur without money. Get rid of credit cards, let someone else be in charge of money, have the bank make automatic payments, and keep a limited amount of cash available at all times.

Medication

Medications for online gambling addiction treatment are often from the antidepressant group. SSRIs (selective serotonin reuptake inhibitors) have proven to be effective in the treatment of gambling addiction that includes mood swings and anxiety. Mood stabilizers like lithium (Eskalith, Lithobid) and medications used to address addictions like naltrexone (ReVia), and antidepressants like clomipramine (Anafranil) and fluvoxamine (Luvox) have been effective for some patients.

Other medications have been helpful in decreasing the urge to gamble or the thrill involved, including anti-seizure medications like carbamazepine (Tegretol) and topiramate (Topamax) (Edwards & Shiel, 2011).

Naltrexone and nalmefene appear to be two of the most promising drugs being studied today. Primarily used to treat alcohol dependence, both drugs have proven more effective than a placebo in treating pathological gambling in three separate randomized clinical trials (APA, 2010).

These drugs are opioid antagonists. "Opioids regulate dopamine pathways in areas of the brain linked with impulse control disorders. The opioid antagonists block opioid receptors in these regions," according to the National Institute of Health (NIH, 2011). There is an ongoing trial to see whether naltrexone treats pathological gambling among those who develop such disorders because they had taken Parkinson's-fighting drugs that may cause addictive symptoms (Dodd, et al.).

A different trial with naltrexolene, unrelated to Parkinson's disease, is being conducted and will attempt to determine whether the drug is effective in a real-world clinical setting. The trial is scheduled to be completed in 2012.

Medication combined with a proven psychotherapy method, such as cognitive behavior therapy, has been effective in treating a variety of Internet addictions, including online gambling addiction.

Internet boot camps

A controversial strategy that has received increased media attention is boot camp-style rehabilitation programs. These programs can be used as an intervention to stop the development of Internet addiction or to treat an existing addiction, according to its proponents. Developed and used in Asian countries, this treatment program is being widely used in South Korea – one of the most Internet-connected nations with one of the highest rates of Internet addiction among its population.

In Korea, online gaming is a professional sport, and the social life of youths revolves around Internet social media. Internet cafés can be found on every corner, and many young people skip school in large numbers to stay online for marathon sessions of virtual games. The government viewed the situation as a national threat and responded aggressively by opening up an extensive network of Internet addiction outpatient clinics, hospital-based programs and intensive boot camps and Internet rescue facilities.

At boot camp, there is no Internet access allowed except for a daily cell phone call home. For some youths who had spent upwards of 17 hours a day on the Internet, this type of treatment produces physical and emotional withdrawal symptoms. The youths are offered substitute games and activities to replace the online gaming. Though the results of these programs have not been independently tested through scientific studies, some of these programs claim a 70 percent success rate and "cure."

Illegal activity and severity

Individuals who engaged in illegal behavior in the year prior to treatment tend to have more severe symptoms of gambling, have more gambling-related debt, and have more severe symptoms during treatment compared to people who are not engaged in illegal activity during that time period. People who engage in breaking laws the year before treatment began need more intensive treatment for a longer period of time, sometimes even requiring inpatient or residential treatment.

Another important fact to consider in treatment is that up to 70 percent of people with this disorder also have another psychiatric problem (Edwards & Shiel, 2011). It is not enough to just treat the gambling problem; any coexistent mental health condition, such as alcoholism or other substance abuse, mood disorder or personality disorder, should be addressed to give the addicted gambler the best chance for recovery from both conditions (Petry, 2005).

Though one third of pathological gamblers may recover from the disease without treatment, the devastation of Internet gambling addiction indicates that positive aspects of treatment outweigh the possible complications resulting from intervention (Edwards & Shiel, 2011).

One of the challenges of treatment for gambling addiction is that two-thirds of addicts who begin treatment for this disorder discontinue treatment prematurely, regardless of whether treatment involves medication, therapy or both (Edwards & Shiel, 2011).

PREVENTING RELAPSE

Understanding behavior chaining

To understand the sequence of behavior that affects their gambling addiction, gamblers must identify the triggers – the external events – that start the behavioral sequence. After the trigger, people's thinking happens very quickly, and they may not have time to stop and focus at this point. The thoughts that trigger feelings may give the individual energy and direction for action. The trigger initiates the behavior or the action to occur. Finally, there is always the consequence for the action (Fong, 2010).

The following is a behavior chain:

1. Trigger.
2. Thinking.
3. Feeling.
4. Behavior.
5. Consequences.

Here are examples of behavioral chains and how they work:

1. After a stressful day at work, Jan heads home. Jan, a recovering Internet gambler, passes the new Internet café that is open 24 hours a day (the trigger). She thinks, "I'm feeling in control, and I think I will go in just for a few minutes of fun," (trigger initiates thinking). Jan wants to gamble and feels a craving (thinking initiates feeling). She walks into the café, which is dimly lit, and feeling anonymous, she enters a room full of colorful online gambling sites ready for play.
2. Jan sits down to play, feeling a rush of excitement (feeling initiates the behavior). Jan lapses and stays three hours, loses money, and feels defeated, embarrassed and exhausted (the behavior has a consequence).
3. It is midnight, and Tom is not asleep (the trigger). He thinks, "I will gamble online just a little so I can sleep" (thinking). He feels anxious about not sleeping two nights in a row (feeling). He gets up, goes to the computer and enters his favorite online gambling site (behavior). He loses a large amount of money and is so depressed and exhausted that he cannot go to work the next morning (consequences).

In a behavior chain, individuals learn that at every point along the chain, they can work on preventing a lapse or relapse. They begin by examining triggers carefully to determine what environmental events could lead to gambling. They learn to re-examine high-risk situations to determine what people, places and things may make them vulnerable to lapse or relapse.

In this way, they can stay away from these triggers as much as possible, and if one occurs, they are prepared to use their new coping skills or substitute behaviors (Fong, 2010). To prepare for continued recovery, they develop a daily relapse prevention program, which

increases their chances of success. This plan includes evaluating their recovery daily and keeping a journal and prevention inventory for continued progress.

This inventory assesses:

- Relapse warning signs.
- Feelings about themselves and others.
- Sleeping, eating, exercise and relaxation habits.
- Progress in the total recovery program.

Efforts to restrict online gambling

With the increasing incidence of online gambling, a commercially produced computer application has been developed to block access to online gambling. GamBlock has been available since 2000 to help problem gamblers avoid unrestricted online gambling.

GamBlock uses a system that continually locates and blocks new gambling sites and software as it is developed. It does not require constant updating of website lists and claims to eliminate all access to online gambling. GamBlock cannot be removed, and could be used at home or in treatment facilities, hospitals, correctional facilities, schools, libraries, government buildings and other institutions. This system is installed by many entities to ensure that online gambling cannot be conducted from their facilities by staff, patients or visitors.

The system could be effective in situations where only one computer is available as well, such as a home computer or controlled therapeutic setting to give computer access to an individual in a treatment/ recovery setting. It would not address the underlying issues involved in a gambling addiction nor serve as a replacement for treatment.

Laws to address online gambling

The Unlawful Internet Gambling Enforcement Act (UIGEA) was enacted in 2006. The measure made it illegal for funds to be transferred from financial institutions to online gambling sites and made it tougher and illegal for Americans to deposit money on those sites. As noted previously, several bills are being proposed to appeal this act in favor of legalized gambling.

Agents from the U.S. Justice Department have arrested international Internet gambling operators for violating the Federal Wire Act. The Justice Department has maintained that the act makes all Internet gambling illegal, though the issue is under study in the federal courts.

YOUNG'S INTERNET ADDICTION TEST

The following 20 questions are examples from K.S. Young's "Caught in the Net: How to Recognize the Signs of Internet Addiction and a Winning Strategy for Recovery." It is being included here because it applies to both topics covered in this course.

Young's Internet Addiction Test
Answer each of the following 20 questions on a scale of 1 to 5:
1. Rarely 2. Occasionally 3. Frequently 4. Often 5. Always

	1	2	3	4	5
1. How often do you stay online longer than you intended?	○	○	○	○	○
2. How often do you neglect household chores in order to spend more time online?	○	○	○	○	○
3. How often do you prefer the excitement of the Internet to intimacy with your partner?	○	○	○	○	○
4. How often do you form new relationships with fellow online users?	○	○	○	○	○
5. How often do others complain about the amount of time you spend online?	○	○	○	○	○
6. How often do your grades or schoolwork suffer because of the amount of time you spend online?	○	○	○	○	○
7. How often do you check e-mail before something else that you need to do?	○	○	○	○	○
8. How often does your job performance or productivity suffer because the Internet?	○	○	○	○	○
9. How often do you become defensive when someone asks you what you do online?	○	○	○	○	○
10. How often do you block out disturbing thoughts about your life with soothing thoughts of the Internet?	○	○	○	○	○
11. How often do you find yourself anticipating when you will go online again?	○	○	○	○	○
12. How often do you fear that life without the Internet would be boring, empty and joyless?	○	○	○	○	○
13. How often do you snap, yell, or become annoyed if someone bothers you while you are online?	○	○	○	○	○
14. How often do you lose sleep because of late-night Internet use?	○	○	○	○	○
15. How often do you feel preoccupied with the Internet when offline or fantasize about being online?	○	○	○	○	○
16. How often do you find yourself saying "Just a few more minutes" when online?	○	○	○	○	○
17. How often do you try to cut back on your online time but fail?	○	○	○	○	○
18. How often do you try to hide how long you've been online?	○	○	○	○	○
19. How often do you choose to spend more time online over socializing?	○	○	○	○	○
20. How often do you feel depressed, moody or nervous when you're offline, a feeling that goes away once you are back online?	○	○	○	○	○

A total score of 49 or less suggests typical Internet use by non-addicts; 50 to 79 points correlates with possible Internet-related problems; an 80 or above is consistent with Internet addiction.

Resources for information on gambling addiction and sexual addiction

Gambling addiction resources

- American Psychological Association. *apa@psych.org*.
- Gamble Anonymous. *isomain@gamblersananymous.org*.
- Compulsive Gambling Center. *www.lostbet.com*.
- Game-Anon International. *www.gam-anon.org*.
- United States Gambling Hotline. 1-800-522-4700.
- UCLA Gambling Studies Program. *www.uclagamblingprogram.org*.
- Massachusetts Council on Compulsive Gambling. *www.masscompulsivegambling.org*.
- National Council on Problem Gambling. *www.ncpgambling.org*.
- Debtors Anonymous. *www.debtorsanonymous.org*.
- Ernie and Sheila Wexler Associates. *www.aswexler.com*.

Sexual addiction resources

- American Psychological Association. *www.apa.org*.
- Co-Dependents of Sex Addicts.
- Emotions Anonymous. *www.mtn.org/EA*.
- National Council for Couple and Family Recovery.
- National Council on Sexual Addiction and Compulsivity. *www.ncsac.org*.
- Recovering Couples Anonymous. *www.recovering-couples.org*.
- Recovery Online. *www.onlinerecovery.org*.
- The National Center For Prosecution of Child Abuse. *www.ndaa.org*.
- S-Anon. *www.sanon.org*.
- Sex Addicts Anonymous. *www.sexaa.org*.
- Sex and Love Addicts Anonymous. *www.slaafws.org*.
- Sexual Addiction Resources/Dr. Patrick Carnes. *www.sexhelp.com*.
- Sexual Compulsive Anonymous. *www.sca.recovery.org*.
- Survivors of Incest Anonymous.

