Illinois Institute for Addiction Recovery
at Proctor Hospital

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Summer 2003

Vol. 8 No. 3

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Angie Raschert

"Overall, I love being with my children at home, as well as "my" kids at school. They are all very special to me and have a lot to offer our society."



Angie received her first bachelor's degree from Illinois State University in Community Health Education in 1993. Initially, she worked at the Peoria City/County Health Department teaching community and school health educational programs. At this time, she also began teaching health programs for Proctor Hospital, including CPR, Safesitter and body fat testing at health fairs. This presented the bug to teach, and she decided to get her teaching degree. In 1997, she graduated Magna Cum Laude with a degree in Early Childhood Education with a Special Education endorsement as well as a K-9 Elementary Certificate.

Angie began substitute teaching and took a K-4th science and computer position at a local elementary school. After working with the younger children, she desired to work with the middle to high school adolescents. Proctor presented a teaching position working with adolescents 12-18 years of age in a drug and alcohol rehabilitation center. In 2001, she began tutoring the adolescents at the Illinois Institute for Addiction Recovery.

This position has provided Angie with a spark for teaching adolescents. She sees how these children have been "lost" in the crowded classroom and have struggled to be heard and understood. Every student remembers one teacher that helped him or her in his or her lives, and her goal is to be that one positive teacher. Angie wants to be on the side of the students and will do whatever she can to help them succeed. She wants them to realize their potential, increase their self-esteem and have them graduate from high school with a dream in their heart.

Angie has finished writing a summer curriculum for the students at the Illinois Institute for Addiction Recovery. Presently, she is working on publishing written programs on short and long-term educational effects of drug use and ADD-ADHD to be presented on family education nights. She has so much to learn in the drug and alcohol field and continues to look at the latest research to use in her class time.

On a personal note, Angie is a single mom blessed with three beautiful children, Kaitlan, Brendan and Nathan. She enjoys spending family time with them and growing in her Christian faith. She also enjoys scrapbooking, movies, travel and many outdoor activities. "Overall, I love being with my children at home, as well as "my" kids at school. They are all very special to me and have a lot to offer our society."

Angie is a very sincere, organized and focused professional. She is always there to help her co-workers in anyway possible and, of course, make them laugh with her sarcastic remarks. Everyday presents new students and challenges in teaching and she looks forward to being a positive as opposed to another negative in her student's lives.▼

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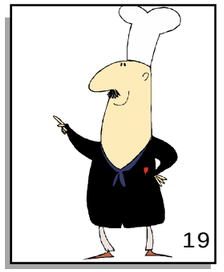
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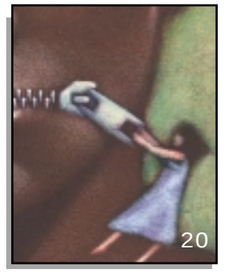


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Chris Farley
1964-1997

"Our brother was a funny, smart, popular guy who had everything going for him. Everybody loved him and laughter followed him everywhere. One day he made a bad choice: He started using drugs. Ultimately, the drugs killed him and the laughter stopped." —Tom Farley, Jr.

On February 15, 1964, Christopher Crosby Farley was born in Madison, Wisconsin. After studying theater and communications at Marquette University, Farley joined the cast of Chicago's Second City Theatre, where he was discovered by Saturday Night Live producer Lorne Michaels.

In addition to an ensemble role on Saturday Night Live, Farley became famous on the big screen through roles as the loveably misguided buffoon. A notorious glutton, Farley's five-foot, six-inch frame could barely contain his 296-pound bulk.

In 1997, he was found dead in his apartment in Chicago. It was later declared that he died of an overdose of cocaine and morphine, exacerbated by advanced heart disease.

Tom Farley, Jr. — Memories of Chris

The Farleys, a large Irish family, grew up in the Midwest wanting to see humor in everything — they loved to laugh. Most of all, they loved to make each other laugh. And that, according to his brother Tom, was what made Chris so enjoyable to watch.

For Chris it wasn't enough to just "be" funny; he really wanted and needed to make you laugh and feel good. The sincerity with which he was able to do that was obvious, whether you saw him on stage, onscreen or up close in person. Chris's humor was right from the heart.

Chris was always willing to make others happy. When we wanted to be amused, we asked Chris to do something outrageous, and he delivered. I imagine that deep down Chris had a very strong need to be accepted. A lifetime of being overweight made acceptance all the more difficult and probably caused a good deal of self-doubt in Chris. So, he did things that would ultimately not be the best for him. Chris chose pleasing others over the long-term cost to himself. When people around him started to drink and take drugs, Chris joined in.

As Tom looks back at some things his younger brother did, he can only wish to live up to his standard. Little is known of how Chris would attend Mass almost daily and help out in a local senior center. He also loved to visit children's wards in hospitals. He was very serious about his faith and service to the community. The smile on the faces of those he helped was worth gold to Chris.

Chris spent his summers as a camper and then a counselor at a boy's camp in northern Wisconsin known as Red Arrow Camp. Chris thrived on the sports and competition at the camp. It was here that Chris first developed his love for acting while hamming it up in the annual camp plays.

Most of all though, Chris loved leading the boys off on some wild adventure. One of Tom's favorite photos shows Chris hiking through the woods with the campers following close behind. It's how Tom prefers to remember Chris — full of life and walking down the "right" path. For most of Chris' thirty-three years, that's exactly how he lived.

Tom's single most memorable moment of Chris was when he asked him to attend an AA meeting that Chris would be leading. The meeting was held on the far west side of New York, in an area known as Hell's Kitchen. Tom found Chris upstairs at the head of the room conducting a meeting that was filled with what looked like refugees from the nearest homeless shelter. But here was Chris talking about the disease he shared with everyone in the room; a disease that made him no better or worse than each person that was present. That was so much like him. Tom will never forget how they all looked at Chris with admiration and respect. Not because he was a famous actor, but because, like them, he was battling a very powerful enemy. A battle that they all would fight each day for the rest of their lives. But that day, they had won their battles. And when Chris was finished, we all celebrated and had cake. Chris loved that day. So did I.

Anyone who knew Chris well also knew of his deep love for our father, Tom Farley. Like Chris, he was a very large man. But people remember him as they do Chris — not for the size of his body, but for the even bigger size of his heart. Chris Farley and his father would be very proud to know that their memory and their work is successfully helping today's teens and young adults to **"THINK. LAUGH. LIVE."**

Live From New York

Adam Sandler, Cast Member — *Farley was a whole other level. It was not even a question of who we all loved and thought was the funniest. When he walked into the room, that was it. (p.357)*

David Spade, Cast Member — *Chris was my best friend in the cast. I was close to Adam Sandler and Chris Rock, too, but Chris and I always had a real good time together. Tommy Boy was Lorne's idea to make something based on how we are in real life, how we fight, how we laugh and how we act. So we tried to make a movie to reflect a little of that; it was great. (p.358)*

Chris Rock, Cast Member — *He was my man. I loved Chris. He was one of the funniest guys. Not competitive at all. We all knew he was funnier than us and it was totally acceptable. (p.359)*

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by Mary Allen



Chris Farley, one of the most popular comic actors in the world, died of the effects of substance abuse at the age of 33. Chris's battle with drugs, his memory and his humor are at the heart of The Chris Farley Foundation. The Foundation wants to reach Chris's audience — teens, high school students and young adults while talking about the dangers of drugs with honesty and credibility. And they want to do it as Chris would have — with humor.

The Chris Farley Foundation would not exist without the driving efforts of his father, Thomas J. Farley, Sr. Seeing that so many people shared his deep grief at the loss of his son, he formed the Foundation in an effort to prevent similar tragedies. He knew just how powerful Chris was at communicating with teens and young adults and established the Foundation's mission of education and awareness.

The Chris Farley Foundation is dedicated to:

- Educating the next generation as to the risks and dangers of drug and alcohol abuse
- Communicating relevant information to teenagers
- Achieving maximum effectiveness by employing comedy to reach their audience

The Chris Farley Foundation wants to challenge and empower kids to respond differently when confronted by pressure from their peers to use drugs and alcohol. They want them to THINK. LAUGH. LIVE.

Mission of the Foundation

The Chris Farley Foundation, a 501(C)(3) non-profit organization, is dedicated to the prevention of substance abuse and is focused on communicating the consequences of drugs and alcohol abuse to kids, teens and young adults. Using Chris's humor as inspiration, they marry the message with the messenger to enable them to develop personal skills to respond positively to pressures that impact choices regarding substance abuse.

In the battle against drugs, The Chris Farley Foundation wants to empower a young audience to think again when it comes to experimenting with drugs. They bring Chris's legacy — his humor and his choices — to teens and young adults while inspiring them to think, laugh and live responsibly.

The Power of the Message

The Foundation knows it's not enough to simply be funny and advocate responsibility, they also need to offer teens and young adults valuable tools and empower them to make responsible choices about drugs and alcohol. Their motto, "Think. Laugh. Live," works because it combines message with practice. By incorporating the message into everything they do, they teach and inspire their audience to act — the tools are built-in.

THINK ...*be clear about consequences, know you have a choice and think enough of yourself to have confidence in your own worth.*

LAUGH ...*use humor as a source of strength and independence.*

LIVE ...*connect with the goodness of life, appreciate te world around you and make decisions that respect your world and your life.*

Programs in Development

With a captive audience, a special brand of humor and a groundswell of support from the entertainment community, The Chris Farley Foundation has demonstrated the powerful impact that Chris's name has among kids, teens and young adults. The Foundation's goal is to leverage their ability to capture the attention of their audiences. *To achieve this, they will work to develop the following three core programs:*

Speaking Tours

The Foundation has been "on the road" delivering its messages to colleges and high schools at various speaking engagements. Future plans call for preparing a short video and a pre-packaged version of their presentation for a broader distribution.

Public Service Campaign

The Foundation will establish a comprehensive public awareness campaign that will include public service announcements that will run nationally, a resource-filled Web site and printed material for general distribution.

