

Sex and Love Addiction

Yes, love and sex can be addictive—and as destructive, at least socially, as compulsive substance use. The high hinges on physical or psychological arousal, and relationships can be marked by desperation. Successful treatment begins with stress management.

Love addicts go through life with desperate hopes and constant fears. Fearing rejection, pain, unfamiliar experiences, and having little faith in their ability or right to inspire love, they wait and wish for love, perhaps their least familiar real experience.

Addictive sexuality is like most other compulsive behaviors: a destructive twist on a normal life-enhancing activity. Defining sex addiction depends less on the behavior itself than on the person's motivation.

Sex addicts lack the ability to control or postpone sexual feelings and actions, with the need for arousal often replacing the need for intimacy. Eventually, thrill seeking becomes more important than family, career, even personal health and safety.

The sex addict follows a routine or ritual leading to acting out on desires, and is then fraught by feelings of denial then shame, despair, and confusion.

Addiction is characterized by the repeated, compulsive seeking or use of a substance or activity despite negative social, psychological and/or physical consequences. It is often (but not always) accompanied by physical dependence, withdrawal syndrome and tolerance.

Withdrawal consists of a predictable group of signs resulting from abrupt removal of, or a rapid decrease in the dosage of, a psychoactive substance or activity. The syndrome is often characterized by overactivity of the physiologic functions that were suppressed by the drug and/or depression of the functions that were stimulated by the object of addiction.

Tolerance is a state in which a drug or activity produces a diminishing response. That is to say, higher doses (or in the case of sex addicts, riskier behavior) is needed to produce the same effect that the user experienced.

Alcohol Abuse

You know a person is abusing alcohol when life at work and at home is seriously disrupted. It's a chronic disease that hits younger adults more prevalently than older ones.

Alcohol abuse is defined as a pattern of drinking that results in one or more of the following situations within a 12-month period:

- Failure to fulfill major work, school, or home responsibilities
- Drinking in situations that are physically dangerous, such as while driving a car or operating machinery
- Having recurring alcohol-related legal problems, such as being arrested for driving under the influence of alcohol or for physically hurting someone while drunk
- Continued drinking despite having ongoing relationship problems that are caused or worsened by the drinking

Alcoholism, or alcohol dependence, is the most severe form of alcohol abuse. It is a chronic disease characterized by the consumption of alcohol at a level that interferes with physical and mental health and with family and social responsibilities. An alcoholic will continue to drink despite serious health, family, or legal problems.

Alcoholism is influenced by both genetic and environmental factors. Alcoholism is chronic: It lasts a person's lifetime. It usually follows a predictable course and has recognizable symptoms.

Alcohol abuse and alcoholism cut across gender, race, and ethnicity. Nearly 14 million people in the United States are dependent on alcohol. More men than women are alcohol dependent or have alcohol problems. Alcohol problems are highest among young adults ages 18-29 and lowest among adults ages 65 and older. Also, people who start drinking at an early age have a greater chance of developing alcohol problems at some point in their lives

Alcohol's effects vary with age. Slower reaction times, problems with hearing and seeing, and a lower tolerance to alcohol's effects put older people at higher risk for falls, car crashes, and other types of injuries that may result from drinking. More than 150 medications interact harmfully with alcohol.

Alcohol also affects women differently than men. Women become more impaired than men do after drinking the same amount of alcohol, even when differences in body weight are taken into account. In addition, chronic alcohol abuse takes a heavier physical toll on women than on men. Alcohol dependence and related medical problems, such as brain, heart, and liver damage, progress more rapidly in women.

Co-Occurring Disorders

Formerly known as dual diagnosis or dual disorder, co-occurring disorders describe the presence of two or more disorders at the same time. For example, a person may suffer substance abuse as well as bipolar disorder.

Just as the field of treatment for substance use and mental disorders has evolved to become more precise, so too has the terminology used to describe people with both substance use and mental disorders. The term co-occurring disorders replaces the terms dual disorder or dual diagnosis. These latter terms, though used commonly to refer to the combination of substance use and mental disorders, are confusing in that they also refer to other combinations of disorders (such as mental disorders and mental retardation).

Furthermore, the terms suggest that there are only two disorders occurring at the same time, when in fact there may be more. Clients with co-occurring disorders (COD) have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder.

Although co-occurring disorder is the most current term used professionally, for the purposes of this article, dual disorders will be used interchangeably.

The acronym MICA, which represents the phrase Mentally Ill Chemical Abusers, is occasionally used to designate people who have a COD and a markedly severe and persistent mental disorder such as schizophrenia or bipolar disorder. A preferred definition is mentally ill chemically affected people, since the word affected better describes their condition and is not pejorative. Other

acronyms include: MISA (mentally ill substance abusers), CAMI (chemical abuse and mental illness), SAMI (substance abuse and mental illness), MISU (mentally ill substance using), MICD (mentally ill chemically dependent) and ICOPSD (individuals with co-occurring psychiatric and substance disorders).

Common examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and polydrug addiction with schizophrenia, and borderline personality disorder with episodic polydrug abuse. Although the focus of this is on dual disorders, some patients have more than two disorders. The principles that apply to dual disorders generally apply also to multiple disorders.

The combinations of COD problems and psychiatric disorders vary along important dimensions, such as severity, chronicity, disability, and degree of impairment in functioning. For example, the two disorders may each be severe or mild, or one may be more severe than the other. Indeed, the severity of both disorders may change over time. Levels of disability and impairment in functioning may also vary.