References

- Aboujaoude, E. (2011) Virtually You: The Dangerous Powers of the E-Personality. New York, New York: W.W. Norton & Company
- Ahn, D.H. (2007). Korean Policy on Treatment and Rehabilitation for Adolescents' Internet Addiction. International Symposium on the Counseling and Treatment of Youth Internet Addiction. Seoul, Korea, National Youth Commission, p49.
- Aire, L. (2003). Festering Beneath the Surface: Gambling Addiction and College Students. Illinois Higher Education Center. Retrieved June 2, 2012 from http://problemgambling.org/Userfiles/Docs/IL
- American Gaming Association Ten-Year Trends Fact Sheet, Retrieved June 8, 2012 from http://www.americangaming.org/Industry/factsheets/statistics_detail.cfv?id=8
- American Psychological Association. Proposed revisions, APA DSM-IV. Retrieved on May 14, 2012. http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision
- American Psychological Association (2013). Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.). Arlington, VA: American Psychiatric Publishing. pp. 797–798. ISBN 978-0-89042-555-8.
- Anderson, C.A. (2008). Longitudinal Effects of Violent Video Games on Aggression in Japan and the United States. Pediatrics 122 no.5: 1067-72.
- Annual Internet Survey by the Center For the Digital Future Finds Shifting Trends Among Adults About the Benefits and Consequences of Children Going Online (2008). Retrieved on May 25, 2012 from http://www.digitalcenter.org/pdf/2008-Digital-Future-Report.
- Bernal, L. (2010). A Predatory Business. New York Times. Retrieved June 10, 2012 from http://www.nytimes.com/roomfordebate/2010/7/2010/should-internet-gambling-be-legalized/internet-gambling-is-one-of-the-most-predatory-businesse.
- Berlin, F.S. (2000) Treatments to Change Sexual Orientation. American Journal of Psychiatry 157, No.5: 838-839.
- Blow, C.M. (2008) The Demise of Dating. New York Times, December13, 2008. Retrieved on May 25, 2012 from http://www.nytimes.com/2008/12/13.
- Brockenbrough, M. (2008) Regrettable Trends in Pop Culture: 2008 Edition. Retrieved on June 6,2012 from http://entertainmantmsn.com/beacon
- Buffardi, L.E, & Campbell, W.K. (2008). Narcissism and Social Networking Websites. Personality and Social Psychology Bulletin 34, No.10: 1301-14.
- Cambridge Health Alliance (2009) Division on Addictions. In Skolnik, S. (Author) High Stakes: The Rising Cost of America's Gambling Addiction. Boston, MA: Beacon Press
- Carnes.P, Delmonico, D.L., & Griffin, M.A. (2001). In the Shadows of the Net: Breaking free of Compulsive Online Sexual Behavior. Center City, MN: Hazelton Foundation
- Carr, N. (2008). Is Google Making Us Stupid? Atlantic.July/August .Retrieved on June 2, 2012 from http://www.theatlantic.com/doc/200807/google
- Chamberlain, S.R., Sahakian, B.J. (2007). The Neuropsychiatry of Impulsivity. Current Opinion in Psychiatry 20, No. 3:255-261.
- Choi, Y.H. (2007). Advancement of IT and Seriousness of Youth Internet Addiction. International Symposium on the Counseling and Treatment of Youth Internet Addiction. Seoul, Korea, National Youth Commission, p20.
- Cooper, A., Delmonico, D.L., & Berg, R. (2000) Cybersex Users, Abusers, and Compulsives: New Findings and Implications. Sexual Addiction and Compulsivity I, No.1-2.
- Custer, R.L., & Rosenthal, R. (2008) A Chart of Compulsive Gambling and Recovery. In Problem Gambling and the Law. Nevada Council on Problem Gambling. Retrieved on January, 3, 2012 from htpp://www.nevadacouncil.org
- Department of Mental Health & Addiction Services. (2011). Gambling Addiction and Problem Gambling. Retrieved on January, 23, 2012 from http://helpguide.org/mental/gambling_addiction.htm
- Dodd, M.L., Klos, K.J., Bower, Y.E., & Geda, Y.E. (2005) Pathological Gambling Caused by Drugs Used to Treat Parkinson Disease. Archives of Neurology 62
- Edwards, R.D. & Shiel, W.C. (2011). Compulsive or Pathological Gambling. Retrieved on December 14, 2011 from http://www.medicinenet.com/script/main/art.asp?articlekey=115135
- Engwall, D., Hunter, R., & Steinberg. (2003) Gambling and Other risk Behaviors on University Campuses. Journal Of American College Health, 52(6), 245-255.
- Family Safe Media (2009). Pornography Statistics. Retrieved on June 1, 2012 from http://www.familysafemedia.com/pornography_statistics.html.
- Ferrell, D. & Gold, M. (1998). Casino Industry Fights an Emerging Backlash: Gambling: Leaders Mount Sophisticated Effort to Protect Interest, as Critics Say Growth is Creating More Addicts. Los Angeles Times, December 4, 1998. Retrieved on January 12, 2012 from http:/articles.latimes.com/1998/dec/14/news/mn-54012.
- Fleming, L. (2007). Mental Disorders: Pedophilia.Retrieved May 12, 2012 from htpp://www.minddisorders.comOb-P
- Fong, T.W. (2010). Pathological Gambling: Update on Assessment and Treatment. UCLA Gambling Studies Program: Semel Institute for Neurosciences and Human Behavior. Retrieved on May14, 2012, http://www.medicinnet.com/script/main/art.asp?
- Gallup Poll. (2004). Gambling a Common Activity for Americans. Retrieved December 29, 2011. http://www.gallup.com/poll/11098/Gambling-Common-Activity-Americans.aspx.
- Gold, M.S.&Edwards, D.W. (2010) What Causes Sexual Addiction? Addictive Behaviors, 2:24-27.
- Goudriaan, A.E., Oostrelaan, J., De Beurs, E., Van Der Brink. (2006). Neurocognitive Functions in Pathological Gambling. Addiction. April 2006,101(4): 534-547 PubMed PMID: 16548922.
- Grohol, J. (2008) Four Phases and Steps of Gambling Addiction. Psychology Central. Retrieved January 4, 2012, from http://psychcentral.com.com/lib/2008/four-phases-and-steps-of-gambling-addiction/
- Harris Interactive Survey (2008). Many Would Take Internet Over Sex. CNN. Retrieved on June 9, 2012 from http://www.cnn.com/2008/TECH/12/15/internet.sex.survey
- Henry, M. (2003) Athletes, Teens are Prime Candidates for Gambling Addiction. Bradenton Herald, Retrieved on January 5, 2012 from http://www.bradenton.com.
- H2 Gambling Capitol(2010).H2 Assesses the Economic Impact of Internet Gaming Regulations in the United States. Retrieved on June 8, 2012 from http://www.h2gc.com/news
- Janis, I.L. (1972). Victims of Groupthink. Boston, MA: Houghton Mifflin.
- Jordan, L.T. (2009). I Never Thought Addiction Could Happen To Me. Campbell, CA: Madison Publishing.
- Kihlstrom, J.F. (2005) Dissociative Disorders. Annual Review of Clinical Psychology I: 227-253.
- Klausner, J. (1998). Tracing a Syphilis Outbreak through Cyberspace. Journal of American Medical Association, 284, No. 4, 447-449.
- Kowolski, R.M., (2008). Cyber bullying: Recognizing and Treating Victim and Aggressor. Psychiatric Times 25, No. 11: 43-47
- Kupfer, D. (2010) American Psychological Association, DSM-5 Revisions. Retrieved December 27, 2011. http://www.dsm5.org/ProposedRevisions/Pages/proprosedrevisions
- Leary, M. (2006). The Curse of Self: Self-Awareness, Egotism, and the Quality of Life. NY: Oxford Press
- Lesieur, H. (1984). Pathological Gambling: Roots, Phases, and Treatment. In I Never Thought Gambling Addiction Could Happen to Me. Loree Taylor Jordan. Campbell, CA: Madison Publishing.
- Lewis, B.D. (2006) An Anti-Addiction Pill? New York Times, June 25, 2006. Retrieved on December 30, 2011 from http://www.nytimes.com/2006/06/25/magazine/25addiction.html
- Marlett, A.G.& Gordon, J.R. (1985). Relapse Prevention, New York: Guilford Press.
- Mayo Clinic (2011). Compulsive Gambling. Retrieved on January 15, 2012 from http://www.mayoclinic.com.
- Mental Health Addiction Services (2011) Gambling Addiction and Problem Addiction. Retrieved on January 10, 2012 from http://helpguide.org/mental/gambling_addiction.htm.
- Miller, M.C. (2007) Is the Internet Addiction a Distinct Mental Disorder? Harvard Mental Health Letter 24, No. 4: 8
- Ministry of Health. (2008). Problem gambling research program: Preventing and minimizing gambling harm. Wellington: New Zealand Ministry of Health. Retrieved on December15, 2011from http://www.moh.govt.nz./moh.nsf/238fd5fb4fd051844c256669006aed57/88cfc3ce7567.

- Money, J. (1989). Love Maps: Clinical Concepts of Sexual and Erotic Health and Pathology, Paraphilia, and Gender Transposition in Children, Adolescence and Maturity. Amherst, New York: Prometheus Books
- National Institute on Media and Family (2007). 12th Annual Media Wise Video Game Report Card.
- National Campaign to Prevent Teen and Unplanned Pregnancy (2008) The 2008 Survey. Sex and Tech. Retrieved on June 10, 2012 from http://www.thenationalcampaign.org/sextech/PDF/SexTech_Summary.pdf
- National Research Council. Pathological Gambling: A Critical Review. Washington, D.C: National Academy Press.
- O'Donahue, W., Regev, L.G., & Hagstrom, A. (2000). Problems with DSM-IV Diagnosis of Pedophilia. Sexual Abuse 12, No. 2: 95-105.
- Padget, P.M. (2007). Personal Safety and Sexual Safety for Women Using Online Personal Ads, Sexuality Research and Social Policy, 4. No. 2, 27-37.
- Parhami, I. (2010) Severity, Gambling, and the DSM-5.A summary of an article submitted by Richard Rosenthal et al, to the Journal of Addiction, March 2010. In the UCLA Gambling Studies Program Newsletter, Volume 1, March, 2010.
- People's Daily Online (2007) The More They Play, the More They Lose
- Petry, N.M. (2007). Internet gambling Is Common in College Students and Associated with Poor Mental Health, American Journal on Addictions 16,5. Retrieved December 30, 2011 from http://onlinelibrary.wiley.com/articles/october2007/swedenresults.htm.
- Popkin, H.A.S. (2009). The Internet Makes Me Feel Fat. Newsweek, September 2, 2008. Retrieved May 25, 2012 from http://www.newsweek.com.
- Prochaska, J.O., Norcross, J.C., & DiClemente, C.C. (1995) Changing for Good. New York: Avon Books.
- Renshaw, P. (2007) Dopamine Genes and Reward Dependence in Adolescents with Excessive Video Game Play. Journal of Addiction Medicine I, No. 3, 133-138.
- Recupero, P.R., Harms, E.S., & Noble J.M. (2008). Googling Suicide: Surfing for Suicide Information on the Internet. Journal of Clinical Psychiatry 68. No. 6: 878-88.
- Robert, L. (2004) Excerpt from a Listserv of Cyber psychology. Retrieved on May 25, 2012 from http://www.roberts@psychology.curtin.edu.au.
- Rosenthal, R. (2010) Severity, Gambling, and DSM-5. Journal of Medicine, March, 2010. Retrieved on January 10, 2012 from http://www.uclagamblingprogram.org
- Schneider, J.P. (2001) A Qualitative Study of Cybersex Participants. Sexual Addiction and Impulsivity 7, No. 4, 12-15.
- Schwartz, J.M. & Beyette, B. (1996). Brain Lock: Free Yourself from Obsessive Compulsive Behavioral Four-Step Treatment Method to Change Your Brain Chemistry. Harper Collins.
- Shaffer, HJ, Hall, MN, &Vanderbilt, J.1999. Estimating the prevalence of disordered gambling behavior in the United States and Canada: A research synthesis. American Public Health. 89: 1369-1376.
- Skolnik,S. (2011). High Stakes: The Rising Cost of America's Gambling Addiction. Boston, MA: Beacon Press.
- Southern Poverty Law Center ((2004). Hate Groups, Militias On the Rise as Extremists Stage a Comeback. Retrieved on June 8, 2012 from splcenter.org/center/splcreport/article
- Starcevic, V. & Porter, G. (2010). Effects of Violent Video Games. The Controversy Revisited. Impulse Control Disorders, ed. Elias Aboujaoude and Lorrin M.Koran. New York: Cambridge University Press.
- Suler, J. (2004) The Online Disinhibition Effect. Cyber psychology Behavior, 7, No.3: 321-326.
- University of Southern California (2013). The 2013 digital future report surveying the digital future year eleven. http://www.digitalcenter.org/wp-content/uploads/2013/06/2013-Report.pdf
- Wallech, D. (2011). Co-addicts, Psycho-education and Support, The Center for Recovery. Retrieved on January, 4, 2012 from http://therapists.psychologytoday.com/rms. /prof.detail.
- Walters, J. (2005). Computer Friendly Gambling Has Found a Growing Fan Base Online. Sports Illustrated, Retrieved on June 10, 2012 from http://sportsillustrated.cnn.com/2005
- Watzlawick, P. Weakland, & J.H.,Fisch,R.(1998). Change: Principles of Problem Formation and Problem Resolution. New York: Norton.
- Weiss, R. (2000) When Sex Is Too Important. Retrived on June 1, 2012 from bpdfamily.com/bpdresources/nk.
- Wexler, A. & Wexler, S. (2002) Facts on Compulsive Gambling and Addiction. Council on Compulsive Gambling, New Jersey ERIC Document reproduction Service N.ED372337.
- Wexler, A. & Isenberg. (2002) Blowing the Whistle on Campus Gambling. Chronicle of Higher Education, p.b19
- Wilson, W.A. (2002) How Addiction Hijacks Our Reward System. Cerebrum 7:53-66.
- Young, K.S. (1996). Psychology of Computer Use: Addictive Use of the Internet. Psychological Reports 79: 899-902.
- Young, K.S. (1998). Caught in the Net: How to Recognize the Signs of Internet Addiction and a Winning Strategy for Recovery. New York: Wiley

INTERNET ADDICTION TO CYBERSEX AND GAMBLING: ETIOLOGY, PREVENTION AND TREATMENT

Final Examination Questions

Select the best answer for each question questions 21 through 40 and mark them on the answer sheet found on page 84 or complete your test online at **SocialWork.EliteCME.com.**.

21. Excessive use of the Internet can lead to addiction with characteristics similar to _____.
    a. Anxiety disorders.
    b. Obsessive-compulsive disorders.
    c. Graves disease.
    d. Bipolar disorder.

22. A study by Dr. John Suler (2004) identified dynamics of Internet use that enhance its appeal and may lead to addiction. These factors include disinhibition, _____, accessibility, the loss of balance or control, and the lack of any real hierarchy in cyberspace.
    a. Socialization.
    b. Compensation.
    c. Anonymity.
    d. Isolation.