Campus and Community Events

The Foundation is currently preparing to pilot a signature campus event that celebrates the college life while showcasing the Think-Laugh-Live messages.

News and Events

• The Substance Abuse and Mental Health Services Administration (SAMHSA) named The Chris Farley Foundation a Specialty RADAR (Regional Alcohol and Drug Awareness Resource) center. The RADAR network is sponsored by the Center for Substance Abuse Prevention's (CSAP) information component, SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI). The network is the largest substance abuse prevention and treatment infrastructure.

• The Foundation was chosen to participate in the White House Office of National Drug Control Policy's (ONDCP) Media Match program. The Media Match Program, as part of the National Anti-Drug Media Campaign, provides non-profits with donated media time to air public service announcements (PSAs) on national television. These PSAs have won a variety of awards since their release in February 2002 — including The Videographer Award of Excellence and a Gold and the Platinum Best of Show at the Aurora Awards.

We hope you will join them in what has become an effective — and highly rewarding — approach to inspiring young people to think, laugh and live responsibly when it comes to drugs and alcohol.▼

For additional information about The Chris Farley Foundation visit the Web site www.chrisfarleyfoundation.com.

Stress
as a Risk Factor for Alcohol Abuse and Dependence

by Mark S. Gold, M.D. and Kimberly Frost-Pineda, M.P.H.

There are many factors — psychological, social, environmental and genetic — that determine whether a person develops alcohol dependence. Researchers who study risk factors have developed "models" of the ways that known risk factors may interact to create pathways to alcohol dependence. One model pathway focuses on stress and distress. Recent events, such as the September 11th terrorist attacks, have prompted researchers to expand what is known about the relationship between alcohol use and stress, trauma and Post Traumatic Stress Disorder (PTSD).

Researchers who study risk factors have developed "models" of the ways that known risk factors may interact to create pathways to alcohol dependence.

Stress and Distress

One explanation for part of how a risk factor may lead to alcohol dependence focuses on drinking to regulate inner distress (Conrod et al. 1995). Some children have temperaments that make them highly reactive to stress and disruption. This type of child may be born into an alcoholic family, where the stressors may be intense, or a nonalcoholic family with everyday types of low-level stressors. No matter which type of family these children find themselves in, they maintain higher levels of inner distress (anxious and depressed feelings) than other children. When they take their first drink, the inner distress dissipates for a while, which leads to more and more drinking and may lead to alcohol dependence. Some recovering alcoholics report that the first time they drank was the first time they felt like themselves.

For some individuals, at certain doses, alcohol may induce, rather than reduce, the stress response. Alcohol can actually induce the stress response by stimulating hormone release by the hypothalamus, pituitary and adrenal glands (Soderpalm and DeWit 2002). Alcohol may be more rewarding when taken under duress, extreme trauma or inescapable stress. Alcohol is rewarding when taken in any situation, but stress appears to make it even more rewarding and dependency producing. More research is needed before we understand the exact role of stress as a risk factor in alcohol dependence. However, stress is a critical factor in terms of relapse (Liu and Weiss 2002).

Early Trauma and Alcohol Abuse

Childhood abuse is a significant risk factor for later alcohol and substance abuse (Schuckit and Widom 2001). Women who were physically abused are 1 1/2 - 2 times more likely to abuse alcohol than non-abused adults. Children who are quick to anger, perceive themselves to be highly stressed, are resentful of parents' absences, or who have repeated conflicts at home are more likely to abuse alcohol as teens.

Disasters, the Events of 9/11, Terrorism and Alcohol Use

Disasters have a significant impact on mental health. Anxiety and panic disorders, depression and Post Traumatic Stress Disorder are just some of the commonly documented psychological consequences of these horrific events (Smith et al. 1990). Studies since September 11th have shown high levels of stress, depression and PTSD in New York and throughout the U.S. (Galea et al. 2002 and Schuster et al. 2002). Recently published results of a telephone survey of Manhattan residents compared alcohol, cigarette and marijuana use prior to and after September 11th(Vlahov et al. 2002). Use of all three substances increased. Of those who consumed alcohol prior to the terrorist attacks, 41.7 percent increased the frequency of alcohol consumption and 20.8 percent reported consuming one or more extra drinks per day. In this study, increased alcohol consumption was associated with current depression, but not current PTSD. The authors suggest that alcohol use may be an important factor in terms of PTSD in the medium to long-term (Vlahov et al. 2002).

Trauma, Stress and Post-Traumatic Stress Disorder (PTSD)

Symptoms of PTSD may include re-experiencing the trauma; avoiding people, places and thoughts associated with the event; and arousal, which may include exaggerated startle response, hypervigilance and trouble sleeping. People who have these symptoms may use drugs and alcohol to self-medicate to escape these realities (Khantzian 1985, Chilcoat et al. 1998). One study of adolescent psychiatric inpatients found that 93 percent had been exposed to one or more traumatic events and 32 percent met diagnostic criteria for current PTSD (Lipschitz 1999). Research has shown high rates of PTSD and Substance Use Disorder comorbidity. In one study, 75 percent of veterans with combat related PTSD also met alcohol abuse or dependence criteria (Kulka et al. 1990). In the general population, rates of drug abuse and dependence are much higher among persons with a history of PTSD. Of those with a history of PTSD, 34.5 percent of males and 26.9 percent of females had a lifetime history of drug abuse and dependence, compared to 7.8 percent of males and 7.6 percent of females without PTSD (Kessler et al. 1995).

In men who have a lifetime history of PTSD, rates of comorbid alcohol abuse or dependence are highest, in women, rates of comorbid depression and some anxiety disorders are highest followed by alcohol abuse and dependence (Kessler et al. 1995). In a community-based study of 15 to 19 year olds, rates of PTSD ranged from 6.3 percent, in the general sample, to almost 30 percent among substance dependent teens (Giaconia et al. 1995). Another study found PTSD prevalence of 19.2 percent among chemically dependent teens (Deykin and Buka 1995).

Substance Use Disorders and PTSD occur together frequently, suggesting that the two are related (Jacobsen et al 2001). Substance abuse and dependence, particularly on CNS depressants, is common in patients with PTSD. In general, the onset of PTSD is thought to precede the onset of substance abuse and dependence (Saxon et al. 2001). In a study designed to explore the relationship between PTSD and substance abuse and dependence, researchers found that persons with PTSD had a four times greater risk of Substance Use Disorders (Chilcoat et al. 1998). Research suggests that patients with PTSD have lower benzodiazapine receptor binding in the prefrontal cortex, which may bring about symptoms of PTSD (Bremner et al. 2000). Again, persons with PTSD may be self-medicating to relieve their symptoms.

Volpicelli and colleagues suggest that people may use alcohol to compensate for decreased endorphin activity following trauma (1999). Endorphins help to numb the pain of trauma during the experience, but levels decrease after the trauma and can lead an endorphin withdrawal (Volpicelli et al. 1999). Because drinking increases endorphins, persons may drink to avoid endorphin withdrawal and to ease the psychological distress of trauma (Volpicelli et al. 1999).

For many reasons, PTSD is hard to prevent. Usually, we do not know when or where disasters will happen, terrorists will attack or when individuals or groups will be victimized or witness violent/traumatic events. In addition, different people may have different reactions to the same event, so there is individual variation in the development of PTSD. It is important that those who have PTSD receive appropriate treatment and that substance use is assessed and monitored. Since comorbidity is high, it is also important that persons with a Substance Use Disorder be evaluated for PTSD.

Conclusions

Alcohol abuse and dependence affects millions of Americans; those suffering from the disease, their families and friends, victims of alcohol related accidents and crimes and society, which bears a huge economic burden. Risk factors for alcohol dependence include but are in no way limited to stress and traumatic events. The recent tragic events surrounding 9-11 have underscored the role of trauma, inescapable stress, depression and other "environmental factors" in risk of abuse and dependence.▼

Dr. Mark S. Gold, *Distinguished Professor, McKnight Brain Institute, University of Florida Brain Institute teaches at the University of Florida College of Medicine — instructing students in psychiatry, neuroscience, addiction medicine and other subjects. He has worked for nearly 30 years to develop models for understanding the effects of tobacco and other drugs on the brain and behavior; and developed new treatments for addicts. Dr. Gold may be best known for writing nearly 700 medical articles, chapters and abstracts on a wide variety of psychiatric research subjects and authoring 27 books on a variety of subject. According to the* Journal of the American Medical Association *(JAMA 272:18, 1996), "Mark S. Gold, M.D. the most prolific and brilliant of the addiction experts writing today... has spent his career trying to bridge the gap in medical education and practice with the belief that addictions are diseases and that all physicians have a critical role in prevention..."*

Kimberly Frost-Pineda *is a coordinator for Research Programs and Services at the University of Florida College of Medicine in the Department of Psychiatry, Division of Addiction Medicine.*

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Risk factors for alcohol dependence include but are in no way limited to stress and traumatic events.

Child Abuse

by Carolyn S. Hughes, Ph.D., L.C.S.W.

The first task of intervention is to focus on the signs and symptoms of child abuse and the effects on the victim.

Advanced Issues in Intervention

This article is a discussion of the issues and concerns regarding the intervention of child abuse at an advanced level of practice. The first task of intervention is to focus on the signs and symptoms of child abuse and the effects on the victim. Issues of victim safety and safe environments are paramount before the practitioner looks to remedial intervention.

The advanced practitioner has a broad responsibility and role to play on behalf of both the family and the community. Even though social workers are trained to understand, assess and respond on multiple levels of practice, one often finds oneself focused on the "micro" aspects of cases, while forgetting about the "macro" challenges.

This article will explore the types of abuse, roles of the practitioner and challenges for advanced practice. This level of practice is often ignored or overlooked by agencies, practitioners and communities.

"Advanced" Does Not Change the Basics... but It Ups the Ante

An advanced practitioner needs to see the big picture... provide immediate response for safety, investigate the allegations, assess for abuse or neglect and then put the events into the context of both family and community.