23. DSM-5 diagnostic criteria for Internet Gaming Disorder includes "Repetitive use of Internet-based games, often with other players, that leads to significant issues with _____".
    a. Finances.
    b. Functioning.
    c. Behavior.
    d. Family dynamics.

24. According to Hertz, Donato and Wright there is a strong correlation between bullying and _____ related behaviors.
    a. Educational.
    b. Family.
    c. Suicide.
    d. Antisocial.

25. The Bureau of Justice School Bullying and Cyber Bullying (2014) reports that bullying often leads to violence. About ____ percent of students say school shootings are motivated by the desire to get back at those who have hurt them.
    a. 35.
    b. 48.
    c. 74.
    d. 87.

26. Researchers have found that the virtual world can _____users to violence and to what is immoral or indecent.
    a. Encourage.
    b. Desensitize.
    c. Entice.
    d. Discourage.

27. _____ refers to a condition of needing higher doses of the experience or substance, whether it's OxyContin, online pornography or gambling, to produce the same effects achieved during initial use, including the same level of euphoria.
    a. Withdrawal.
    b. Tolerance.
    c. Relapse.
    d. Dependency.

28. The average Internet user spends 15 minutes a day viewing _____ online.
    a. Pornography.
    b. Travel websites.
    c. Facebook.
    d. E-mail.

29. Dr. Robert Weiss of the Sexual Recovery Institute describes cybersex as the "_____" of sexual addiction and states that cybersex reinforces and normalizes all forms of sexual disorders.
    a. Crack cocaine.
    b. Technology.
    c. Evolution.
    d. Antithesis.

30. Carnes, Delmonico, and Griffin (2001) categorize individuals who have no previous problem with online sex or any history of problematic sexual behavior as the:
    a. Novice group.
    b. Discovery group.
    c. Predisposed group.
    d. Lifelong sexually compulsive group.

31. According to The National Center for Missing and Exploited Children (2005), of those arrested for child pornography possession, 40 percent had _____.
    a. Severe mental health diagnosis.
    b. Sexually victimized children as well.
    c. Lost employment as a result.
    d. Participated in on-line gambling as well.

32. _____ is a disorder that is characterized by recurrent intense sexual urges and sexually arousing fantasies generally involving nonhuman objects, the suffering or humiliation of one's self or one's partner, animals, children or other nonconsenting persons.
    a. Paraphilia.
    b. Pedophilia.
    c. Sexual addiction.
    d. Nymphomania.

33. _____ disorder identifies people who are sexually aroused by dressing as the opposite sex but who experience significant distress or impairment in their lives socially or occupationally because of their behavior.
    a. Sexual deviant.
    b. Paraphilia.
    c. Transvestic.
    d. Pedophilia.

34. The sexual behaviors in _____ cover a range of activities from online child pornography and solicitation to actual contact and may or may not involve the use of force.
    a. Sexual deviant.
    b. Paraphilia.
    c. Transvestic.
    d. Pedophilia.

35. _____ is often used to treat pedophilia as well as other addictions.
    a. Psychotherapy.
    b. Family counseling.
    c. Cognitive behavioral therapy.
    d. Group therapy.

36. Internet gambling addiction is commonly described as on-line gambling behavior that causes _____ in any major area of life, psychological, physical, social or vocational.
    a. Interest.
    b. Disruption.
    c. Need for therapy.
    d. Mental health diagnosis.

37. Under the DSM-5, the previously utilized diagnosis of Pathological Gambling was removed and its elements are included in the newly developed diagnosis category of _____.
    a. Gaming Disorder.
    b. Pathological Gaming Disorder.
    c. Gambling Disorder.
    d. Compulsive Gambling.

38. One major change in the DSM-5's clinical description of gambling disorders is the _____ of the criterion "has committed illegal acts such as forgery, fraud theft or embezzlement to finance gambling."
    a. Addition.
    b. Revision.
    c. Elimination.
    d. Expansion.

39. Risk factors for developing a gambling disorder include _____, mood problems, antisocial behavior, personality disorder, bipolar disorder, and alcohol or cocaine addiction.
    a. Schizophrenia.
    b. PTSD.
    c. Loss of employment.
    d. History of physical abuse as a child.

40. Medications for online gambling addiction treatment are often from the _____group.
    a. Stimulant.
    b. Hallucinogenic.
    c. Antidepressant.
    d. Placebo.

Chapter 4: Understanding Enabling Behavior and How to Address It

4 CE Hours

By Wade Lijewski, Ph.D.

Learning objectives

- Understand the elements of enabling behavior.
- Explore the definition and research on codependency.
- Review and understand the various family dynamics related to enabling behavior.
- Understand the different techniques to address and stop enabling behavior (from the perspective of a counselor dealing with addiction and enabling and the perspective of the person who is enabling a loved one).
- Consider the existing myths about enabling behavior and myths about therapy.
- Discover the various elements of confrontation and how to use them.

Overview

In the world of psychology, the term "enable" is used in both a positive and a negative sense. It is used by psychologists in a positive light to describe the empowerment of others as well as the implementation of positive resources to address a problem. However, enabling is also used as a term to describe approaches by individuals that are intended to help but in fact may perpetuate a problem.

A common theme of enabling in the latter sense is that third parties take responsibility, blame, or make accommodations for a person's harmful conduct. They often have the best of intentions, but become an element that needs to be addressed when counseling individuals and families on addiction.

Enabling is a term that is frequently used in 12-step recovery programs to describe the behavior of family members or other loved ones who rescue an alcoholic or drug addict from the consequences of his or her own self-destructive behavior. It also includes rescuing anyone who is caught up in any of the compulsive or addictive self-destructive behaviors that are symptoms of codependency, such as:

- Gambling.
- Spending.
- Eating disorders.
- Sexual or relationship addictions.
- Inability to hold a job.

Enabling comes in many forms, such as giving addicts whatever they want. This deprives them of learning how to build self-esteem, which you build by doing esteemable acts, such as going to work every day, going to school, being productive, and building a life and healthy relationships. Another example of enabling is setting boundaries but failing to uphold them when the time comes. An addict/alcoholic must understand the consequences of his or her actions or will most likely continue with the same behavior; this responsibility lies with the family.

Another common example of enabling can be seen in the relationship between alcoholics/addicts and their codependent spouses. The spouses often believe incorrectly that they are helping alcoholics by calling into work for them, making excuses that prevent others from holding them accountable, and generally cleaning up the mess that occurs in the wake of the alcoholic's impaired judgment. In reality, what those spouses are doing is hurting, not helping. Enabling prevents psychological growth in the person being enabled and can contribute to negative symptoms in the enabler.

Many people who are drug abusers and addicts recognize that they can't stop using on their own. Likewise, a large number of these same people literally wouldn't be able to continue to use on their own if they weren't being helped by an enabler. From covering up lies and criminal activity to making excuses to other family members, enablers often make a person's substance abuse and addiction possible. However, the reality of the matter is that enablers are doing the addict great harm, and in some ways are just as responsible for their behavior as the addicts themselves. Understanding the enabler's role and how it can be reversed is critical for anyone who wants to permanently break the cycle of drug abuse, alcoholism and addiction.

To enable the individual with the addiction, the mutually dependent person makes excuses and lies for the addict, which enables the addiction to continue. Codependency is reinforced by a person's need to be needed. The enabler thinks unreasonably by believing he can maintain healthy relationships through manipulation and control. He believes he can do this by avoiding conflict and nurturing dependency.

Is it normal for people to think that they can maintain a healthy relationship when they do not address problems and lie to protect others from their responsibilities? The way a codependent person can continue to foster this dependency from others is by controlling situations and the people around them. The ongoing manner of a codependent home is to avoid conflicts and problems and to make excuses for destructive or hurtful behavior. (Albury, 2011)

Why does enabling cause so much hurt in a relationship? The power afforded to the mutually dependent person in a relationship supports his need for control, even if he uses inappropriate means to fulfill that need. A second and overlooked reason, centers on the contradictory messages and unclear expectations presented by someone who is codependent. These characteristics lead to a relationship filled with irrational thoughts and behavior. This kind of relationship has no clear rules to right and wrong behavior. The unhealthy patterns a person enables may be one or more of these behaviors:

- Drinking too much.
- Spending too much.
- Overdrawing bank accounts and bouncing checks.
- Gambling too much.
- Getting into trouble with loan sharks and check cashing agencies.
- Working too much or not enough.
- Maxing out credit cards.
- Abusing drugs (prescription or street drugs).

- Getting arrested (the enabler must bail him or her out).
- Any of a number of other unhealthy behaviors and patterns of addiction.

Any time people help or allow another person to continue their unproductive, unhealthy, addictive behavior, whether actively or passively, they are enabling. Even when they say nothing, they are enabling the behavior to continue. Sometimes people say nothing out of fear – fear of reprisal; fear of the other person hurting, hating or not liking them; or fear of butting in where they don't think they belong. Perhaps they even fear being hit or worse.

Enablers often participate in such behavior because of their own low self-esteem. They haven't gained the ability to say no without fear of losing the love or caring of that other person. People who learn tough love have to learn that their former behaviors have been enabling and that to continue in them would represent allowing the other person's pattern of behavior to continue and to worsen.

Because enabling behavior is most often discussed in substance abuse issues, it is interesting to note the prevalence of this issue and its impact on society.

A major source of information on substance use, abuse, and dependence among Americans age 12 and older is the annual National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration. Following are facts and statistics on substance use in America from 2010, the most recent year for which NSDUH survey data have been analyzed.

- Illicit drug use in America has been increasing. In 2010, an estimated 22.6 million Americans age 12 or older – or 8.9 percent of the population – had used an illicit drug or abused a psychotherapeutic medication (such as a pain reliever, stimulant or tranquilizer) in the past month. This is up from 8.3 percent in 2002. The increase mostly reflects a recent rise in the use of marijuana, the most commonly used illicit drug.
- In 2010, 7.0 million Americans age 12 or older (or 2.7 percent) had used psychotherapeutic prescription drugs non-medically (without a prescription or in a manner or for a purpose not prescribed) in the past month – similar to previous years. And 1.2 million Americans (0.5 percent) had used hallucinogens (a category that includes ecstasy and LSD) in the past month – unchanged from previous years.
- Cocaine use has gone down in the last few years; from 2006 to 2010, the number of current users age 12 or older dropped from 2.4 million to 1.5 million. Methamphetamine use has also dropped, from 731,000 current users in 2006 to 353,000 in 2010.
- Most people use drugs for the first time when they are teenagers. There were 3.0 million new users (initiates) of illicit drugs in 2010, or about 8,100 new users per day. Over one-half (57 percent) were under 18.
- Binge and heavy drinking are more prevalent among men than among women. In 2010, 30.9 percent of men 12 and older and 15.7 percent of women reported binge drinking (five or more drinks on the same occasion) in the past month; and 10.1 percent of men and 3.4 percent of women reported heavy alcohol use (binge drinking on at least five separate days in the past month).
- In 2010, 17.9 million Americans (7.0 percent of the population) were dependent on alcohol or had problems related to their use of alcohol (abuse). This number is basically unchanged since 2002.
- There continues to be a large treatment gap in this country. In 2010, an estimated 23.1 million Americans (9.1 percent) needed treatment for a problem related to drugs or alcohol, but only about 2.6 million people (1 percent) received treatment.

UNDERSTANDING ENABLING BEHAVIOR

Many people think they are helping a loved one with an addiction, when in reality they are giving an addict permission to sink further into it. As the addiction has more room to grow, the addict gets sicker, and loved ones become more discouraged that the addict will ever recover.

In most cases, an addict needs to hit rock bottom to make a paradigm shift and get into recovery. Consistent rescuing of the addict will only extend the time it takes for someone to hit rock bottom.

What is the difference between helping and enabling?

- Helping includes doing things that will positively benefit another.
- Enabling allows the addict to continue destructive behavior, often by supplying money, shelter, legal, or any other form of help.
- Enabling is done with good intentions but is not truly healthy.
- Enabling prevents addicts from experiencing the consequences of their actions; it may keep them from seeing they have a problem.

Some common examples of enabling

- **Giving or lending money:** Giving addicts money might open more doors for addicts to invest in their addiction. Having easy access to money can keep them from realizing how much their addiction is actually costing because they don't experience the pain of struggling to get money.
- **Providing a place to live:** A roof over our heads is a necessity. If an addict has pushed the boundaries so far that keeping him or her in your home will feed the person's addiction more, then you might need to consider kicking the individual out. This can be a painful and scary situation for both individuals involved, but might be what creates a rock-bottom moment for the addict.
- **Cleaning up after messes:** When an addict doesn't have the chance to see what messes he or she has created, the person will not know how bad it has gotten. As hard as it might be, you need to let things sit until the person is able to clean things up on his or her own.
- **Supplying a car:** Having a car gives addicts an easier ability to participate in an addiction. The freedom a car provides can enable people to be blinded to their addiction. This could also be a safety issue in that they may use a car after engaging in an addiction and could hurt themselves and someone else. (Claassen, 2011)

Here are some additional examples of behavior that enable those struggling with addiction:

- Repeatedly bailing them out of jail, financial problems or other "tight spots" they get themselves into.
- Giving them "one more chance," ... then another ... and another.
- Ignoring the problem because they get defensive when you bring it up or because you hope that it will magically go away.
- Joining them in the behavior when you know they have a problem with it, such as drinking, gambling and so on.
- Joining them in blaming others for their own feelings, problems and misfortunes.
- Accepting their justifications, excuses and rationalizations, such as, "I'm destroying myself with alcohol because I'm depressed."
- Avoiding problems to keep the peace, or because of a belief that a lack of conflict will help.
- Doing for them what they should be able to do for themselves.
- Softening or removing the natural consequences of the problem behavior.
- Trying to "fix" them or their problems.
- Repeatedly coming to the rescue.
- Trying to control them or their problems.

Effects of enabling

Over time, enabling becomes routine, but the frustration grows in the enabler. The combination of continued drug use of the addict and the cycle of frustrated enabling affects the entire family. Mental health issues can develop in the enabler or other members of the family, such as:

- Depression.
- Bursts of verbal and physical anger.
- Anxiety.
- Uncontrollable emotions.

Stages of enabling

Much like addiction itself, it is believed that enablers actually experience their own stages in their behavior and see how it impacts them as a result.

Early stage

- Relief through enabling, such as eating for comfort, spending, working or helping someone with his or her problem to avoid an internal focus and experience the payoff.
- Increase in tolerance for the behaviors of the problem person.
- Preoccupation with the problem person or persons.
- Loss of control over emotions or behavior, such as excessive eating, yelling at the kids.
- Continued use of enabling behavior despite serious negative consequences to the enabler as well as the person with the problem.

Middle or "crucial" stage

- **Family problems** – The drama triangle or the variation below (punishment/forgiveness cycle).
- **Social problems** – Embarrassment, avoiding parties where there may be "too much temptation" for a partner.
- **Emotional problems** – Depression, anxiety, chronic stress.
- **Financial problems.**
- **Legal problems** – Domestic disturbances.
- **Occupational or academic problems** – Loss of concentration due to preoccupation with the problem person or persons.

Late or chronic stage

- **Physical deterioration** – Headaches, stomach problems, stress disorders and so forth.
- **Serious physical withdrawal syndrome** – Cannot stay away after a break-up or separation.
- **Obsession** – Preoccupation increases until it takes the majority of the person's thoughts.
- **Loss of social supports** – Stops seeing friends and begins to isolate; other people give up trying to get the person to see what he or she is doing.
- **Collapse of the alibi system** – Can no longer make excuses for themselves OR the problem person.
- **Drinking, using prescription meds, eating, working, etc. to keep functioning or "feel normal.**"
- **Hopelessness and despair.**
- **Untimely death** – Accident, suicide, illnesses secondary to the codependency.

Enabling and eating disorders

While the majority of research on enabling behavior focuses on addiction and substance abuse, the problem of enabling exists in another prevalent issue: eating disorders.

- It is estimated that 8 million Americans have an eating disorder – 7 million women and 1 million men.
- One in 200 American women suffers from anorexia.
- Two to three in 100 American women suffers from bulimia.
- Nearly half of all Americans personally know someone with an eating disorder. (Note: One in five Americans suffers from mental illnesses.)
- An estimated 10-15 percent of people with anorexia or bulimia are males.
- Mortality rates:
  - Eating disorders have the highest mortality rate of any mental illness.
  - A study by the National Association of Anorexia Nervosa and Associated Disorders reported that 5-10 percent of anorexics die within 10 years after contracting the disease; 18-20 percent of anorexics will be dead after 20 years; and only 30-40 percent ever fully recover.
  - The mortality rate associated with anorexia nervosa is 12 times higher than the death rate of ALL causes of death for females 15-24 years old.
  - 20 percent of people suffering from anorexia will prematurely die from complications related to their eating disorder, including suicide and heart problems.
- Access to treatment:
  - Only 1 in 10 people with eating disorders receives treatment.
  - About 80 percent of girls and women who have accessed care for their eating disorders do not get the intensity of treatment they need to stay in recovery; they are often sent home weeks earlier than the recommended stay.
  - Treatment of an eating disorder in the U.S. ranges from $500 per day to $2,000 per day. The average cost for a month of inpatient treatment is $30,000. It is estimated that individuals with eating disorders need anywhere from three to six months of inpatient care. Health insurance companies for several reasons do not typically cover the cost of treating eating disorders.
  - The cost of outpatient treatment, including therapy and medical monitoring, can extend to $100,000 or more.
- Adolescents:
  - Anorexia is the third most common chronic illness among adolescents.
  - 95 percent of those who have eating disorders are between the ages of 12 and 25.
  - 50 percent of girls between the ages of 11 and 13 see themselves as overweight.
  - 80 percent of 13-year-olds have attempted to lose weight.
- Racial and ethnic minorities:
  - Rates of minorities with eating disorders are similar to those of white women.
  - 74 percent of American Indian girls reported dieting and purging with diet pills.
  - Essence magazine in 1994 reported that 53.5 percent of their respondents, African-American females, were at risk of an eating disorder.
  - Eating disorders are one of the most common psychological problems facing young women in Japan.

The National Institute for Clinical Excellence (NICE) guidelines for eating disorders recommend that most people with anorexia nervosa (AN) and bulimia nervosa (BN) should be managed on an outpatient basis (NICE, 2004). This places family members in the forefront of care. Family members report that they have insufficient information and skills for this role, which involves managing very challenging behaviors.

Living with someone with an eating disorder is associated with mental and physical ill health and a poor quality of life (de la Rie, van Furth, De Koning, Noordenbos, & Donker, 2005; Santonastaso, Saccon,

and Favaro, 1997; Treasure, Murphy, Szmukler, Tood, Gavan, & Joyce, 2001). Emotional reactions to the symptoms may inadvertently play a role in maintaining the problem. Families then become stuck in unhelpful interactions and lose sight of their own strengths and resources. The resulting transformation of family life can be perceived as a direct demonstration of dysfunctional relationships within the family, and one that is considered to be a causal factor rather than a consequence of the illness.

The purpose of an assessment of family function is to allow family members to stand back and reflect on whether and in what way the eating disorder has become the central organizing principle of home life.

The organization of the family around the eating disorder can be conceptualized using an AMC framework.

- "A" represents the antecedents, which include the shared vulnerabilities of anxiety and compulsivity. The three types of traits that run within families of people with eating disorders include anxiety, compulsivity and eating disorders.
- "M" is for the meaning that is made of the symptoms and the repercussions that this has on the role of other family members. The lack of a clear, coherent, conceptualization of eating disorders produces a lack of understanding with idiosyncratic meanings ascribed to the illness.
- The response to the illness behavior varies according to the meaning constructed by individual family members. For example, the belief that an eating disorder is attributable to the sufferers' personality is associated with less warmth (Whitney et al., 2007; Whitney, Murray, Gavan, Todd, Whitaker, & Treasure, 2005).
- If the illness is seen as life-threatening, a form of self-destruction or suicide, parents become anxious, and then an overprotective parenting style that accommodates and even accepts some of the behaviors develops (Kyriacou et al., 2008). If the illness is thought to be a "hunger strike," families may feel guilt and bend over backwards to make reparation. Others may see it as a form of revenge that results in criticism and hostility in retaliation.
- The shame of having a family member with an overt form of mental illness leads to family isolation, and so family reactions to the illness are not buffered by normative forces.
- "C" is for the consequences, which include the emotional reaction to the illness and how families accommodate and allow eating symptoms to dominate their lives that may, in turn, enable some of the behaviors to continue. The reactions and behaviors of family members can inadvertently reinforce eating disorder symptoms.
- Family members may give attention or acceptance to the eating disorder "voice," or they may remove negative consequences that arise from the eating disorder behavior. They may accept that eating disorders symptoms dominate the household:
  a. By becoming subservient to eating disorder food rules (where, why, how, when and with whom, and so on).
  b. By accepting safety behaviors (exercise, vomiting, body checking, fasting or cutting back) and
  c. By adhering to obsessive-compulsive behaviors (reassurance seeking, counting, checking and control).
- Individuals with an eating disorder control those around them by explicit or implicit emotional blackmail and by the unbending rigidity and narrow focus of their opinions. For example, if eating disorder rules are disobeyed, then the person threatens to not eat at all or to harm her- or himself or act destructively in other ways. Those with eating disorders may control, compete, compare or calibrate themselves with other family members (often siblings) on what and how much to eat or exercise.
- This behavior is tolerated in an effort to keep the peace and because there is fear over the consequences of resistance. Family members may be drawn into removing negative consequences, covering up or removing or buffering the natural negative consequences that would accrue from the behavior, for example, replacing missing food, cleaning kitchens and bathrooms, making excuses to others and so on.

CODEPENDENCY

Codependency (or codependence, interdependency) is defined as a psychological condition or a relationship in which a person is controlled or manipulated by another who is affected with a pathological condition (as in an addiction to alcohol or heroin).

In broader terms, it refers to the dependence on the needs of or control of another. It also often involves placing a lower priority on one's own needs, while being excessively preoccupied with the needs of others.

Codependency can occur in any type of relationship, including family, work, friendship, and also romantic, peer or community relationships. Codependency may also be characterized by denial, low self-esteem, excessive compliance, or control patterns.

The benefits of enabling are two-fold. Let's look at substance abuse specifically:

- Individuals who use substances can continue the behavior they want, and enablers do not have to acknowledge that anything is wrong. This action, however, is a short-term solution to a long-term problem. Over the long term, enabling drug abuse behavior leads to unhappiness for the enabler and the further deterioration of the individual using drugs.
- Another reason enabling occurs is because of codependency, which occurs when people are overly involved in another person's life. Codependents have a constant preoccupation with another person's behavior and feel unnecessarily guilty when not taking care of that person's needs. This often stems from not having adequate self-esteem.

Some common themes in the codependency cycle for the dependent person are:

- My feelings are not important.
- I am not good enough.
- I am responsible for my friend or significant other's behavior.
- I am not lovable.
- Having my own problems is not acceptable.
- It's not OK for me to have fun.
- I don't deserve love.

Historically, the concept of codependence comes directly out of Alcoholics Anonymous as part of the realization that the problem was not solely the addict, but also the family and friends who constitute a network for the alcoholic. It was later broadened to cover the way that the codependent person is fixated on another person for approval, sustenance, and other things.

Codependency describes behaviors, thoughts and feelings that go beyond normal kinds of self-sacrifice or caretaking. For example, parenting is a role that requires a certain amount of self-sacrifice and giving a child's needs a high priority. However, parents can nevertheless still be codependent towards their own children if the caretaking or parental sacrifice reach unhealthy or destructive levels.

Typically, parent who take care of their own needs (emotional and physical) in a healthy way will be better caretakers, but codependent parents may be less effective or may even do harm to a child. Another way to look at it is that the needs of an infant are necessary but temporary, but the needs of the codependent are constant.

People who are codependent often take on the role as a martyr. They consistently put others' needs before their own, and in doing so, forget to take care of themselves. This creates a sense that they are needed. They simply cannot stand the thought of being alone and no

one needing them. Codependent people are constantly in search of acceptance. When it comes to arguments, codependent people also tend to set themselves up as the victim. Further, when they do stand up for themselves, they feel guilty.

In marriage, codependency occurs when one partner puts the needs of the addict spouse before his or her own. It fosters the tendency to behave in overly passive and caretaking ways that harm the relationship. When a codependent partner has had enough, it can nudge the addict toward change.

Codependency is a vicious cycle in which both the person being enabled and the enabler need to disentangle themselves. It is recommended by experts in the field that codependent family members or loved ones remind themselves on a regular basis that they did not cause the problem and cannot control or fix the problem. They need to understand that the only thing they can do is offer assistance, which may or may not be heeded. The codependent person needs to understand that the only person who can help a substance abuser is the substance abuser him- or herself, and that the person needs to obtain the help that is available.

In a codependent situation, both the abuser and dependent person need assistance. The substance abuser needs to fix both the chemical and psychological bonds he or she has to alcohol or substances, and the codependent individual has to understand why he or she feels the need for this dependency. Experts in the field recommend that help in the form of substance abuse counseling be obtained for the substance abuser as well as therapy for the dependent person.

ADDRESSING FAMILY AS PART OF TREATMENT

As a counselor or therapist, it is important to understand the elements of enabling behavior and how to address it with the client as well as those involved in the client's life.

The important thing is to educate the family about what is really going on. Their issues have never been looked at because everything was hiding behind the addiction. As a counselor, if you only provide services to an alcoholic/addict and send the person back to a dysfunctional family, he or she will relapse into the self-destructive behavior within months.

Families need education about drugs and alcohol and help with healthy parenting. Quite often, by the time an individual comes in for treatment, the whole family is dysfunctional. Some people don't even realize a loved one is on drugs. They don't keep the connection with those close to them on a daily basis, so they can't gauge what is right or what is wrong.

One of the roles of a counselor is to help families reevaluate what they're doing and to be humble enough to change. Drug addiction and alcoholism provide an opportunity to help families change for the better. Families get very frustrated, which is why they need as much help as the addict/alcoholic. The family also needs to change and learn not to enable or shame the person.

Addictions are a painful reality for all involved. Whether it is alcohol, drugs, food, sex, gambling or the list of many others, it is imperative for counselors and family members to not enable addicts to continue down their self-destructive path. (Jay & Jay, 2011)

Some things to consider

One is that family members may be so angry that they don't want to be a part of treatment. They simply avoid the situation, treating it as if it's not their problem. They may believe that it's the wife's problem or the child's problem or the husband's problem. The other is that the family is afraid of being blamed. In reality, they already have been blamed. Addicts and alcoholics are always pointing their finger at the people closest to them. In their minds, they are the victims; everyone else has caused their problems.