The advanced practitioner needs to keep abreast of the changing face of the community of practice. That means not only continuing education at the practice level, but also paying attention to families on the case load and making certain that she or he understands the cultural facets of those families.

The United States is a rich and fluid arena for social work practice. The changing face of families in America is a challenge, because the practitioner must be culturally trained and sensitive to a myriad of arenas and across issues.

Families are groups of people residing together who offer support, nurturing, love, parenting and other caretaker responsibilities to each other. For example, a family can be married or unmarried; teen or older parents; heterosexual, gay, lesbian, bisexual or transgender. A family can represent multiple ethnic groups within a family unit or within a community; new immigrants with many languages within a community; different religious and spiritual practices and beliefs; different health care practices and beliefs; and different parenting styles, values and beliefs — including discipline styles.

The competent practitioner needs to be well versed and well trained in all of these arenas, as well as in aspects of abuse and neglect. The competent practitioner, as *investigator*, will focus on the allegations, the "facts" and the "evidence." The competent practitioner, as *intervenor*, must focus on the parties and develop a culturally relevant intervention plan.

Cultural relevance is more of a factor than ethnicity. Culture begins with the family unit and encompasses values and beliefs about self and the world; ethnic identity; gender roles and identity; parenting beliefs and practices; religious and spiritual beliefs; political ideology; education; physical and mental health status; class; and income and resources. All of these facets must be taken into account when developing an intervention plan.

The practitioner must develop a plan that is understood and accepted by all parties, is possible to achieve based on time, energy, money, values and beliefs, and is intended to have the parties succeed rather than fail.

This does not suggest that any type or group of people, whether victim or perpetrator, should be treated differently under the law based on any characteristic(s). However, it does suggest that interventions need to make sense to the parties, given their unique values, beliefs and needs. This is an individualized treatment plan approach, rather than a "cookie-cutter" approach.

Practitioner Roles

The practitioner must realize that she or he has multiple roles including investigator, case manager, therapist, liaison and/or advocate... and does **not** have other roles, such as judge, jury, rescuer or biased practitioner.

As *investigator*, one should assess for the presence of, and degree of, harm to a child. Physical abuse includes bruises, cuts, burns, fractures, internal injuries, sub-dural hematoma and death. Assess for who the perpetrator is and what the motive was, as well as assessing the victim's safety within the family.

Sexual abuse includes inappropriate sexual comments or exposure, coercion, molestation, assault and rape. Assess for victim safety, assess family dynamics towards the victim and assess for victim response and expectations.

Emotional and verbal abuse include name-calling, disparagement, taunts, threats, withholding affection, lack of stimulation in the environment and use of fear as a tool or weapon of control. Assess for emotional or psychological effects of these and other types of abuse, and assess for emotional or psychological effects of witnessing abuse of others.

Neglect includes physical, emotional, medical, dental and educational concerns. Assess for developmental milestones and phases, severity, duration, failure to thrive, victim safety and family resources to remedy the concern.

As *case manager*, one engages in continuous assessment of strengths and challenges or barriers that face a family along with a continuous assessment of safety. The case manager links to all providers and programs involved with the family, monitoring the treatment plan, and reporting the progress as appropriate.

If *therapist* is an appropriate role, one will work with the individuals or family unit while assessing for safety, supporting the treatment plan and working with other providers and agencies for continuity.

As *liaison*, one maintains awareness of the family's ability to successfully complete the treatment plan and of the community's expectations for the case. The liaison must also be aware of political and policy issues of the case such as cost, beliefs about the family, biases and stereotypes while acting as a bridge between the family and the community.

As *advocate*, one creatively exerts pressure on agencies, the community and institutions to better serve the family while challenging treatment plans and biases as needed. The advocate also insists that the "system" see the family as a unique unit within the context of the community.

Advanced Practitioners Must Work at Micro and Macro Levels Simultaneously

Advanced practitioners need to remember the macro issues of practice and place individual cases into a macro context for the community. The challenge is to assess each case as part of community trends, beliefs, values and biases while guarding against discrimination or oppression by not allowing any individual or family to be treated in a disrespectful or unacceptable manner.

Child abuse cases happen within a family context and need to be assessed for intervention within that context. Stereotypical beliefs about certain types of families based on race, ethnicity, class, sexual orientation, age or other discriminatory factors should not dictate how a family, victim or perpetrator is treated.

The advanced practitioner must constantly point out the realities of racism, classism, sexism and other "isms" (versus justice and stereotypes) to agencies and institutions, such as the courts, within a community. Each case is an opportunity to stress the need for non-biased decisions not based on discrimination or oppressive belief systems of the community.

Change Language and Change the World

One of the most powerful and immediate changes a practitioner can make in a community is to change her or his language when referring to individuals, populations or issues. Removing pejorative or discriminatory words changes the picture and the emotional effect of any statement. The advanced practitioner thinks about language and word choice constantly and strives to offer as neutral a playing field as possible.

For example, describing a client as "non-compliant" paints a very different picture than "is not adhering to." The first is paternalistic and suggests a refusal or challenge to authority. The second is non-judgmental and suggests that the individual has made a choice. *This change does not imply or suggest that the consequences will be different for the client, but it does alter the impression of the client* from "disobedient" to "decision maker." One sounds like a recalcitrant child; the other sounds like an adult.

This same "picture shift" can affect how groups of people are perceived and even valued, by both individuals and communities. When groups or individuals are presented in a respectful and non-judgmental fashion, the emotionality of biases and stereotypes is immediately muted. The advanced practitioner uses this strategy in any setting and at any occasion (including courtroom testimony) to enhance a practice of respect and regard for all members of the community.

Changing language is a subtle (or not so subtle) approach to gaining rapport with families through modeling respect and positive regard. Often, people are used to being treated disrespectfully or disdainfully by the "system," and NOT being treated that way is significant.

Conclusion

The advanced practice challenge is to keep paying attention. This article is not intended to suggest soft selling child abuse or family violence through language changes or cultural sensitivity. It is also not intended to suggest that family or individual values and beliefs (family culture) should allow any families to be treated differently in a community. The law is the law, and abuse is abuse. However, after abuse has been established, the interventions to best address the stresses and concerns within that family unit need to be "culturally relevant" to that family.

The practitioner should not develop treatment plans with all of the same elements or in the same order for all clients. Contemplation should be given to how best to work with the family to achieve the desired outcomes of child safety and reduction or eradication of further abuse and neglect.▼

The practitioner should not develop treatment plans with all of the same elements or in the same order for all clients.

Dr. Carolyn S. Hughes *is a social work educator and practitioner. She maintains a private consulting practice providing training, supervision and program development and evaluation. Dr. Hughes may be contacted by calling (530) 219-0290, via email at g.g.hughes@worldnet.att.net or writing to: 99 Lyford Drive, Suite #43, Tiburon, CA 94920.*

by Anthony J. Centorbi, RAS, CCDC-1

Motivational Anxiety

Anxiety is motivational if it is sculpted towards a constructive and positive outcome.

Using Motivational Anxiety as a Treatment Option

Chemical dependency professionals must tip the scales of client ambivalence in regards to motivational anxiety and how it can assist and benefit the chemically dependent client. Many in the mental health community view anxiety as a destructive and intrusively debilitating disorder. The basic premise is that most chemically dependent individuals have the necessary defense mechanisms to ensure their safety within their socio-economic environments. This ignores the possibility that it is mechanism mismanagement that leads to an individual experiencing uncontrolled anxiety. Anxiety is a very prominent associative disorder among the chemically dependent population, and it can be "motivationally empowering" in treating the chemically dependent client by guiding the client towards a more positive understanding of their substance abuse issues.

Basic Construct of General Anxiety

According to the *DSM-IV*:[1]

> *general anxiety is excessive anxiety and worry (apprehensive expectation), occurring more days than not for a period of at least six months, about a number of events or activities (Criterion A). The individual finds it difficult to control the worry (Criterion B). The anxiety and worry are accompanied by at least three additional symptoms from a list that includes restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension and disturbed sleep (only one additional symptom is required for children) (Criterion C) (pp. 432-433).*

Although other criterions are in place, only the primary factors were identified.

An Early Concept on Anxiety

Sigmund Freud postulated two major ideas about anxiety. Freud described what he called *objective anxiety* as "a reaction to the perception of an external danger, ... with the reflex of flight, which is instinctual of self-preservation." Freud believed that objective anxiety was rational and perhaps a somewhat expedient thought process. Freud divided this idea into two distinct processes; anxious readiness, which refers to a "heightened sensorial perception and [tightened muscular] motor tension," and he identified this as the expedient element. While development "... is limited to a flash...the less it hinder[s]...the state of anxious readiness" was labeled the inexpedient element.

The second type, *neurotic anxiety*, was referred to by Freud as "expectant dread" or "anxious expectation." Freud relates, "People who are tormented... always anticipate the worst of all possible outcomes, interpret every chance... as an evil omen, and every uncertainty to mean the worst." He later renamed this disorder anxiety-neurosis due to the marked degree of expectant dread.[2]

With these Freudian concepts as a basis, it is then best to move on to more current thoughts on the subject.

Current Concepts

Anxiety works as a "stimulus to motivate." Anxiety is motivational when "... the defenses are working... daily business remains intact even though some apprehension or worry is felt." Kaplan believes that there are two basic types of anxiety referred to as *signal anxiety* and *state of anxiety*. Signal anxiety is identified as the normal part of living — for example, "apprehension serves as a motivator of activity whose purpose is to diminish apprehension." When coping defenses are not working, Kaplan states, "anxiety does not decrease and an *anxiety state* (panic) occurs during which [normal activities] are not possible."[3]

Signal anxiety can certainly be a positive and constructive motivating force as a focus-tool in the treatment of the chemically dependent client. Kaplan relates, "Maintaining a focus on the role of anxiety as a motivating force ... permits the inference that anxiety occurs when the person is not able to protect [themselves] from it."[3] Without the proper management of defense skills, anyone can experience various degrees of anxiety mismanagement. I believe anxiety is a motivational impetus redirecting energy and psyche into a positive empowered outcome. The proper management of defense anxiety mechanisms can lead a client towards being *"ambivalent about change."*[4]

Thombs and fellow colleagues describe their viewpoints about motivation:

Traditionally, clinicians have found fault with clients for being "unmotivated" to change. When a client prematurely terminated treatment, there was the tendency to blame the client — not the treatment model. Recently there has been growing recognition that inflexible treatment models contribute to this problem, and that an explicit goal of psychosocial treatment should be motivational enhancement.[4, 5, 6, 7]

Thombs further states: "client motivation is influenced not only by the client's personal characteristics and dispositions but by the conditions external to them as well."[4] This strongly correlates to the preconception that substance abusers can be treated through motivational anxiety.

Motivational Anxiety

I feel that anxiety alone is a minor contributing factor in relation to the disorders listed in the *DSM-IV*. Idyllically, individuals have the defense mechanisms to ensure survival within their socio-economic environments. It's the inherent misuse of defense mechanism mismanagement that leads an individual to experience *uncontrolled anxiety*. Anxiety has an underlying socio-dramatic influence in today's society, as it's understood that through human development we develop temperamental predispositions towards the environment in which we interact with.[8] It's how we as individuals experience positive and negative moods or emotions within the environment that affects our anxiety levels. According to Norem, there is "mounting evidence...[suggesting] that there are underlying neuropsychological structures that relate to these emotional predispositions, as well as to an associated pair of motivational predispositions-the tendency to seek reward (an approach motivation) and the tendency to avoid threat or punishment (an avoidance motivation)."[8] From this, one can derive that a client's predisposition can affect the treatment outcome.

Anxiety is motivational if it is sculpted towards a constructive and positive outcome. For example, an important exam is coming up, and many students, including myself, have this unusual apprehensive (anxious) feeling about the exam. Some students will be overcome with the sense of fear and perform poorly on the exam. While others will embrace the sense of fear and manage their anxiety and perform well on the exam. In doing so, they refocused their energy (anxiety) or psyche. This indicates proper management of defense mechanisms — it is a *survivability* that can be measured as a client's *"ambivalence about change."*[4] According to Miller, "[Client's] with [substance abuse] problems do... posses high levels of resistance. Resistance is to be avoided at all costs. How a [therapist/counselor] responds to resistant behaviors is key to motivational enhancement."[6]

The majority of chemically dependent clients lack the proper and necessary management of coping skills to deal with life on life's terms. This mismanagement has been caused through chemical abuse, neglect and negative social interactions. Most chemically dependent clients experience varying levels or degrees of anxiety mismanagement as it relates to their treatment. As Schuckit relates, "the range of psychological feelings and emotions that can be expressed by [chemically dependent] individuals is relatively limited, it's not surprising that intoxication and/or withdrawal from most [drugs of abuse]... can produce feelings of confusion... as well as feelings of anxiety..."[9] Even after clients have successfully managed to withdrawal from their substance of choice, they still have the biological residual effects from the drugs.

During this state of confusion, chemically dependent clients exhume a sense of failure within themselves and perhaps their place in society. Misra and Thombs reiterate the *Anxiety Achievement Theory,* which states that drugs are initially used to seek relief from the pressure of achievement and productivity Therefore, the client's motivation or willingness to change has to be addressed immediately. Misra and Thombs further developed their concept by "Noting that continued abuse of drugs tends to reduce the difference between work life and leisure time activities."[10] If clients continue their mismanagement of non-coping behaviors, it will lead to full-blown chemical addiction.

Conceptual Framework

X .....Y

Anxiety	Motivation to receive help
a) Mild	Least Motivation
b) Moderate	Marginal Motivation
c) Severe	Highest Motivation

Summary

The fear of underachievement besieges the client into evading the pressure that society places upon them. Then in turn, this puts the client at risk to seek relief from this societal pressure by indulging in their substance of choice. Over time, the client becomes socially withdrawn and engrossed in the circular nature if chemical addiction. This sense of failure is very encompassing for any client to endure. Taking anxiety to motivationally empower clients to explore their feelings can assist in overriding their ambivalence toward underachievement. Clients can then accept their imperfections and start to make positive choices for themselves. This social developmental process leads to the necessary and positive outlook clients must have toward their addiction and recovery. In this way, it's possible that motivational anxiety can shed more light as to how it affects chemically dependent individuals across the life span of human development and cross-cultural boundaries.▼

Most chemically dependent clients experience varying levels or degrees of anxiety mismanagement as it relates to their treatment.

Anthony J. Centorbi *is a senior social work student at Capital University-Cleveland, Ohio. He currently holds two professional certifications in the addictions field, as a Registered Addictions Specialist and as a Certified Chemical Dependency Counselor-1. Mr. Centorbi previously worked with the adolescent population for four years before focusing on the research interest of motivational anxiety as an effective treatment tool. You may contact Mr. Centorbi by email at a.centorbi@att.net.*

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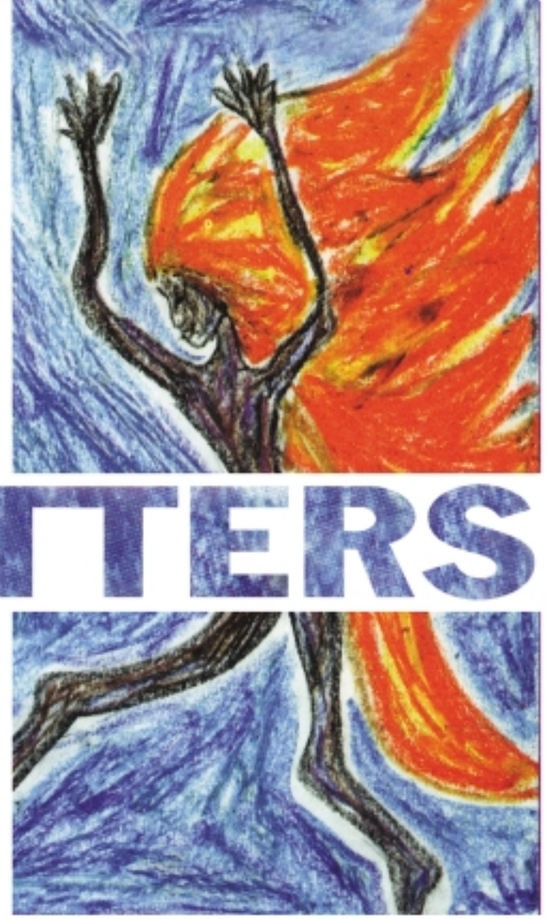
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by Karen L. Gold, Psy.D.

FEMALE FIRESETTERS

Aggressive, hostile behavior has always been accepted as inevitable among the males of our species. Early history's cave drawings, clay tablets and papyrus scrolls proudly proclaimed acts of war, spectacular hunts, male dominion and aggression. Popular and quasi-scientific debates about male behavior have persisted throughout history, with increasingly more formal efforts to conceptualize it.

Women arsonists have been perceived as "monsters of the mental health system, patients with a personality disorder, threatening life, allegedly 'for no apparent reason.'"

In 1838, the theory was proffered that "dangerous classes" of men (e.g., the poor, the homeless, the unemployed) posed a threat to law and order. This theory gave way in the 1870's to the notion that some men were born with a predisposition to commit crimes. Then, in the first decade of the twentieth century, it was believed that criminals were defective in intelligence. Today, we see criminals as "disordered personalities," driven by personal motives and social stressors. None of these theories, based on the behavior of males, can be completely disregarded; criminals may be impoverished, predisposed, intellectually limited and/or mentally disordered. As time marches on, we can expect still other theories to float to the surface of criminology and be added to the stewpot, or later discarded.

A most intriguing puzzle throughout history, however, has been the criminal conduct of females, often perceived as the more tenderhearted gender. But very little "tender heartedness" truly flavors the acts of arson committed by women. In the early 19th century, two hundred and thirty four women arsonists scorched Ireland, with the intent of joining husbands and lovers who had been expelled from their homeland and sent to Tasmania as dangerous criminals. Many historians and feminists have perceived these women as brave, loyal and loving. But is crime in the name of family reconstitution, in the name of love or in the name of loyalty any less egregious than crime motivated by greed, revenge or power lust?

Women arsonists have been perceived as "monsters of the mental health system, patients with a personality disorder, threatening life, allegedly 'for no apparent reason'" (Arson Intelligence Newsletter, 1999). Many therapists search in vain for that seed of tender heartedness, or even for a thread of tangential reasoning, in the stories told by women who set fires. But the most common reason that women articulate to explain their sometimes shocking, bizarre and incomprehensible behavior ***is love***. Linda, a patient of this author, said, "The first time, it was the warmth I remember most. Like being in bed on a cold rainy morning. It was comforting, warming and vaguely loving. The light danced off the walls and floor, washing everything in orange and white. I was amazed. I couldn't let go of the feeling of warmth, love and power. By the fifth time, it had become a ritual, a ritual that needed love and attention. It was almost like putting a doll to bed. I knew it, loved it, and could care for it. I belonged in a way to fire. I was important; I gave it life, helped it grow, nourished it and watched after it. At times I even protected it. I played with fire and took it to new levels. Eventually it took on a life of its own. When I looked inside the fire I saw all the possibilities; the things I couldn't do that it could. So I made my first aggressive move, destroying something that someone else loved. That theme has since followed me throughout my fire setting career. The search for the cause of fire... it was a task that many therapists attempted to tackle and failed. It was always viewed as an excuse for some other dark and looming problem. It was never looked at, as maybe I just loved fires. I did just love fires. It was a seemingly simple problem that many people have tried to make into a complex puzzle."

There is love in this narrative, but in this case, as in too many others, the love object is fire itself — supporting the belief that some female firesetters are passionate paramours of flame. In his famous pop music recording, Robert Palmer told us that we might as well admit that we're "Addicted to Love." Significant numbers of women are addicted to fire. The combined power, heat, vibrancy, sight, sound, smell, taste and feel of fire is as thrilling as sexual intimacy. Suzette, another patient of the author, stated, "It's like doing drugs. I feel high and spaced out... euphoric, I guess would be the word. After, I feel so good."