Enabling is linked to denial, which is when family and friends refuse to recognize or refuse to admit to a problem. This happens not only with substance abuse, but also is a defense mechanism that is used when people find the truth of a situation too difficult to deal with. In this case, denial of substance abuse behavior can mean that family and friends do not recognize how the behavior is affecting work, school, relationships, or causing financial problems.

Most striking in the denial phenomenon is the enabler's refusal to acknowledge the deterioration of the relationship he or she has with the substance abuser. In fact, quite often, the denial mechanism will continue until it no longer can – meaning, until something horrific occurs.

Helping others recognize early signs

There are times in relationships when we cross that sometimes invisible line between truly being helpful and supportive and acting as enablers, or becoming codependent with another person. Sharon Wegscheider-Cruse in her work with families suggests that 96 percent of the general population, and persons in helping professions especially, exhibit some forms of codependent behavior at one time or in fairly consistent patterns. (Burress, 2008)

Counselors should equip themselves with a list of relevant questions to engage family members in the issue at hand. Here are some examples of questions counselors may use to help family members identify what it is that they are dealing with and recognize their own responses to early warning signs of enabling:

- Do you find yourself worrying about a person in ways that consume your time, or do you find yourself trying to come up with solutions to his or her problems instead of letting that person do the solving?
- Do you find yourself afraid for this person, or convinced that he or she cannot handle a situation or relationship without falling apart?
- Do you ever do something for a person that he or she could and even should be doing for him- or herself?
- Do you ever excuse this person's behavior as being a result of stress, misunderstanding, or difficulty coping, even when the behavior hurts or inconveniences you?
- Have you ever considered giving or given this person money, your car, or talked to someone for this person as a way of reducing this person's pain?
- Do you feel angry if this person does not follow through with something you have suggested – or do you worry that you may not be doing enough for this person?
- Do you ever feel you have a unique and special relationship with this person, unlike anyone else they may know?
- Do you feel protective of this person – even though he or she is an adult and is capable of taking care of his or her life?
- Do you ever wish others in this person's life would change their behavior or attitudes to make things easier for this person?
- Do you feel responsible for getting this person help?
- Do you feel reluctant to refer an individual to a source of help or assistance, uncertain that another person can understand or appreciate this person's situation the way you do?
- Do you ever feel manipulated by this person but ignore your feelings?
- Do you ever feel that no one understands this person as you do?

- Do you ever feel that you know best what another person needs to do or that you recognize his or her needs better than he or she does?
- Do you sometimes feel alone in your attempts to help a person, or do you feel you may be the only person to help this individual?
- Do you ever want to make yourself more available to another person at the expense of your own energy, time or commitments?
- Do you find yourself realizing that an individual may have more problems than you initially sensed and that you will need to give him or her your support or help for a long time?
- Do you ever feel that as a result of getting to know this person, you feel energized and can see yourself helping people like him or her to solve their problems?
- Have you ever begun to see yourself in this person and his or her problems?
- Has anyone ever suggested to you that you are too close to this person or this situation?

If family members answer "yes" to two or more of these questions, it is likely that they have crossed the line from being supportive to being an enabler or codependent. Having heard themselves answer such questions often helps them understand how they may have contributed to the issue, and further discussion with that family member on changes they may need to make can ensue.

When working with families, you don't know what issues will crop up. Eventually, everyone falls back into the old pattern, which is why you can't just change the addict/alcoholic. You have to change the family system. It's about the family as a whole.

Each case is different, but it is often recommended that addicts/alcoholics distance themselves from the family unit for their own well-being. When working with young adults with addiction, it is suggested that they become more independent. They hate the dependency, but they're too scared of being on their own. Once sober, they can enter the homes of family members who live sober lives. Programs such as AA or NA help them to stand on their own two feet and build self-esteem.

With married couples, if there is a spouse who is highly dysfunctional or unwilling to give positive support, it may be suggested through therapeutic means that the spouse move out. Treatment is an attempt to get the family unit to be open to change, just as the addict/alcoholic must be.

What do families most misunderstand about the role of the family?

In many circumstances, family members are too controlling. However, there's no intimacy in control. Counselors must focus on helping family to let go a little and develop some trust. Family members have to allow addicts to grow and build self-esteem on their own or to fall on their face and hit rock bottom and learn from their mistakes.

Conversely, addicts often misunderstand their family members and their role within the family. Addicts can be very self-centered; most mistakenly think that everything is all about them. They feel like victims to the world and take no responsibility for how their behavior has hurt so many people.

How do counselors begin to change such ways of thinking?

Case study on family dynamics (as presented by Burress, 2008)

"A mother of a 16-year-old teenage boy wrote to me saying that her son has become increasingly disrespectful towards her over the last couple of years, going so far as to cuss and swear at his parents over what she refers to as 'trivial matters.' This mother, I'll call her 'Jane,' says that she has always prided herself on doing everything she possibly could to make things as easy on her son as possible, including preparing her son's school lunches, doing his laundry, cleaning his room, making his bed, giving him spending money, etc., but says, 'Nothing I do for my son is appreciated, and he's always asking for more money and telling his father and I to leave him alone,' followed by the slamming of his bedroom door. (Burress, 2008)

"Jane has discussed the problems with other family members and close friends, and they have all told her that she needs to 'learn to let go' of her son and stop controlling his life. Her husband also told her that she's enabling their son, and that she needs to allow their son to deal with the responsibilities that go with growing up and becoming a responsible adult. Those responses, along with being told that she is too close to her son, caused her to begin looking for information about what it means to be an enabler, in order to improve her relationship with her son.

"I was very surprised that Jane continues to do these various chores for her teenage son, including making his lunches, cleaning his room and doing his laundry, even though her son is fully capable of doing these things for himself. Jane was shocked to learn that my now-grown children were taught from a young age how to do their own laundry, and that they began doing it themselves since they were about 10 years old, because I taught them how. I also allowed them the freedom to do these things on their own, so they could feel proud of themselves and their own accomplishments. (Burress, 2008)

"I explained to Jane that from the time my children learned how to walk, I began teaching my children everything they needed to know in order to become responsible, independent adults. Each of my children learned how to prepare basic meals, including cooking on the stove, from a very young age. I still remember the excitement in their young voices when they each learned how to make macaroni and cheese, or grilled cheese sandwiches, and the sheer glee of knowing they did it all by themselves (while I carefully observed, of course). My sons were not going to grow up with the idea that cooking and cleaning was 'women's work,' and my daughters were not going to grow up thinking they 'need a man to take care of them.' (Burress, 2008)

"I am a firm believer in the old saying, 'Give a man a fish and you'll feed him for a day. Teach a man to fish, and you've fed him for a lifetime.' Does that put me in line for the next 'mother of the year award'? No. It only means I take parenting very seriously. It is the responsibility of each and every parent, mothers and fathers alike, to teach and train their children how to become responsible, independent, self-sufficient adults." (Burress, 2008)

"Very young children can and need to be taught how to pick up after themselves and put their clothes and toys in their proper place; how to make their bed; how to wash dishes; how to dust and vacuum; how to properly clean a bathroom; how to cook or prepare basic meals, and so on. But most important, parents must allow their children the needed age-appropriate independence, to have pride in their own achievements. When children have learned how to do these basics of living, parents must learn to let go of any controlling tendencies, such as not criticizing their children when chores aren't completed perfectly.

"Final advice: The advice given to Jane was that she immediately stop the enabling behaviors and allow her teenage son to do for himself what he is capable of doing, as well as lovingly teach her son the life-skills that he may be lacking. Looking at the situation from a teenager's point of view, one can see how Jane's son might feel oppressed and angry by his mother's efforts to make things as easy on him as possible, and I believe his angry outbursts and door slamming is his way of acting out his frustrations of being controlled. He's growing up to become a man, and he needs to know that his mother and father have faith and trust in his ability to handle the many responsibilities of being an adult."

HOW TO STOP ENABLING

The following information can be useful in your approach as a counselor or provided to family members to address enabling behaviors by using rational emotive behavioral therapy (REBT):

Building high frustration tolerance

In the world of addictions, the path of least resistance is often the path to inevitable defeat. Let's look at how to get on the path of high frustration tolerance. When you feel blocked from reaching an important goal, your perception activates brain centers that are associated with pain. When you feel frustrated and uncomfortable, those feelings can stimulate you to solve a problem and get past the barrier. It can also signal taking the easier, more comfortable path. (Knaus, 2012).

Some individuals tend to tolerate frustration well. They work through it and continue to press on to achieve their shorter or longer-term goals. However, let's consider the idea of what if you don't tolerate frustration well, and you have an addicted friend or relative who takes advantage of your tendency to take the easy way out?

To practice high frustration tolerance, you put reason between an impulse to escape discomfort and discomfort-dodging actions. (Knaus, 2012) That step can make a big difference. Once you delay reacting, you are in a position to start choosing. Part of this imposing reasoning process involves accepting that it is important to live through the discomfort if you expect to overcome barriers. This acceptance is like building emotional muscle. The more you work at it, the stronger you get.

By working at building high frustration tolerance, you are likely to solve more of your immediate problems and reach more of your longer-term goals.

Seven steps to end enabling using rational emotive behavioral therapy (REBT)

Family members and friends of those who abuse substances can often benefit from building their frustration tolerance. Rational emotive behavior therapy (REBT), previously called rational therapy and rational emotive therapy, is a comprehensive, active-directive, philosophically and empirically based psychotherapy that focuses on resolving emotional and behavioral problems and disturbances and enabling people to lead happier and more fulfilling lives (Ellis, 1994).

For example, your family member, Bob, tells you that he needs to get past a tense time and then he will quit using. Could you spare some money for these tough times? If you cave in, you are enabling him by rewarding his dependency on you. You are probably rewarding yourself by caving in to avoid a conflict. Whatever the dynamic may be, by giving Bob money to fund his substance abuse habit, you are signaling that you may also have low frustration tolerance in this situation.

You can use REBT principles and practices to boost your tolerance for frustration. By modeling high frustration tolerance for conflict and for resisting Bob's demands, you avoid procrastinating on building high frustration tolerance. You help him see that you are no longer a pushover. Bob may still have an addictive problem, but you are no longer helping him sustain it. You may also be in a stronger position to influence a change. (Knaus, 2012).

This is obviously easy to say and harder to do. However, if you see the merit in building high frustration tolerance, here are seven steps to help yourself build high frustration tolerance by combating low frustration tolerance:

1. Remind yourself that frustration tolerance is like a muscle. The more you build it, the stronger you get. Recognize that you won't build it overnight. Then remind yourself that in the process of learning to avoid knee-jerk, low frustration tolerance reactions, you are building high frustration tolerance. So, seriously consider frequently practicing high frustration tolerance.
2. Focus on the longer-term goal that you want to achieve. Consider whether you would like to see your family member get healthier. Would you prefer a relationship based upon a healthy bond (rather than one of dependency)? If so, then make decisions that will support your family member's independence and health. Remind yourself that the real rewards normally come from high frustration tolerance actions. Low frustration tolerance gives you a specious reward of quick relief from enabling.
3. Make two lists: (1) the short- and long-term advantages and disadvantages of you engaging in enabling behavior and (2) the short- and long-term advantages and disadvantages of enabling your loved one. The enabling trap is a joint venture. Your loved one also has responsibility to think and do better. That includes stopping baiting this trap.
4. Reward yourself when you practice high frustration tolerance. Allow yourself to do something you enjoy, such as watching a movie, taking a bubble bath, listening to favorite music, calling a friend, or reading a favorite book.
5. When you practice low frustration tolerance, enabling behavior with your loved one, give yourself a response-cost. For example, force yourself to do something you dislike, like cleaning for an extra hour. Deny yourself the reward you identified in No. 4.
6. Accept yourself regardless of whether you practice low or high frustration tolerance, but know that it is to the advantage of all concerned if you practice high frustration tolerance.
7. Get help and support when you find it necessary to strengthen your resolve. Connect with resources that could support you in your journey.

What if I'm the enabler?

- Do you sometimes feel as if you were put on earth to serve others?
- Are you overly accommodating and find it difficult to say no?
- Are you drained from overdoing for others?
- When you complain, are you told that you sound like a martyr?

If your answers are yes, you might wish to consider the possibly that you are an enabler.

Enablers are motivated by love and the need to be valued, qualities especially encouraged in females. An enabler is a person who through his or her action allows someone else to attain something. Most often, the term enabling has been associated with alcoholism, but it is not always the case. Enabling can have broader implications and include other forms of codependent behavior. Enabling is considered codependent because the act will often satisfy the need to help someone, but simultaneously foster dependency. Are you an enabler? Are you in any codependent relationships? Have you ever wondered why? (Ceccarelli-Egan, 2009)

If you are like most enablers, you were born with a generous heart and enjoy helping others. You might have been an older sibling or had non-available parents. It was necessary for you to step into the void

and help out in your family. Your behavior became identified, and you received positive reinforcement for your actions. The recognition helped you feel good about yourself and internalize the belief that your role in life was to help others. Eventually, your role became cemented into the system, and people stopped appreciating your kind acts and came to expect them.

This response would have caused you to develop a low self-esteem because you experienced love as conditional, and feel selfish when you were not doing enough for others. I once had a client who was such an enabler that when someone bought her a thank-you gift for helping them out, she actually bought them a "small thank-you gift" to thank them for their thank-you gift!