Female firesetters vary greatly in age. In this author's experience, they have ranaged from as young as 5 years to as old as 84 years. Female adolescents and even young girls have also been able to express their fire setting behavior as grounded in love. Said one, "I have always loved fires. I was never scared of them. I watched them. And then, I discovered that they were even prettier at night. Eventually, I always set fires at night so I could watch from a long distance away." Another young girl said, "I love fire. Setting fires is something I know how to do, and I do it real good. I don't do anything else as good. I don't get good grades, I don't have lots of friends and I'm not good at games. But I'm real good at starting fires."

While the number of fire lovers is actually small, the number of fires they start and the dollar amount of property losses is incalculable, for each one ultimately admits to hundreds to thousands of fires. Females account for 10 to 18 percent of arson arrests. However, only 10 percent of all fires set are ever reported, and only 16 to 17 percent of those reported result in an arrest. In addition, only a tiny percentage of the arrests result in convictions, as the fires often devour all evidence. Therefore, data is quite limited; only a handful of studies have focused on females who set fires.

David Wilcox (1999) has reviewed the literature and concluded that female firesetters are more likely to have a history of sexual abuse; aim at destroying their own property or the property of someone close to them; are motivated by revenge or perceived rejection in a relationship; and have behavioral patterns of poor impulse control and/or self-harm.

A fair amount of literature attempts to link trauma and fire setting, and by default, imbuing female firesetters with a diagnosis of Post-Traumatic Stress Disorder. This is certainly true in some cases, but by no means true in all. Violet, for example, told the author, "I had a stable home life. My mom and my dad always got along OK, but they were hardly ever home because they both worked full time." Violet was never abused, and was, in fact, privileged.

There is too little information available to justify solid conclusions, but Saunders and Awad (1991), in a study of 13 female adolescent firesetters, identified a number of common characteristics. Impoverished families, substance abuse, domestic violence, father absence, poor school achievement, truancy and antisocial behavior at home, school and in the community were universal. "Most of the girls' behavior seemed to be in response to the chaos and abuse at home." In the author's experience, boredom, over-indulgence and "wretched excess" with undervaluation of possessions, parental workaholism, peer pressure, the sense of power and control over authority figures and retaliatory thinking also figure prominently.

Bourget and Bradford (1989) studied 15 female arsonists and determined that psychosexual aspects of their behavior were relevant and that poor impulse control may be requisite. Age distribution was similar to that among male arsonists, but the females were unattached, of borderline intellectual functioning, and more prone to alcohol abuse and personality disorders. The majority set fire to their own place of residence, without regard to possible financial gain, and all had a criminal history. A majority were sexually precocious or promiscuous. The rate of recidivism was high, and the behavior was linked to deficient impulse control. All the women exhibited psychopathic features, but did not necessarily meet the criteria to justify a robust diagnosis of personality disorder.

Other research (Stuart, 1993) found that 92 percent of female arsonists carried a psychiatric diagnosis (most often depression), were often low in self-esteem and had poor communication and social skills. A report from the United Kingdom Parliament Select Committee on Health cogently states, "Women are more likely to internalize their anger and pain. When there is a serious violent offense, it is usually an isolated offense committed in a clear family or social context. Arson is the most common index offense for women and research indicates that there is rarely any intention to endanger life or property."

Generally, there is agreement that global warfare, with greater participation by females, is eroding societal feminity. Today, we are not surprised to learn of women suicide bombers, terrorists and arsonists for profit. But perhaps we are more disturbed by increasing numbers of women setting fires on the home front — out of anxiety, frustration and anger. Terry Lynn Barton, a Forest Service employee, set a fire near Florissant, Colorado in June 2002, which burned more than 136,000 acres. Barton admitted starting the fire, but at first said that it happened by accident, when, acting on anger, she burned a letter from her estranged husband. It was later determined that Barton staged a scene in the Pike National Forest, creating what appeared to be an improperly abandoned campfire. The fire she set was the worst in Colorado history. Two journalists (St. Clair and Cockburn), however, speculate that frustration regarding her difficulties in raising two children on the meager pay she earned after 18 years in the Forest Service played into her ultimate misconduct. There is additional speculation that Barton may have been "out for glory." A family friend indicated that Barton was in fear of losing her job. "Once the fire started, Terry went out to do her best, almost killing herself, to go out and try to put the fire out herself. She loved that job." Therefore, this

But the most common reason that women articulate to explain their sometimes shocking, bizarre and incompre-hensible behavior is love.

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by Kathryn Seifert, Ph.D.

Attachment, Family Violence and Disorders

of Childhood and Adolescence

Family violence, childhood maltreatment, school shootings, rampant substance abuse, increasing prison populations and insufficient support for human services are significant social issues in the U.S. There are several studies documenting relationships among social, psychiatric and behavioral problems. For example, Kleinman (1997) reported that epidemiological studies have found that various social problems such as substance abuse, violence and family breakdown are strongly linked to mental health issues among youth. Additionally, in a previous study by this author (Seifert, 2000), it was stated that violent youth and adults have problems in multiple domains such as school, family, community, work and peers. Rulo-Pierson (2001) found that a large percentage of youth with histories of abuse and neglect are found among youth or adults with both ADHD and behavioral disorders, while DeFrancesco (2001) documented the high level of co-morbidity between ADHD and disorders of conduct.

In the present study, it was hypothesized that some percentage of children with this co-morbidity (ADHD and conduct disorders) may be attachment disordered, as well. While there may be other causes, many Attachment Disordered individuals have been severely neglected, abused or exposed to domestic violence. This results in behaviors that are often violent, oppositional and antisocial.

There are relationships between high levels of arousal and trauma. Severe abuse, neglect or exposure to violence in childhood often results in a "fight, flight or freeze" (Levine, 1997) reaction that is both emotional and physiological. Post Traumatic Stress Disorder can be an outcome of this, characterized by continued heightened arousal and difficulties with mood and concentration long after the trauma has passed. Those who have been traumatized can, therefore, develop symptoms of anxiety, attention or mood disorders. If maltreatment, neglect or exposure to violence occurs before the age of 4, the ability to bond with others can also be affected.

There are relationships between high levels of arousal and trauma. Severe abuse, neglect or exposure to violence in childhood often results in a "fight, flight or freeze" reaction that is both emotional and physiological.

The fight, flight or freeze response results from the felt need to engage in extensive movement. This is seen in various settings. In an effort to self-soothe and discharge stress chemicals in the body, many traumatized people often feel the need to pace, run, walk or rock. Stress management trainers often recommend physical exercise as a positive method to discharge stress. Practitioners who are treating Attachment Disordered children have observed the frequent co-occurring attention and hyperactivity problems (Levy and Orlans, 1998), as well. This may be the child's way of trying to cope with a traumatizing experience.

Until we study and understand the factors that support or decrease the likelihood for these problems, we cannot effectively prevent or treat them. It is hypothesized that these are not independent issues, but that there are relationships among them. The present study looks at the correlations among individual violence, psychiatric disorders, substance abuse, attachment disorders, sexual offending, childhood trauma and a history of family violence.

Method

The Sample

The sample included 479 youth and adults from inpatient, outpatient and prison settings. Ages ranged from 2 to 74 years old. Twenty-three percent of the sample were diagnosed with attachment disorder, 36 percent were substance abusers, 23 percent had committed sexual offenses, 79 percent had a psychiatric disorder, 57 percent had been assaultive and 76 percent had experienced childhood trauma. Gender distribution of the sample was 69 percent male and 31 percent female. Sixty percent of the sample were Caucasian, 31 percent African American and 9 percent were Hispanic, Asian, Native American or other ethnicity.

Procedures

Data was collected in a variety of settings as part of an intake process or an evaluation. Data was subjected to statistical analysis. Descriptive statistics for the six subpopulations: psychiatric, substance abuse, attachment disordered, sex offenders, assaultive and those with childhood trauma were examined.

The Measure

The CARE (Child & Adolescent Risk Evaluation) is a screening tool that assesses behavioral problems in children and teens (Seifert, Phillips, and Parker, 2001). It measures both risk and protective factors for behavioral disorders. The risk categories include individual characteristics and history (such as history of violence, enuresis, poor anger management and psychosis); peer interactions (for example, bullying behaviors and deviant peer group); educational, school, and work problems (like learning problems, lack of work success and school failure); and family characteristics and dynamics (such as a history of harsh disciplinary practices and family violence). Static and dynamic factors are used, as well. Dynamic factors are those that can be changed with treatment, such as social skills and problem solving ability. The adult version of the CARE uses the same items and scoring, but is reworded to be age appropriate.



Art by Yvonna Zygman — Age 11 Courtesy of Lawrence Alive! Diversity • Vitality • Community Project

Variables

The risk and resiliency items of the CARE (Child and Adolescent Risk for Violence, Seifert, 2000) or (for adults) the ARE (Adult Risk Evaluation) were used. Variables included a history of behavior problems, impulsivity, attachment disorder, family violence, psychosis, enuresis and aggression. Individual characteristics included social skill problems, difficulty with problem solving, substance abuse, anger management problems, deviant peers, assaultive behavior and delinquency. School behavior and learning problems were also recorded.

Results

Populations can be statistically assessed in a variety of ways. Some are of more practical utility and others may lead to a theoretical model of the disorder or behavior. Several statistical descriptions are used for sex offenders, assaultive offenders, delinquent offenders, attachment-disordered persons, substance abusers and the psychiatric population for comparison purposes.

Regression Analysis

A regression analysis was applied to each subgroup using the items on the CARE/ARE to determine the strongest statistical predictors. Psychosis ($r = .24$, $p = .00$) and parental discipline that was harsh, lax or inconsistent ($r = .23$, $p = .01$) were statistical predictors of Psychiatric Problems. Severity of behavior problems ($r = .31$, $p = .03$) and delinquency or crime ($r = .40$, $p = .00$) were significantly associated with substance abuse. Childhood trauma was associated with attachment disorder ($r = .34$, $p = .00$) and family violence ($r = .77$, $p = .00$). Assaultiveness was significantly correlated with Attachment Disorder ($r = .38$, $p = .01$), severity of behavior problems ($r = .69$, $p = .00$) and enuresis ($r = .23$, $p = .01$). Many sexual offenders were male ($r = -.29$, $p = .00$), had also been physically assaultive ($r = .29$, $p = .03$), had a deviant peer group ($r = .23$, $p = .04$) and had lower IQ ($r = -.25$, $p = .01$).

Comorbidity of Populations

All subgroups had a high percentage (greater than 72%) of persons with psychiatric problems with the Attachment Disordered group having the highest percentage (92%). More than 75 percent of all groups had histories of childhood trauma with the Attachment Disordered group having the highest percentage (98%). Greater than 70 percent of those in all groups reported histories of family violence. The psychiatric group had the lowest percentage (74%) of family violence. Greater than 70 percent of all sub-groups, except the psychiatric group (57%), had histories of assaultiveness. Sexual offenders were the most likely to have other delinquencies or criminality (76%), and those in the psychiatric group were the least likely to have a criminal history (43%). Comorbidity among these populations demonstrates the need to assess clients and their families for multiple issues, regardless of the presenting problem.

Descriptive Statistics

All groups had a significant percentage of those with skill deficits. Greater than 70 percent of all groups had anger

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The fight, flight or freeze response results in the felt need to engage in extensive movement.



Treating Adolescents at the Illinois Institute for Addiction Recovery

Adolescent Treatment at IIAR

The goal of our treatment program is to help the addicted young adult achieve a lifestyle that is free of mood-altering chemicals and addictive behaviors. Research in the area of addiction has demonstrated that this is the only viable goal for the addicted individual and that any use of a mood-altering chemical or addictive behavior by a recovering person can result only in a return to addiction.

Our program features a **behavioral management system** that is designed to encourage appropriate behavior and discourage inappropriate behavior, as addicted young adults often learn to use inappropriate behavior to control the people around them and so continue their addiction.

Another feature of our treatment program is the involvement of the **family**. We recognize that the addicted person's actions have affected everyone in the family (thus, it is often called a "family illness") to such an extent that they may be experiencing serious disruptions in their family life, as well as being individually confused and upset. However, a loving and caring family that understands this illness and supports the recovery of their family members is crucial. To this end, we involve families in our Family Program, Family Night and family conferences, as well as Families Anonymous and Al-Anon to help them mobilize their love and support effectively for the addicted family member.

A **medical exam** is conducted on admission by one of our physicians, who continues to provide regular visits and medical coverage to ensure the patient's physical health.

Our treatment program features an **educational component** that has several facets. These are designed to encourage mental functioning and good study habits. A certified teacher works with patients in conjunction with their home school to continue work on class assignments and encourage positive intellectual skills and study habits.

Therapy groups and individual counseling sessions help to increase awareness of feelings and encourage non-chemical means of coping with those feelings, as well as effective communication skills. They also serve as a forum to discuss addiction and addictive behaviors.

Our **physical fitness/recreation component** encourages a return to healthy metabolic and physical functioning, as well as teaching use of leisure time that does not involve addictive behavior.

Upon discharge from the young adult unit to aftercare, young adults and their parents negotiate a home contract, which states expectations for behavior at home as well as develops a continuing recovery plan specifying goals set for the period following treatment.

Research has shown that **continuing recovery** after treatment is strongly related to participation and peer support groups such as Alcoholics Anonymous, Narcotics Anonymous and Gamblers Anonymous, as well as continued involvement in counseling groups. Our inpatient phase of treatment is viewed only as the first step in a life-long journey of recovery. While the patient is in the young adult unit, we will involve him or her in these support groups so that, following treatment, continuing involvement will be more likely. We will also arrange for participation in continued outpatient counseling groups following discharge from the inpatient phase of treatment.

For additional information, call the Illinois Institute for Addiction Recovery at 1 (800) 522-3784 or visit our website at www.addictionrecov.org.

CONSEQUENCES OF ADOLESCENT ADDICTION

Addiction can most readily be identified through its affect on different areas of an individual's life. In adolescents, the progression of the illness and severity of consequences are accelerated as compared to adults. Below are some of the areas in which consequences occur and some examples of those consequences.

Physically, the addicted adolescent will experience hangovers, bad trips and/or unpleasant experiences with drugs. Sleep and appetite disturbances may occur with resulting weight loss or gain. The person may suffer from overdoses, injuries and respiratory problems. Personal hygiene generally suffers and appearance may deteriorate.

Mentally, the adolescent spends much time and energy involved in their addictive behaviors. Social occasions generally involve drug use. The adolescent begins lying to parents and making excuses for their behavior. Blackouts will begin — specifically, a period of time during which the individual cannot recall what they are doing, although they are awake and active. Shorter attention span, decreased motivation and some difficulties with memory are also likely.

Emotionally, mood swings may be noticed. Normal emotional tasks such as dealing with relationships and issues of autonomy and independence are delayed or accentuated. Depression and suicidal thoughts may occur. Feelings of isolation, alienation, anger, loneliness, hurt, inferiority and worthlessness are likely.

Spiritually, there is likely to be an extensive conflict between moral, religious or family values and drug-using values.

Legally, consequences will range from being a minor in possession of illicit drugs to selling drugs and prostitution. Initially, many of these infractions go unnoticed simply because the adolescent is not caught. Eventually, the child's criminal behavior becomes evident.

At school, performance begins to suffer. Suspensions, truancy, tardiness and lack of motivation are generally seen. The student may begin avoiding teachers. He or she may quit school or may use school to sell drugs. Use during school hours becomes common with predictable results on academic performance.

At home, problems also surface. The individual starts sneaking out at night while giving vague explanations for whereabouts and activities. He or she becomes less responsible for activities and chores around the home. Family fights may occur and may become physical. He or she may eventually stay away from home for long periods of time or leave all together.

Socially, friends and peer groups typically begin to center around drug use and addictive behaviors. Friends who do not use drugs drop by the wayside. By the time the individual is in the final stages of addiction, even using friends may show some concern over the addict's behavior.▼

This is adapted from Choices and Consequences *by Dick Schaefer.*

The Illinois Institute for Addiction Recovery is Pleased to Announce its Newest Services

Extended Care Program

Designed to accommodate those adult clients, age 18 or older, who need a setting which provides more time and structure to deal with the problems associated with addictive behaviors such as chemicals, gambling, food, sex, spending or Internet. The extended length of stay can assist with entrenched denial, chronic relapse and other complicated issues such as chronic pain or multiple diagnoses. The program staff is also skilled at working with professionals whose licensure may be in jeopardy.

Chronic Pain and Addiction Treatment Program

This program identifies, evaluates and treats chemical and process addictions and chronic pain. Addiction and chronic pain are treated separately, yet simultaneously, by utilizing a chronic pain treatment team. Everyone admitted to the IIAR for addiction treatment is also assessed for issues with pain.

*"**The Extended Care Program**" and "**The Chronic Pain and Addiction Treatment Program**" accept nationwide referrals and provide a full continuum of care.*

For more information, call (309) 691-1055 or 1 (800) 522-3784 or visit the Web site www.addictionrecov.org.

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management problems, impulsivity and poor social skills. At least 80 percent of all groups had poor problem solving skills. More than 65 percent of all groups had moderate to severe behavior problems before the age of 12. The psychiatric group had the lowest percentage of those with learning problems (56%), school behavior problems (54%) and bullying behaviors (26%). Seventeen to twenty percent of all groups had neurological problems. There was a large percentage of family problems in each group.

Correlations

An assaultive history is significantly correlated (correlations greater than .3 are reported here) with severity of behavior problems (r = .75), sexual assault (r = .34), impulsivity (r = .38), delinquent/criminal behavior (r = .41), anger problems (r = .39), attachment disorder (r =.40), poor social skills (r = .30) and school behavior problems (r = .46). Delinquent and criminal behavior is correlated with severity of behavior problems (r = .53), sexual assault (r = .34), assaultiveness (r = .41), impulsivity (r = .31), substance abuse (r = .44) and school behavior problems (r = .43). Attachment Disorder is associated with severity of behavior problems (r = .40), assaultiveness (r = .40) and childhood trauma (r = .35). Sexual Assaultiveness is correlated with severity of behavior problems (r = .35), physical assaults (r = .34) and delinquency/criminality (r = .34). Psychiatric disorders show no associations above .3. The correlation between Attachment Disorder and other psychiatric disorders is .16, and it is significant. Substance abuse is correlated with severity of behavior problems (r = .33) and delinquency/criminality (r = .44). In summary, there appears to be a significant relationship between childhood trauma and severity of behavior problems (r = .37). The value of describing these populations and the commonalities and distinctions between them, is in fashioning treatment modalities that can be tailored to their needs, as well as those of their families.

Agencies should be using multimodal assessments and interventions that address the needs of the entire family group.

Discussion

Implications for Practice

The implications for intervention are that regardless of the reason that a person comes to the attention of a criminal justice, social service or mental health agency, there is a high likelihood that other problems exist within the individual and the family. All problem areas should be assessed and either treated or referred for treatment. This study also makes a case for providing early mental health services for the children who have been abused, neglected or exposed to domestic violence. To end youth and adult violence, we must look at the violent family roots and intervene as early as possible.

Limitations of the Study

There were several problems with this study. A larger and more diverse sample is needed. More research is needed on the issues of violence and attachment problems. Abuse and neglect before the age of 4 is often not in the record, and youth or adults either do not remember, are in denial or do not want to say that they were abused or neglected at an early age. The definition and study of attachment disorders is still quite new, so those rating children may not have the knowledge base to recognize it.