Enablers unconsciously believe that relationships can only be maintained by doing nice deeds and placating others. If you are an enabler, as a child you probably became motivated by a desire to be loved, learned to avoid conflict and give in to unrealistic demands. You learned that to challenge a loved one might result in anger and possible rejection. To survive in this type of system, you began to ignore and overlook problems, because to address them or your feelings would be too risky. (Ceccarelli-Egan, 2009)

Unfortunately, this behavior exacerbates the loss of self because with each capitulation, you further disconnect from your true feelings and minimize your sense of entitlement. Your behavior not only makes you appear more accommodating, it also allows you to become prey to more selfish people. Suddenly you find your life filled with takers, and there is no reciprocity in your relationships. You become increasingly upset because others do not tune into your needs, but then criticize yourself for being selfish or not acting in a loving manner.

If this sounds familiar, what can you do about it?
The first step is to recognize that you are an enabler or have tendencies toward enabling. If so, admit it and make the decision to practice some new ways of relating to people. Begin to engage in solitary activities that bring you pleasure and satisfaction. This will help you keep the focus on your needs and get in touch with exactly how, when and where you want to do something. Give yourself some of the pampering that you usually give to others; spend time and money on yourself instead of a loved one or friend. State the affirmation that "I am as important as everyone else" and "I do not have to give in order to be loved." (Ceccarelli-Egan, 2009)

Commit to looking for new, healthier relationships as you pledge to change your old relationship patterns. Decide to become your own person, not the person others want you to be. Begin associating with people who have the ability to have a mutual relationship and are responsible for their own behavior. Go slowly in a new relationship, and practice new behavior: abstain from rescuing people, stop overfunctioning and graciously accept assistance when offered to you.

Are you tired of being the person who seems to have been put on Earth to help others? Do you sometimes feel unappreciated, exploited and used? If so, I invite you to explore the following dynamics and solutions:

Ask yourself if the person is asking for your support and if your help is appropriate. Sometimes an individual is merely looking for a listening ear. If you are an enabler, when a problem is presented, you tend to feel duty-bound to fix the situation. When someone comes to you with a problem, take a deep breath, listen, then ask, "What do you need?" and "How would you like me to help you?" For years, I jumped in and offered my daughter lots of solutions when she came to me with a problem. This resulted in both of us feeling frustrated! I thought that she was not listening to my sage advice. It turns out, she just wanted to vent, knew she could solve her own problem and took my advice as a vote of no confidence.

Sometimes a person does approach you with a specific request for assistance. In this case, you want to ask yourself whether this is a reasonable request and consider whether you have the time, energy or desire to assist them. While helping others can be seductive and feed your enabler's "need to be needed," you do not want to prevent another from learning life's lessons. An example would be the parent who always brings her forgetful children's homework to school or drives them to school when they miss the bus.

- Does this merely perpetuate irresponsibility?
- Would it better for the child to have the consequences in school rather than as an adult?
- Is this well-meaning parent preventing the child from learning to take responsibility?

It might be more helpful for the parent to support the child by compassionately asking, "What do you need to do about it?" or "What can you do to avoid it happening next time?" This offers support and compassion, but puts the onus on the person and encourages personal responsibility.

Do you feel good about your participation? Enablers tend to feel used because they go too far with their help. While it stems from a generous heart, they will often overfunction and end up feeling exhausted, unappreciated and resentful. This is a case where you want to measure the "return on your investment" and estimate what benefit the person might receive from your assistance versus what it is costing you. If you are unsure about whether you want to be of assistance, tell the supplicant that you will need to get back to them, then step away and get some distance.

You will also want to consider your current level of emotional energy. When your energy is low and you assist another, you may end up giving out of your reserve and become further depleted. In this case, everyone would be better served if it is possible for you to postpone your assistance until a time when your energy is higher and the service does not drain you. When you give from a place of greater emotional energy, you are able to be more attentive and generous with your assistance and feel good about the service.

- Is the individual doing 50 percent or more of the work?
- Do you feel as if you are dragging the person up the hill?
- Are you doing the majority of the person's work?

If you are working harder than the person that you are trying to help, you are overfunctioning.

If you have a "need to be needed," allow yourself to recognize this fact and explore the reasons that motivate you as well as the price that you pay. Is it habit? Is it the way you define yourself? Do you wish to continue overfunctioning? As you begin to look at the benefit you get out of helping another, notice your reaction, the cost to you and whether you feel used and resentful.

The next time you are tempted to help another, examine your intentions for doing so as you refrain from automatically offering help and giving advice. When you feel you are being treated unfairly or being taken advantage, speak up right away. Set limits, and say, "No, this is not a good time to talk," or "No, I will not be able to help you at this time," when you feel that another's request or appeal would be too demanding for you. Trust yourself to know what you want and need and make your feelings known because they are important. If someone has to be unhappy or do all the giving, it doesn't always have to be you!

What if it's my child? – How to stop being an enabler to your adult child

Once you become a parent, your life changes forever. You always will be concerned with your children's well-being, no matter their age. When your concern become enabling, you need to take control back. No one ever said being a parent was without conflict.

When your children were just toddlers and learning how to walk, you held their hand to keep them safe. As they became steadier on their feet, you didn't need to hold their hand as much. As they grew and entered school, you did your best to teach them values and help them

find their way in the world. As any parent knows, no parent is perfect and no child is perfect. No child is the same. Parents who have more than one child know this. You can raise two children the same way, and the effect might not always be the same. (Albury, 2011)

We have all heard the term "late bloomer." Some children grow up having a strong desire to "be" something when they grow up. Nothing keeps them from their goal. Then there are the kids who march to a beat of a different drummer – not that is a bad thing; it can be good. Then there is the child who, for whatever reason, seems to struggle. Sometimes, as a parent, we unwillingly find ourselves caught in an unhealthy pattern of enabling.

Here are a few tips on how to break the pattern:

Step one: **Resist the urge to fix your adult children's problems.** It is not up to you to fix everything. Sometimes you have to fall in order to learn how to get back up. If you keep fixing things, how are they ever going to make it on their own?

Step two: **Allow the situation to get worse.** As hard as it might seem to do, you must. You can push someone out of the way of a speeding train, but you can't stop the train.

Step three: **Your adult child might regress to acting like a spoiled 2-year-old.** Demanding and abusive behavior should not be tolerated. It is all right to hang the phone up if your child is being abusive. You gave her a time-out when she was 2 because she didn't obey the rules. You don't have to be subjected to her behavior now.

Step four: **Try not to feel guilty about being firm.** Whatever you do, don't apologize. Don't scream back, just calmly inform your child you deserve to be spoken to respectfully, and you will not accept any other kind of behavior. Fighting the guilt that you feel is why some people have a lot of trouble with tough love. It is called "tough" for a reason.

Step five: **Keep a journal.** Writing how you feel is so good to do. It helps get out some of the pain and frustration that you can be feeling. It is also a great way of tracking your progress with the situation.

Step six: **Call on your friends for support.** Once you get to talking about it, you might find they went through a similar situation. That's what friends are for!

Step seven: **Don't give up, and don't give in.** Your child might act angry at you, but trust me, they will get over it. Remember why you are doing this. It is to better them as a person, and in return, it will better your relationship with them.

This might take time. Remember to praise yourself for standing firm. Take it one day at a time, and try not to get overwhelmed by the situation. You love your child, remember that sometimes love is tough love.

MYTHS ABOUT THERAPY AND ENABLING BEHAVIOR

Because many family members of addicts have gone to clergy, counselors, and general mental-health practitioners, and have become even more confused and despairing after doing so, this is meant to clarify why the sessions may have been ineffective and why an individual's problems may have gotten worse instead of better during the course of the therapy. (Drews, 2011)

Myths can prevent the healing process for both clients and their families when counseling addiction. Understanding myths about therapy and enabling behavior can be very helpful to the ever-growing number of therapists who are recognizing how pervasive all forms of addiction are in their caseloads, and are looking for addiction education and understanding to add to their expertise and enhance their effectiveness.

Myth No. 1: Patients always tell therapists the truth about their drinking.
Many parents take their children to see a therapist in an effort to bring some sanity back into their households. After the therapist poses a question or two to the child about his or her drinking, the matter is often dropped. Why? Let's look at a typical encounter:

Therapist: Do you drink?

Child: Yeah, some.

Therapist: How much?

Child: A couple of beers at parties, with other kids. That's all. All the kids do it. My mother's paranoid.

Therapist: Why do you say that?

Child: I don't know. Ever since we moved, after my father got transferred on his job, my mom is really unhappy. She takes it out on all of us. My dad's always telling her she nags.

Therapist: Does she?

Child: Yeah! Ask my sister if you don't believe me. She's going to leave home as soon as she's 18 next year. She told me she can't stand it there anymore.

Therapist: Do you feel the same way?

Child: Yeah.

Therapist: Let's talk about that next session. Maybe we can find some ways for you to talk more directly to your mother about how you feel about the way she treats you.

This therapist has made her first mistake by believing the alcoholic's minimizing of the drinking problem. The child's disease helped him divert the issue completely.

Those struggling with addiction (even child alcoholics) will lie to protect their habit. In counseling, alcoholics are incapable of telling the truth because of a disease process that is extremely cunning in its efforts to protect its supply of alcohol. This is not a moral judgment. It is merely a fact of the disease.

Myth No. 2: These "underlying mental-health issues" can be resolved by teaching good communications skills to members of that alcoholic family.
This concept is impossible. Those dealing with addiction can be very sincere and really want to cooperate by trying to communicate better. But even after a terrific family therapy session, all their insight can go flying out the window with the next intake of alcohol.

Furthermore, every day a person continues to drink, the disease is progressing. That means that in addition to experiencing secondary physical problems, his or her ability to cope with life at all is progressively diminished. If someone is going through withdrawal, the severe agitation will cause anger, anxiety, and overall, an inability to have any "good communications." (Drews, 2011)

Myth No. 3: Alcoholism is a result of unresolved conflicts, anxieties, and anger. As soon as a therapist can get at the root of the problem, the need to drink will wither away by itself.
Putting it simply, problems do not cause alcoholism. Almost all of the time, after alcoholics stop drinking and attend AA regularly, their serious emotional problems disappear or at least diminish greatly with help. On the other hand, it is impossible for the still-drinking alcoholic to get well emotionally.

Myth No. 4: Even if the addiction is not dealt with as the primary issue, good therapy is being practiced if families are straight about feelings.
Even during therapy sessions where the addict is acknowledged to be an addict, many therapists have been trained to focus on asking family members how they feel about all this. On the surface, this may seem sensitive and caring. Unfortunately, such an approach often leads to 15, 30, or even 50 sessions on how each family member feels about everybody else, and not much else is accomplished.

In this erroneous process, the next step for the therapist is to help everybody improve their communications skills about how they feel! By that time, the drinking is no longer brought up on any regular basis. The drinking is merely discussed in terms of how everyone else feels about it. More damaging, perhaps, is the probability that a therapist can get sucked into believing the addiction might be overexaggerated and lose focus on the intent of therapy.

Myth No. 5: The addict does not know how the family feels.
Counselors often wish that if parents stated their feelings and needs in a straightforward manner (that is, learned good communications skills to "express feelings appropriately"), then the child would be given the incentive needed to want to stop the drinking or drug use. Not only is this magical thinking, resulting from lack of knowledge about the dynamics of the disease process of alcoholism, but it also again subtly places the responsibility for the cause of the drinking on the parents instead of on the alcoholism. (Parents often quit the counseling at this point, feeling even more depressed and despairing than when they entered counseling.)

There may be at least a partial explanation for this lack of understanding and knowledge about the disease concept of alcoholism. We all once believed alcoholism's lie that "the alcoholic wouldn't drink if all was right with his or her world." Unfortunately, no one's world can be just right.

Another partial explanation for this professional lack of knowledge about the disease concept of alcoholism is more hidden: Many helping professionals are themselves adult children of alcoholics, spouses or former spouses of alcoholics, and parents of addicts. Because denial is the main symptom of alcoholism and addiction – and because professionals are no more immune to the symptom than anyone else – when counselors are themselves untreated for their family disease symptoms, they bring this denial symptom to their work. Thus, we have a client whose main problem is a disease that may remain undiagnosed because the therapist's own family disease remains undiagnosed, and the therapist's main symptom, too, is denial about even seeing the disease. (Drews, 2011)

Myth No. 6: When parents are told they are "enablers," it leads them to stop the rescuing.
Enabling is meant to describe the rescue operations that the spouse or parent of an alcoholic carries out when he can't stand watching the alcoholic suffer the consequences of the disease. When that happens, he cleans up the alcoholic's messes (such as, lies to the school that his son has the flu when the child was actually picked up for drunken driving). That way, the alcoholic doesn't suffer the real consequences of his behavior.

Parent must learn eventually to get some detachment watching these crises happen so they can stop cleaning up after the child. They need to accept that they must allow the disease to hurt the child so much that he or she wants to get sober. Of course, it takes parents a lot of time in a healing group such as Al-Anon to be able to do this. And this detachment can't be forced or rushed by counselors. It is a slow process, and very frightening. (Albury, 2011).

When a mother rescues her alcoholic child and I label her an enabler, she obviously is still doing the rescuing behaviors and is not yet unafraid enough to give them up. She knows I am being judgmental when I use this term. Even when I say it lovingly, I seem to be admonishing her to go faster than she is capable of doing at that time. And she feels despairing, because she is doing her best. She may get so discouraged and frustrated and overwhelmed that she stops treatment.