Conclusions

There was considerable comorbidity among the five groups studied. All groups had a high percentage of youth or adults who had experienced childhood trauma or were from families with histories of violence. All groups had a high level of those with psychiatric problems. The majority of substance abusers, sexual offenders and those with attachment disorders were also physically assaultive. A large percentage of substance abusers and sexual offenders also had histories of other criminal or delinquent activities. Specifically, 83 percent of the violent youth or adults had an Attachment Disorder and 92 percent of that group had psychiatric problems.

Violent offenders had attachment disorders, severe behavior problems, enuresis, impulsivity, anger problems, poor social skills and school behavior problems. Those with attachment disorders had experienced childhood trauma and had demonstrated emotional displays that were flat or out of control, severe behavior problems and physical assaultiveness. Substance abusers had severe behavior problems and were delinquent or criminal. The psychiatric group had psychosis, parental discipline that was lax, inconsistent or harsh, childhood trauma and family violence. The sexual offenders were primarily male and had low IQ, physical assaults, deviant peers, severe behavior problems and other delinquencies.

The treatment of comorbid conditions needs further study. Effective assessments and interventions for attachment disorders need to be developed. Agencies should be using multimodal assessments and interventions that address the needs of the entire family group.▼

Dr. Kathryn Seifert *received her Ph.D. from the University of Maryland, Baltimore Campus in 1995. She is a Diplomate (DABPS) in forensic psychology and a Fellow in the American College of Advanced Practice Psychologists and the Maryland Psychological Association. Dr. Seifert has had over 30 years experience in mental health, addictions, and criminal justice work. In addition to creating the CARE/ARE, Dr. Seifert has authored articles and lectured nationally and internationally on youth or adults violence. She founded Eastern Shore Psychological Services, a multidisciplinary private practice that specializes in working with high-risk youth or adults and their families. The CARE is available through Research Press. The ARE is available in research form from the author (email drkathy2@cswebmail.com).*

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A Baker's Dozen of Tips, Secrets & Tricks of the Trade

While youth workers are supposed to teach and lead kids, I've probably learned more than anyone over the past thirty years. And the lessons have not been easy. They've mostly come as the result of my youthful arrogance and pitiful ignorance; fits of blinding frustration and boneheaded stubbornness; demonstrations of stunning stupidity and masterful mistakes; and at least one gut-wrenching tragedy. Here's what I've learned:

by Tom Klaus

1. Always remember who you are. Knowing a lot about diversity and sensitivity is really great. More important is that you know that you are unique, accept that it is "okay," and behave with kids in a way that says, "You don't have be just like me." To remember who you are allows you to work non-judgmentally with kids.

2. No matter how tempting, never begin a sentence with, "When I was your age..." Remember; they don't care. It is a cliché that gives permission for boredom, and you will sound just like their parents. Sure, you've got valuable experience to share, but don't lose them in the first few words.

3. Everyone love stories... tell them! This is how you share that experience, by telling stories about how you changed. Remember to look for a "universal truth" that others can get from your telling the story.

4. Don't even try to be cool. Of course you looked cool in the latest fashions "when I was your age," and you think you look cool in today's fashions — but you really only look like a middle-aged doofus to most kids, even if you are in your twenties (which is middle-aged to many teens anyway). If you are more than two years older than the youth you work with, you may already by one generation removed. Don't you just hate growing older?

5. Be the butt of your own jokes. Humor is a powerful tool when working with kids, but it has to be handled with care. Healing humor affirms kids, is more subtle — though it can be edgy — and, most of all, it facilitates relationships. Anytime humor damages a relationship — it is being misused.

6. Don't be afraid to think twice... even thrice... about your own best ideas. Theory doesn't always translate into good practice, and practice is a key ingredient in good theory.

7. Before you try to say anything, earn the right be heard. Earning the right to be heard is a matter of creating relationship. Creating a relationship between you and kids requires you to be honest and genuine.

8. Relationship comes first... but don't hide behind it. Ideally, in any helping profession, the relationship precedes the responsibility of doing the tough things with people. But when it comes to matters of health and safety, we have to be able to take action with or without a relationship to buffer the tough stuff.

9. Don't expect to know it when anything you've done has made a difference. What no one ever told me about youth work was that the gratification was not immediate. When that occasional kid looks you up to say thanks or tell you how you helped, savor it.

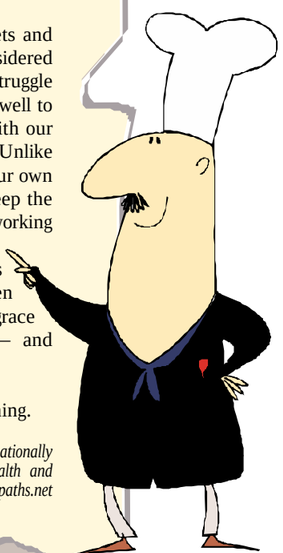
10. Give hurting kids space. No matter how much you care, don't assume you have the right to enter any kid's personal space. Wait to be invited but, even then, think twice. Kids who've experienced boundary damage may not know how to set appropriate ones. You may have to set them on their behalf.

11. Never say, "I'd never do that!" Our need for recognition of our efforts and the messed up boundaries of hurt kids can be a lethal combination. It can lead to an emotional attraction and bond, followed by a physical attraction and ending up with a sexual relationship. The first step toward this kind of inappropriate and illegal situation is denying our own vulnerability.

12. Play as a part of your work. Kids have the ability to learn extremely well while having fun so make your work fun. Sometimes, though, "fun" just needs to be "fun."

13. Don't expect many (if any) of these tips, secrets and tricks to work with your own kids. We are often considered the "expert" on kids in our community, so we struggle against the idea that our own kids have to turn out well to validate our role. We will always deal differently with our children than we will with another person's child. Unlike our youthful clients, we are tied at the heart with our own kids, and that makes all the difference. We can't keep the cool, professional objectivity that we have when working with other's kids. That's okay. We're only supposed to be mom or dad, and that change of role changes everything. So, what do we do when our own children don't turn out as we had hoped? We give ourselves grace and forgiveness. Then, we give our children — and ourselves — a referral to a good therapist.▼

The lessons aren't always easy, but let's keep learning.



Tom Klaus *is a middle-aged pudgy guy from Iowa who is also a nationally known speaker, writer, trainer and consultant on adolescent health and wellness issues. He can be contacted via email at helpingkids@crosspaths.net or phone at 1 (888) 349-6447.*



The Unspoken Affliction

by Jacqueline Marcell

People, who would never have dreamed of crossing the line, are finding themselves lashing out in utter frustration.

Dementia and Elder Abuse

Elder abuse is an expanding serious problem, affecting hundreds of thousands of elderly people in the United States. Unfortunately, the issue remains largely hidden by the families, causing gross under-reporting of the growing crisis. Compounding the problem is the fact that one out of every 10 persons by the age of 65 gets some form of dementia (Alzheimer's is just one type), and that statistic rises to one out of every two by the age of 85 — adding an enormous burden on families who are ill-prepared for the strain of caring for their aging loved ones. Amazingly, the fastest growing segment of our population is the 85 + group, so the problem will undoubtedly get worse before it gets better.

Various studies have attempted to estimate the size of the problem of elder abuse, but the true figure remains unknown. Seven years ago, in 1996, the National Center on Elder Abuse (NCEA) estimated that there were 1.01 million victims of elder abuse (2.16 million when including self-neglecting elders). The median age of victims was 77.9 years of age with 66.4 percent being caucasian, 18.7 percent African American, 10 percent Hispanic, and less than 1 percent each Native Americans, Asian Americans/Pacific Islanders. The report also indicated that the victims were typically female (68.3 percent).

New Report

Preliminary information from the new 2000 survey of state adult protective services agencies indicates that there were 473,000 reports of abuse in 2000 nationally, but only 169,946 were ever substantiated. This corroborates the fact that the problem remains protected in a shroud of shameful secrecy by the families. The report indicates that the perpetuators of the abuse are more often male relatives: 30 percent spouse or intimate partners and 17 percent adult child.

It is frightening that 303,054 cases couldn't be substantiated, and we will never know how many hundreds of thousands were never even reported to adult protective services. It is estimated that only one out of 14 incidents come to the attention of authorities, and criminal prosecution rarely occurs because by the time law enforcement gets involved, the incident has passed, and the family doesn't want to press charges nor bring attention to their disgraceful family secret.

It is not surprising then, that only 16.3 percent of all reported cases of domestic elder abuse come from family members and relatives of the victim. The rest is by concerned friends and neighbors, law enforcement, clergy, banks/business institutions and the victim.

As our population ages, unless a concerted effort is made to deter it, elder abuse will undoubtedly increase. It's an issue that has to be examined as closely as the issue of domestic violence, which has been deterred by abundant public service announcements on radio and television. Also, the availability of shelters and counseling for battered women has made a huge difference in the awareness of the issue. The same is needed for elder abuse. Through education and public awareness, another taboo subject can be brought out in the open so offenders will think twice before they lash out — ideally seeking the help of a mental health professional before they cross that line.

Caregiver Stress

Overburdened caregivers of chronically ill loved ones ride a roller coaster of emotions: such as feeling overwhelmed, out of control, angry, guilty, sad and never free of being constantly in demand. They lose touch with friends who don't understand, their careers suffer when they must take time off work, they suffer from sleep deprivation, and they donít get adequate nutrition or exercise. They live with the oppressive feeling of impending death and the overwhelming frustration of not being able to make their loved ones better.

NCEA reports that the rate of depression for caregivers of non-demented patients is 35.2 percent, which is twice that of the general public. Among dementia caregivers, the rate is 43 to 46 percent. The Caregiver Health Effects Study[1] revealed the shocking finding that, of caregivers who experienced the greatest levels of stress, were 63 percent more likely to die within the next 4 years than non-caregivers. The use of Adult Day Care can reduce caregiver stress and improve the quality of life for the patient.