More specifically, the term enabler implies that while the parents did not cause the drinking, their rescue operations contributed to the perpetuation of the drinking. Such thinking is dangerous; it leads alcoholics, who are already looking for a way to blame others for the drinking, into again placing responsibility for the drinking on the family.

Alcoholics do not need any encouragement to blame others. Alcoholism counselors spend most of their time trying to crack through the blame systems of alcoholics. It is considered to be a major breakthrough in the wellness process of alcoholics when they begin to acknowledge that nothing got them drunk. In contrast, alcoholics who have had relapses and are re-entering treatment are now often heard saying, "I wouldn't have gone out that time if I hadn't been enabled!" (Drews, 2011)

The alternative to being labeled enablers is to teach you to end the rescue operations through the simple but effective process of detachment. It is your fears that originally caused you to rescue, and detachment will help end those fears. And even though in this book, we are primarily talking about parents and kids, the detachment process is especially important if you also are married to an alcoholic. It is important for you to lose your fears of that adult alcoholic so you can get on with your life and become more able to deal with your children-alcoholics.

Detachment

How does detachment work? How does it help you to lose your fears of your alcoholic child or spouse? The general process goes something like this:

1. When you begin to learn ways to stop watching the alcoholic and to begin the healing process of seeing to your own needs, the alcoholic has radar and senses this switch in focus.
2. Much of the games stop then, because the alcoholic child knows that less attention will be paid to him or her.
3. By continuing to focus on yourself instead of the alcoholic, you get an even greater distance (detachment) from the threats, and begin to lose your fears of them. You begin to see how you gave the alcoholic so much of his or her power. You can take it back!
4. Again, the alcoholic senses this. He or she begins to threaten even less.
5. You see that detachment works! You gain more confidence. Many of the illusions in your household are beginning to end.
6. You lose much of your preoccupation with the alcoholic. Your preoccupation was based on your need to stop him or her from hurting you. You now see they are much less capable of hurting you than you thought. They've already done most of the damage they can do. But the game has been to keep up more of the same junk, to keep up the illusion that the alcoholic is powerful. This no longer works. You have learned not to look at him or her, to walk out of the room and out of the house and to not beg.
7. The alcoholic now stands alone with his or her disease. The person has lost his or her audience, and therefore drops much of the bullying. You are not watching it.
8. The alcoholic can no longer get you to believe you are responsible for his or her drinking and for the craziness in that house.
9. The alcoholic has a chance to grow up and make a decision to get help.
10. You are free.

When parents start to understand the dynamic of what was just described, they begin to naturally let go of the disease, to detach, and therefore stop enabling because they are losing their fears of addiction. All of us stop manipulating and controlling people when we lose our fears of them.

As a counselor

- Try to let parents know that you will gently help them along the not-straight road toward freedom from their fears.
- Let them know that they do not have to meet a timetable. In fact, let them know that you are aware that you do not walk in their shoes, that they must be comfortable to make even a small step; that what you will do is love and accept them, even when they vacillate in their ability to detach from the disease.
- Let the parents know that you know they will be ready some day. Try to give them the same hope that Al-Anon holds out – that your acceptance of them will be part of the healing process and will help move them along toward health and the choices that they now can only dream of.
- And then, gently, naturally, interventions do happen, because with one hand you can provide the healing embrace and comfort of total acceptance and without pressure; while with the other hand, hold up the mirror of reality and nudge them along ever so gently toward reality.

Many counselors do not call people "enablers," but instead refer to them as "rescuers." This is a much more kind word; the connotation allows them to gently look into their behavior and begin to make some changes. It draws them into healing and does not shame them or drive them away from getting help. (Albury, 2011)

ELEMENTS OF CONFRONTATION

Confronting addicted persons and their families

In this context, confronting means your compassionate perception that the person is addicted, and urging him or her and relevant family members (enablers) to commit to a meaningful recovery program. Such confrontations are becoming known as "interventions."

An intervention is an orchestrated attempt by one or many people (usually family and friends) to get someone to seek professional help with an addiction or some kind of traumatic event or crisis or other serious problem. The term intervention is most often used when the traumatic event involves addiction to drugs or other items. Intervention can also refer to the act of using a similar technique within a therapy session.

Three areas that counselors need to consider for the confrontation of addicts are why, who, and how.

Why confront?
A quick response might be "To help the addict." A more thoughtful reason is "To honor my integrity and earn my self-respect by doing what I can to help the addict's family break their denials." Another reason is "To reduce the stress I and others feel because of the addict's behavior." This is especially true if the addict is parenting young children.

Confront who?
Your most likely choices are: the addict, one or more family members (enablers), or both (separately or together). The most powerful as well as difficult confrontation is with an addict's whole family.

If you focus only on "fixing" an addict's way of thinking and toxic actions without confronting the underlying personal and family causes of their addiction, you greatly reduce your odds for long-term success. Notice the difference between saying...

"I want to help Pat break her denials, hit bottom, and want to manage her gambling addiction," and ...

"I want to do what I can to respectfully help Pat's family adults recognize how their beliefs, wounds, and habits are enabling Pat's compulsive gambling and its harmful effects."

An initial confrontation goal is getting all affected people (including helpers) to see changing the addict's family as the target. Doing this will often evoke family adults' denial of their enabling, psychological wounds, and ignorance.

Like any addiction, enabling is a symptom of the core problems: psychological wounds and unawareness.

Typical enablers...

- Have many false self-behaviors, and will deny, rationalize, or discount them ("I know I should confront Frieda about her compulsive shopping, but ..."), and then deny or justify it.
- May choose a helpless rationale, saying "I can't help (enabling)."
- Have codependent (relationship-addiction) traits and deny, minimize or defend them.
- Refuse to learn about or discuss addictions, enabling, and recovery, or to attend an addiction support group like Al-Anon or equivalent.
- Get significantly angry, hostile, defensive, or combative if someone brings up the addiction and the enabler's behaviors and choices.

Reality check!

Think of the person you feel is addicted and his or her key family members, friends, and co-workers. Then one at a time, decide whether any of them has any of the enabling symptoms above. Not identifying or confronting enablers raises the odds of an addict's relapsing.

Confront how?

There are many approaches and variations of approach in choosing how to confront individuals. You may choose to confront:

- The addict and some or all of the family adults.
- Over time or one-time.
- Alone.
- With informed help.

Many factors affect which of these options you and any supporters choose, such as ages; responsibilities; priorities; family composition and member locations, family roles and history; family-relationship quality; grieving progress; communication styles; and family ethnicity, customs, and nurturance level. Regardless of the factors involved, there are some general confrontation guidelines to consider.

General confrontation guidelines

- Keep a long-term perspective (i.e., the rest of the addicted person's life or the life span of the family's youngest child).
- Remember that you and any partner are not responsible for the addicted family adults' decisions; they are.
- Keep your priorities clear and firm. **Suggestion:** put your integrity (self-respect) first, any primary relationship second, and everything else third, except in emergencies.

- Stay clear on the specific results you want to achieve by confronting. The alternative is "riding off in all directions" or major disappointments, anxieties and family conflicts.
- Work steadily to improve your communication over time. Awareness, digging down, empathic listening, and assertion are especially powerful in any addiction confrontation (intervention). Experiment with these examples.

If you choose lay or professional people to help make the confrontation, ask them to prepare with steps like these:

- Be clear that in this context, confrontation and addiction/wound recovery are lengthy processes, not events. It is also important to remember that addictions can be managed, not cured.
- Help each other to stay aware of the difference between true and pseudo (trial) recovery and the relationship between preliminary (addiction) recovery and full (false self-wound) recovery.
- Aim to help the addicted person hit true bottom versus stopping or controlling their addiction.
- Correct the misperceptions that addiction is a shameful conscious choice and a disease rather than a compulsive, unconscious self-medication reflex and a sign of family dysfunction.
- Stay aware that a vital part of family confrontation is to inform minor kids in the family of key concepts, such as inner pain, compulsions, personality subselves, addiction, enabling, and recovery, and how to and express their feelings without anxiety, guilt or shame.
- Consider that trying to help someone who isn't asking for help is inherently disrespectful no matter how well-intentioned. It implies "I know what you need better than you do." This may be true, but it still feels insulting and promotes resentment and resistance.
- View personal and family resistance to breaking addiction and enabling denials as a frantic attempt to avoid pain and loss of security, not stubbornness, rigidity, ignorance, stupidity, defiance, arrogance, weakness, and self-centeredness.

Of course, you should always consider adding any personal confrontation guidelines that you feel are important in your unique situation.

Types of confrontation

Once you're well prepared, you've decided whom to confront, and your self is usually guiding you, you have a few options with each client or each person you care about:

- An indirect confrontation over time ("plant seeds").
- A direct confrontation alone or with one or more helpers.
- Plan and make a group intervention.

Let's look at each of these choices:

Indirect confrontation – "Seeding"

Trying to confront some people directly about their addiction will only evoke conflict, hurt, anger, anxiety, guilt, hostility, and frustration. This will increase family dysfunction and the addict's inner pain.

The practical alternative is to make indirect comments about addiction and recovery over time, i.e., to plant seeds that may help break denials later. An effective way to plant seeds is a series of sincere statements spoken calmly, with good eye contact and an attitude of mutual respect.

Another way is to ask relevant questions. Some examples include:

- "Maria, did you know that when you don't keep your promise to stop losing our money at the casino, I get really frustrated, and I'm learning to distrust you?"
- "What do you think about the idea that addictions are a family problem, not an individual one, Phil?"
- "I think Harry has a food addiction, but he can't admit that. Some people say that addictions are attempts to self-medicate major inner pain. What do you think?"
- "Our son just asked me if you were a rageaholic. Did you know he was wondering about that?"
- "I found another collection of pornography hidden in the basement, and I worry that you're addicted to it, Larry. Your denying that increases my fear."
- "Janice just told me about a book she read which said that parental drug addiction causes major psychological problems for all kids in the family."
- "Do you agree that Joan hasn't helped with her obsessive workouts and dieting?"
- "I just read that mental health pros define 'workaholism' as a true addiction. Some say it's being unable to work less than 65 hours a week, despite major health and family problems. Alex, I'm really concerned that that's true of you and us recently."
- "Would you say that your grandfather is addicted to poker and gambling? Has he ever tried to cut back because of his losses and marital strife?"
- "I hear that chronic overeating is linked to addiction to compulsive craving for sugar and fats, just like addiction to heroine and marijuana. Our doctor told me yesterday that he feels you're at least 70 pounds overweight, despite his warnings about related health risks. That really scared me, Roberto."
- "Helping other people avoid taking self-responsibility is called 'enabling.' I think Janice is enabling her mother by chauffeuring her all over the place, and not insisting that she learn to drive herself. Janice may be codependent, too – what do you think?"
- "Norma just told me her sister just got caught shoplifting again, despite her arrest last February. That really shows the power of true addictions, doesn't it?"
- "Sal, you say you can quit marijuana anytime, but you smoke it every day. I'm scared that's going to result in major health problem for you, and that it teaches the kids that using toxic drugs is OK."
- "I just finished reading 'Bradshaw on: The Family' – a book about children of alcoholics. It made me think of you and your mother, and I felt sad."

Please note that these statements and questions are not judgmental, sarcastic, scornful or critical, and they don't request or demand any change in the listener. Imagine the accumulated emotional impact of an addict or enabler hearing a focused series of statements (the "seeds") like these over weeks or months.

Recall that the primary goals of confronting an addict are:

- To preserve your self-respect (integrity).
- To increase the odds the individual will hit true bottom and break protective denials.

Can you imagine saying things like these to the person you're concerned about? If so, how would he or she react over time? If not, what is it that you are scared of? Does it make sense that patiently planting seeds like this would prepare all affected people for a direct confrontation about an addiction?

If you can tolerate the effects of the addicted person's behaviors and you estimate the person is not ready to hit true bottom, you can patiently plant seeds without expecting change – i.e., make respectful, informational statements and observations about wounds, unawareness, inner pain, self-medication, addiction, denials, enabling, and recovery.

Confront directly with qualified assistance

The emotional impact of any confrontation rises significantly if you ask one or two other concerned adults or older children to join you in asserting your needs and any boundaries. If you choose this option, you need to carefully pick and prepare qualified helpers.

Ideally, each adult you ask to help you confront will:

- Be clearly guided by his or her true self.
- Have studied and discussed this article or equivalent.
- Be willing to discuss and follow the foundation preparations fully.

Additionally, qualified helpers should:

- Be able to clearly describe their own reasons (primary needs) for confronting.
- Want to join you in preparing specifically for each confrontation you want to make, whether indirect or direct.

There are a couple of downsides to this type of confrontation:

- First, each additional person you involve raises the odds you'll have to resolve conflicts over whether, who, how and when to confront.
- Second, your target person is more apt to resist (feel embarrassed, guilty, anxious, resentful, hurt, angry and defensive) if several people confront him or her. The local confrontation preparations can help you handle this calmly.

It's important to reflect on how you want to interview prospective helpers to decide if you want to ask their help. There are many choices. Four criteria to consider are:

1. Who would have the most impact on the addicted person?
2. Who is most likely to agree to help you?
3. Who is least likely to cause major polarization and uproar in the target person's family if she or he confronts with you?
4. Who best meets the criteria above?