Elder Rage

Caregiving is challenging in the best of circumstances, but when a patient becomes aggressive and difficult to manage, the caregiver has yet another level of frustration to cope with. One study from Columbia University in 1997 found that agitation occurred in 40 to 60 percent of demented patients and aggression from 5 to 20 percent. Since there are nearly 5 million people diagnosed with Alzheimer's Disease, only one debilitating illness, and 7 out of 10 are being cared for at home, is it any surprise that elder abuse can occur when an overstressed caregiver reaches the limit with a challenging elder? People, who would never have dreamed of crossing the line are finding themselves lashing out in utter frustration.

NCEA reports that 20 percent of caregivers live in fear that they will become violent themselves, and this rate increases to 57 percent among caregivers who have experienced violence from those they now care for.[2] The researchers concluded that violence by the care receivers could move persons, who are normally fearful of becoming violent, to actually commit violent acts.

Denial of Early Stage Dementia is Costly

Compounding the problem is the fact that most people are in denial about eldercare and dementia until they are in a crisis. They don't realize that with the proper treatments and medication such as Aricept, Exelon or Reminyl, dementia symptoms might be masked and slowed down by 2-5 years. This keeps a person independent and in Stage One longer, which is intermittent and mild.

Also misunderstood is the fact that Alzheimer's is typically preceded by Mild Cognitive Impairment (MCI), which can last 5-10 years. Ninety percent of these patients will then progress to Stage One Alzheimer's, which lasts 2-4 years. Stage Two requires full-time care and lasts 2-10 years, while Stage Three, the end, lasts 1-3 years. Unfortunately, most of the time, professionals don't get the call until after a crisis — by then the loved one has often irreversibly progressed to Stage Two.

Seeking help early from a geriatric dementia specialist can save families a lot of heartache and money, while saving our society the burden of caring for so many elders who decline sooner than need be. Statistically families (and many doctors who are not dementia specialists) ignore the early warning signs, because they incorrectly believe that these intermittently odd behaviors are just a normal part of aging and untreatable senility. It is a costly mistake in every regard.

The Alzheimer's Association reports that by delaying the onset of AD in individuals for five years, we could save $50 billion in annual health care costs. Even a one-month delay in nursing home placement could save $1 billion a year.

The bottom line is that when caregivers have fewer difficult behaviors to cope with, elder abuse will be drastically reduced. Early diagnosis and education is the key.

Solutions

- Professionals need to learn the early warning signs of dementia and be open to referring their patients to geriatric dementia specialists for early diagnosis.
- National education, media awareness and community support to teach caregivers how to cope with the challenges of caregiving.
- Family doctors and therapists should screen for caregiver burnout when working with individuals and families in order to immediately address any problems.
- Eldercare workers should be required to undergo criminal background checks.
- Encourage the reporting of suspected cases of elder abuse.
- Help caregivers cope via support groups, both physical and online.
- Help caregivers manage their stress through respite care.
- Refer to the National Center on Elder Abuse (www.ElderAbuseCenter.org) for assistance, data, publications and answers to questions concerning elder abuse.▼

The bottom line is that when caregivers have fewer difficult behaviors to cope with, elder abuse will be drastically reduced.

Ten Warning Signs of Alzheimer's

• Recent memory loss that affects job skills • Difficulty performing familiar tasks • Problems with language • Disorientation of time and place • Poor or decreased judgment • Problems with abstract thinking • Misplacing things • Changes in mood or behavior • Changes in personality • Loss of initiative

Jacqueline Marcell *is the author of* Elder Rage, or Take My Father... Please! How To Survive Caring For Aging Parents, *a self-help work of non-fiction that is required reading for several university graduate psychology programs and is endorsed by the Duke University Center for Aging, the Johns Hopkins Memory Clinic, the National Adult Day Services Association and celebrities such as Hugh Downs, Regis Philbin and Art Linkletter. Her book talks of a serious subject with a humorous tone — teaching families and physicians how to manage "Jekyll and Hyde" patients. Ms. Marcell lectures nationally on the effective management, both medical and behavioral, of challenging elders who resist care. Her radio show, "Coping with Caregiving," (www.wsradio.com/copingwithcaregiving) is an uplifting resource for anyone tackling the challenges of caregiving, including those who think it will never happen to them.* Elder Rage *can be purchased online at www.elderrage.com or by calling Impressive Press at (949) 975-1012.*

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Continued from page 13

may have been a so-called "vanity fire," set to allow the firefighter to act heroically. Whatever the motivation, Terry Barton faces more than a decade behind bars, and her case provides a sumptuous feast for theorists in mental health.

... "all too frequent failure to prosecute psychiatric patients when prosecution could in fact be an important part of the patients' ongoing care."

Publicizing Barton's story may unintentionally help women firesetters. Rather than spending time exploring fire setting dynamics in long-term psychotherapy, the professional community must make it clear that fire setting behavior simply will not be tolerated. This author agrees with Dr. Ann Barker, a noted forensic psychiatrist, who insists that there is an "all too frequent failure to prosecute psychiatric patients when prosecution could in fact be an important part of the patients' ongoing care."

It is time to remove the assurance that firesetters with a psychiatric diagnosis will not be held culpable. Violet said, "I still feel like setting fires, even at the age of 31, after spending ten years in prison. Being outside of a structured setting makes me crave my drug, which is fire. I tend to do better inside than out. I still feel lost in society, but I am being treated by people who really don't know what they are doing. They want me to talk about my feelings and my childhood. But I need to be told I better not burn stuff, or else."

Three steps need to be taken towards resolving the problems posed by female firesetters:

- Establishment of an appropriate continuum of legal consequences in every jurisdiction
- Thorough assessment of a female firesetter's mental status and treatment needs, e.g. anger management, social skill building, etc.
- A multidisciplinary (judicial, fire service, mental health) decision in every case as to what consequences to impose, with no exonerations for psychiatric diagnosis

If these measures fail, we have no choice but to incarcerate the female firesetter, to protect her from herself, and the community from her.▼

Possible Behavioral Indicators:

- ***Victimization or trauma***
- ***Poor impulse control***
- ***Self-harm***
- ***Deficient coping skills***
- ***Inept socialization***
- ***Unusual candor regarding destructive behavior***
- ***Family history of firesetting***
- ***Substance abuse***
- ***Impaired self-esteem***

NOTE: An indirect but open inquiry to women such as "Do you engage in any dangerous activity?" Readily and almost always elicits information about firesetting.

Dr. Karen L. Gold, *a native of Baltimore, Maryland, is a clinical and forensic psychologist educated at the University of Maryland, Loyola College, the University of Louisville, Baylor University and the University of Texas Medical Branch in San Antonio. She has a varied professional background as a teacher, counselor, administrator, diagnostician, college lecturer, public speaker, forensic examiner, trial consultant, mediator and psychologist.*

Dr. Gold lives in El Paso, Texas and is an active member of the community. She serves on numerous boards and consults frequently with entities such as the Sheriff's Department, Adult Probation, the Fire Department and the Family Law Courts. She has worked with female firesetters from preschool age to elderly since 1983, and is also a published author of professional articles on a variety of topics. You may contact Dr. Gold by email at goldkl@aol.com.

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ILLINOIS INSTITUTE FOR ADDICTION RECOVERY 2003 TRAINING AND WORKSHOP SCHEDULE

Problem and Compulsive Gambling

Presented by the Staff of the Illinois Institute for Addiction Recovery. This training will consist of a 30-hour course delivered throughout a five-day series. It will provide participants with the requisite knowledge for the State of Illinois written certification exam for counselors of problem and complsive gambling. At the end of this workshop, participants will have developed a strong clinical base for compulsive gambling issues as well as cultural competencies and client-centered treatment for compulsive gamblers and their families. Please call for additional information and training dates.

2003 Program Workshops

August 21 and August 22, 2003

Topic: **Critical Incident, Stress, Trauma and Crisis**
Registraton deadline: July 18
Gerald Lewis, Ph.D.

The CDC estimated that there are more than 10 million work-related injuries and 7,000 trauma-related deaths each year. The emotional, financial and organizational impact of accidents, deaths, robberies, lay-offs and other crises is far reaching. The workshop will cover, and expand beyond the concept of Critical Incident Stress as it relates to Emergency Services Personnel. It will discuss policies, procedures, and programs for the management of trauma/crisis in the workplace and community and clarify appropriate responses and interventions for dealing with such issues. This will be a participatory training experience for mental health/addiction, EAP, clergy, public safety, education and human resource personnel.

About the speaker
Gerald W. Lewis received his Doctorate in Clinical Psychology and has been practicing in the Boston area since 1977. He is the director of COMPASS which provides employee assistance programs, consultation services and training programs. Dr. Lewis has authored two books and several articles on crisis response in the workplace and is an international speaker and trainer.

November 21, 2003

Topic: **Co-occurring Psychiatric and Substance Use Disorders: Assessment, Diagnosis and Treatment**
Seth Eisenberg M.D.

Co-occurring psychiatric and substance use disorders are common in most settings that provide behavioral healthcare services. Being able to accurately assess symptoms and discern a differential diagnosis is essential to effective treatment. This workshop will review the challenges of assessment and diagnosis for this population and discuss various treatment approaches most effective for the dually diagnosed patient.

About the speaker
Dr. Eisenberg is the Medical Director of the Illinois Office of Alcoholism and Substance Abuse and Director of the Addiction Psychiatry Residency Training program at Northwestern University Medical School. He provides clinical psychiatric outpatient services for the Midwest Physicians group in Orland Park, Illinois. Dr. Eisenberg is a licensed psychiatrist who has over 20 years experience with adult psychiatry, child and adolescent psychiatry and addiction medicine.

Registration and CEU Information

CEU credits have been requested through the Illinois Department of Professional regulation for social workers and LPC/LCPC, IAODAPCA, EAPA, and the National Council on Problem Gambling.

Registration deadline is one week prior to the workshop. (with the exception of the August workshop)

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

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5409 N. Knoxville Ave.
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If you have questions regarding addictions, call 1 (800) 522-3784, or write to Eric Zehr at Proctor Hospital, 5409 N. Knoxville Ave., Peoria, IL 61614.
On the Internet, contact: Eric.Zehr@Proctor.org
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