Plan and make a group intervention

Probably the most effective choice you can make toward helping an adult hit bottom and want to recover is to do a well-planned group intervention To intervene means "to come between." In this context, an intervention is a planned group meeting to come between a person dealing with addiction and their denials and compulsive toxic behaviors (i.e., to respectfully force them to confront the effects of their behavior.)

The two goals of an effective intervention are to:

- Motivate the addict to participate in a qualified in-patient recovery program.
- Satisfy the deep need of people who care about the addict and her or his family to do their best to offer meaningful help without feeling responsible.

If the first goal isn't met, the second one may be.

Typical intervention steps

A typical intervention starts with a concerned person who decides there is enough of a problem to act. *That person then* locates and consults with a trained addictions counselor. Some people attempt interventions without professional help, which lowers the odds of successful outcomes. If the counselor agrees that an intervention is warranted after hearing the situation, he or she will outline a version of the steps below. (Howard, 2012)

If you are the concerned person requesting help from the counselor, the counselor would then ask if you'll commit to these steps. If you commit, then the counselor asks you to identify every relative, friend, co-worker, neighbor, professional (like clergy or doctor), and church mate who is concerned about the addict, and has been significantly affected by the addict's (or enablers') behaviors. This list includes older children and people who live far away.

The counselor is responsible for identifying and providing basic educational material about addictions, recovery, and the intervention process.

Those materials can be used to guide the process of contacting each adult and child on the list in person or by phone without telling the addict. You explain the intervention goals and process, and ask them if they would be willing to help. If they are, ask the helpers to review the educational materials and thoughtfully write down several instances where the addict's actions inconvenienced, hurt, frustrated or concerned them.

The general format of each instance is:

> *"(Name), I really care about you. On (date) at (place), you (did something) which affected me (in these specific ways), and I felt _____."*

An instance might sound like:

> *"Jeff, last August 15th, you told Marcy and me that you and your partner would meet us at Granville's at 7 p.m. for dinner the following Saturday. We waited at the restaurant for 50 minutes, and the maitre d' said we had a phone call. It was your partner, who apologized and said you hadn't come home from work yet. Marcy and I were hurt, puzzled, frustrated and concerned, and were out the price of an expensive baby sitter. You never offered us an explanation."*

The intent is not to shame, guilt-trip, attack, blame, or preach to the addict, but to inform him or her factually of the impacts of their behavior. Other goals are for helpers to affirm their deep concern for the addict and to respectfully describe new boundaries if the target person chooses to make no change. The general format is:

> *"(Name), if you choose not to get help now, the next time you (do specific addictive behavior), I'm going to (take some specific nonpunitive action)."*

The addict may complain that this is a threat, power play or a controlling ultimatum. His or her defensive subselves may choose to see it that way, rather than seeing each helper's statement as a respectful assertion with clear consequences. Each helper's statement says: "Because I care for you and myself, I will no longer enable you. You have free choice on how to respond."

With the counselor's help, concerned individuals can research local addiction-recovery treatment facilities and pick one that provides the best mix of reputation, service, accessibility and cost. Then they should negotiate a planning date that helpers and the counselor can attend, and make reservations for the addict at the treatment facility without her or his knowledge (Albury, 2011).

The next step is for all of the helpers (including the older children) to meet with the counselor. You introduce each other and the counselor facilitates planning the intervention and answers any questions. Everyone then reaffirms their common goals (to help the addict hit bottom and protect their integrities); review key realities about addiction and recovery; rehearse and edit each helper's anecdotes for objectivity, clarity and impact; and discuss effective ways of responding to the addict's likely reactions to hearing these anecdotes and new consequences.

The role of the counselor is to educate and coach everyone, offering questions, examples, suggestions, confrontations and encouragement.

When everyone feels ready enough, you then pick a date, time and location for the planned intervention. Someone approaches the addict with a fictitious request on that date, and gets his or her agreement to come. The addict walks into a room where you all are gathered, and someone explains that you're all there to help.

Conclusion

An enabler is someone who (usually unintentionally) helps to make a person's drug use problems and addictions possible by engaging in behaviors they mistakenly think will help the person. In reality, the enabler only hurts the user. When defining family roles in addiction, Colorado State University describes the enabler:

> "The enabler is the person who allows substance abuse to continue by 'saving' the abuser from the consequences of his or her actions. For example, if an alcohol-dependent teen doesn't come home on time, an enabler would likely make excuses to other family members for that absence."

While this description is accurate, the example is somewhat benign. Enablers have been known to directly procure drugs for the user because they assume they'll simply acquire them elsewhere if they don't. They'll lie about the user's criminal activity because they fear losing them to incarceration. And perhaps worst of all, some enablers simply pretend like there isn't a problem at all and allow chronic addiction to continue unabated for years or even decades.

Drug Addiction Treatment.Com makes some other important observations about damaging enabler behavior:

- Enablers aren't always family members. They can be neighbors, friends, co-workers, or even teachers.
- Enablers generally believe that they are actually helping those they care about by preventing worst-case scenarios.
- Enablers may also fear rejection from their loved ones if they do not yield support. It could be something as simple as providing the addict with housing or transportation because he is spending all his money on drugs.

The definition of enabling in Random House dictionary is as follows: "To make able; give power, means, competence or ability to authorize. To make possible or easy." Now, what does that have to do with drug abuse? After all, no one wants a loved one to do something that would hurt themselves or others. So how could an individual possibly enable someone else's behavior? Furthermore, why would one want to enable someone to use drugs?

The reality is, this behavior does occur and contributes to substance abuse. There are three factors related to perpetuating substance abuse: denial, enabling and codependency.

As enabling makes a behavior possible or easy, behaviors by family members allow individuals with addiction problems to avoid the negative consequences that may accompany their actions. There are many ways in which this behavior can manifest. In addition, enabling behavior can be instigated by various individuals, including:

- Parents.
- Siblings.
- Co-workers.
- Supervisors.
- Neighbors.
- Friends.
- Teachers.
- Doctors.
- Even therapists.

Though initially, enabling occurs as a way to protect individuals from their behavior, it can go on to perpetuate actions that cause repetitively bad behavior. Some ways in which enabling takes place are:

- Doing something for people that they should do themselves.
- Making excuses for the individual's behavior.
- A spouse calling his or her significant other's employer to say that the person is sick and can't work, when in reality, the person is just hung over.
- Bailing out a child who has been arrested for possession, use or abuse of drugs, or breaking other societal rules.
- Defending the substance abuser, thereby allowing the behavior to continue, instead of recognizing a problem.
- Generally covering the tracks of the individual in question, whether it be by giving or loaning money, finishing up work, or just generally ignoring behaviors that should have repercussions. Usually, the enabler stays silent when faced with repeated inappropriate or destructive behavior.

As a counselor, it is important to understand the impact of enabling behavior and what can be done about it. While we've discussed several methods of approach, each client is different and each family has a different dynamic. Over time, counselors may be able to determine what type of intervention and level of support that needs to occur to diminish enabling behavior and help addicts overcome their addiction.

References

- Albury, D. (2011). Who and what is an enabler?
- Burress, L. (2008). Are you an enabler? Identifying early warning signs of enabling behaviors.
- Ceccarelli-Egan, J. (2010). Are you codependent and do you enable others? Discover why, learn to stop and gain life balance.
- Claasen, T. (2012). Family: The first step: Addiction is a family disease; it requires a family solution, Psychology Today. 45 (2), 26-27.
- De la Rie, S. M., van Furth, E. F., De Koning, A., Noordenbos, G., & Donker, M. C. (2005). The quality of life of family caregivers of eating disorder patients. Eating Disorders, 13, 345–351.
- Drews, T. (2011). An enabler: many myths prevent healing. Recovery Communications, Inc.
- Ellis, A. (1994). Reason and Emotion in Psychotherapy: Comprehensive Method of Treating Human Disturbances: Revised and Updated. New York, NY: Citadel Press
- Howards, S. (2012). Family: The first step: Addiction is a family disease; it requires a family solution.
- Knaus, W. (1984). Children and low frustration tolerance: Rational-emotive approaches to the problems of childhood, New York: Plenum, 1984.
- Kyriacou, O., Treasure, J., & Schmidt, U. (2008). Expressed emotion in eating disorders assessed via self-report: An examination of factors associated with expressed emotion in careers of people with anorexia nervosa in comparison to control families. International Journal of Eating Disorders 41, 37–46.
- Gerlach, P. (2012). About addiction, recovery, and personality subselves.
- National Collaborating Centre for Mental Health (2004). National Clinical Practice Guideline: Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and related eating disorders. London, UK: National Institute for Clinical Excellence.
- Santonastaso, P., Saccon, D., & Favaro, A. (1997). Bruden and psychiatric symptoms on key relatives of patients with eating disorders: A preliminary study. Eating and Weight Disorders, 2, 44–48.
- South Carolina Department of Mental Health (2012). Statistics. Retrieved from www.state.sc.us/dmh/anorexia/statistics.htmCached - Similar
- Substance Abuse and Mental Health Services Administration (2010). National Survey on Drug Use and Health (NSDUH).
- Treasure, J., Murphy, T., Szmukler, G., Tood, G., Gavan, K., & Joyce, J. (2001). The experience of caregiving for severe mental illness: A comparison between anorexia nervosa and psychosis. Social Psychiatry and Psychiatric Epidemiology, 36, 343–347.
- Whitney, J., Haigh, R., Weinman, J., & Treasure, J. (2007). Caring for people with eating disorders: Factors associated with psychological distress and negative caregiving appraisals in careers of people with eating disorders. British Journal of Clinical Psychology, 46, 413– 428.
- Whitney, J., Murray, J., Gavan, K., Todd, G., Whitaker, W., & Treasure, J. (2005). Experience of caring for someone with anorexia nervosa: Qualitative study. British Journal of Psychiatry, 187, 444–449.

UNDERSTANDING ENABLING BEHAVIOR AND HOW TO ADDRESS IT

Final Examination Questions

Select the best answer for each question questions 41 through 50 and mark them on the answer sheet found on page 84 or complete your test online at **SocialWork.EliteCME.com.**.

41. Enabling includes rescuing anyone who is caught up in any of the compulsive or addictive self-destructive behaviors that are symptoms of codependency, such as:
    a. Gambling.
    b. Spending.
    c. Sexual or relationship addictions.
    d. All of the above.

42. Enablers often participate in such behavior because of their own:
    a. Needs.
    b. Low self-esteem.
    c. Fear.
    d. Motives.

43. Mental health issues can develop in the enabler or other members of the family, such as:
    a. Depression.
    b. Bursts of verbal and physical anger.
    c. Anxiety.
    d. All of the above.

44. What is used to allow family members to stand back and reflect on whether and in what way an eating disorder has become the central organizing principle of home life?
    a. Home study.
    b. Phone consultation.
    c. Orientation.
    d. Family assessment.

45. Which of following can help family members identify what it is that they are dealing with and recognize their own responses to early warning signs of enabling?
    a. An external provider.
    b. Financial incentives.
    c. Play therapy.
    d. A list of relevant questions.

46. Which of the following is a comprehensive, active-directive, philosophically and empirically based psychotherapy that focuses on resolving emotional and behavioral problems and disturbances and enabling people to lead happier and more fulfilling lives.
    a. Group therapy.
    b. Rational emotive behavior therapy.
    c. Principle assessment.
    d. Fulfillment therapy.

47. Many counselors do not call people "enablers," but instead refer to them as:
    a. Oversupporters.
    b. Rescuers.
    c. The caring.
    d. Distractions.

48. What is an orchestrated attempt by one or many people (usually family and friends) to get someone to seek professional help with an addiction or some kind of traumatic event or crisis or other serious problem called?
    a. Intervention.
    b. Group therapy.
    c. Acknowledgement.
    d. Clinical supervision.

49. Like any addiction, enabling is a symptom of which of the following?
    a. Love and support.
    b. Loss and recovery.
    c. Psychological wounds and unawareness.
    d. Time and money.

50. The primary goals of confronting an addict are:
    a. To preserve your self respect (integrity).
    b. Express love and support.
    c. Increase the odds the addict will hit true bottom and break protective denials.
    d. Both A and C.

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1	○	○	○	○	11	○	○	○	○	21	○	○	○	○	31	○	○	○	○	41	○	○	○	○
2	○	○	○	○	12	○	○	○	○	22	○	○	○	○	32	○	○	○	○	42	○	○	○	○
3	○	○	○	○	13	○	○	○	○	23	○	○	○	○	33	○	○	○	○	43	○	○	○	○
4	○	○	○	○	14	○	○	○	○	24	○	○	○	○	34	○	○	○	○	44	○	○	○	○
5	○	○	○	○	15	○	○	○	○	25	○	○	○	○	35	○	○	○	○	45	○	○	○	○
6	○	○	○	○	16	○	○	○	○	26	○	○	○	○	36	○	○	○	○	46	○	○	○	○
7	○	○	○	○	17	○	○	○	○	27	○	○	○	○	37	○	○	○	○	47	○	○	○	○
8	○	○	○	○	18	○	○	○	○	28	○	○	○	○	38	○	○	○	○	48	○	○	○	○
9	○	○	○	○	19	○	○	○	○	29	○	○	○	○	39	○	○	○	○	49	○	○	○	○
10	○	○	○	○	20	○	○	○	○	30	○	○	○	○	40	○	○	○	○	50	○	○	○	○

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