Thus, there is no single combination of dual disorders; in fact, there is great variability among them. However, patients with similar combinations of dual disorders are often encountered in certain treatment settings.

More than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs).

Compared to patients who have a mental health disorder or a COD use problem alone, patients with dual disorders often experience more severe and chronic medical, social, and emotional problems. Because they have two disorders, they are vulnerable to both COD relapse and a worsening of the psychiatric disorder. Further, addiction relapse often leads to psychiatric decompensation, and worsening of psychiatric problems often leads to addiction relapse. Thus, relapse prevention must be specially designed for patients with dual disorders. Compared with patients who have a single disorder, patients with dual disorders often require longer treatment, have more crises, and progress more gradually in treatment.

Psychiatric disorders most prevalent among dually diagnosed patients include mood disorders, anxiety disorders, personality disorders, and psychotic disorders.

Depressive Disorders

A depressive disorder is an illness that involves the body, mood, and thoughts. It interferes with daily life, normal functioning, and causes pain for both the person with the disorder and those who care about him or her.

A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years. Depression is a common but serious illness, and most people who experience it need treatment to get better. Appropriate treatment, however, can help most people who suffer from depression.

Depressive disorders come in different forms, just as is the case with other illnesses such as heart disease. Three of the most common types of depressive disorders are described here. However, within these types there are variations in the number of symptoms as well as their severity and persistence.

Major depression is manifested by a combination of symptoms (see symptom list) that interfere with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. Such a disabling episode of depression may occur only once but more commonly occurs several times in a lifetime.

Dysthymic disorder, also called dysthymia, involves long-term (two years or longer) less severe symptoms that do not disable, but keep one from functioning normally or from feeling good. Many people with dysthymia also experience major depressive episodes at some time in their lives.

Some forms of depressive disorder exhibit slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression. They include:

Psychotic depression, which occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality, hallucinations, and delusions.

Postpartum depression, which is diagnosed if a new mother develops a major depressive episode within one month after delivery. It is estimated that 10 to 15 percent of women experience postpartum depression after giving birth.

Seasonal affective disorder (SAD), which is characterized by the onset of a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy.

Bipolar disorder, also called manic-depressive illness is not as prevalent as major depression or dysthymia, and characterized by cycling mood changes: severe highs (mania) and lows (depression).

Not everyone who is depressed or manic experiences every symptom. Some people experience a few symptoms, some many. Severity of symptoms varies with individuals and also varies over time.

- Persistent sad, anxious, or empty mood
- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness, or helplessness
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- Decreased energy, fatigue, being "slowed down"
- Difficulty concentrating, remembering, or making decisions
- Insomnia, early morning awakening or oversleeping
- Appetite and/or weight loss, or overeating and weight gain
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability

Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders and chronic pain

Eating Disorders

The three major eating disorders—anorexia, or voluntary starvation; bulimia, marked by bouts of bingeing followed by compensatory behavior such as purging; and binge-eating, marked by episodes of out-of control gorging—are common but complex conditions and often accompanied by depression and perfectionism.

Eating disorders happen as a result of severe disturbances in eating behavior, such as unhealthy reduction of food intake or extreme overeating. These patterns can be caused by feelings of distress or concern about body shape or weight and they harm normal body composition and function. A person with an eating disorder may have started out just eating smaller or larger amounts of food than usual, but at some point, the urge to eat less or more spirals out of control.

Eating disorders are very complex, and despite scientific research to understand them, the biological, behavioral and social underpinnings of these illnesses remain elusive. Eating disorders frequently develop during adolescence or early adulthood, but some reports indicate their onset can occur during childhood or later in adulthood. Many adolescents are able to hide these behaviors from their family for months or years.

Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable medical illnesses in which certain maladaptive patterns of eating take on a life of their own. The main types of eating disorders are anorexia nervosa and bulimia nervosa. A person with anorexia nervosa starves himself or herself to be thin, experiencing extreme weight-loss. An estimated .5 to 3.7 percent of females suffer from anorexia nervosa in their lifetime. Bulimia nervosa is binge eating followed by purging (vomiting). An estimated 1.1 percent to 4.2 percent of females have bulimia nervosa in their lifetime. A third disorder, binge-eating disorder, is characterized by frequent episodes of out-of-control eating. A cycle develops due to feelings of shame and disgust caused by obesity brought on by the overeating and leading to bingeing again. Community surveys have estimated that between 2 percent and 5 percent of Americans experience binge-eating disorder in a six-month period. This illness has only been suggested but has not yet been approved as a formal psychiatric diagnosis.

Eating disorders frequently occur together with other psychiatric illness such as depression, substance abuse, or anxiety disorders. In addition, people who suffer from eating disorders can experience a wide range of physical health complications, including serious heart conditions and kidney failure, which may lead to death. Recognition of eating disorders as real and treatable diseases, therefore, is critically important.

Females are much more likely than males to develop an eating disorder. Only an estimated 5 to 15 percent of people with anorexia or bulimia and an estimated 35 percent of those with binge-eating disorders are male.

Generalized Anxiety Disorder

Extreme, unfounded worry that can interfere with sleep is usually accompanied by body symptoms ranging from tiredness to headaches to nausea. Treatment with antidepressants or other medications and psychotherapy, alone or combined, may alleviate the condition.

Generalized anxiety disorder (GAD) is much more than the normal anxiety people experience day to day. Without provoking, it is chronic and exaggerated worry and tension. This disorder involves anticipating disaster, often worrying excessively about health, money, family or work. Sometimes, though, just the thought of getting through the day brings on anxiety.

People with GAD can't shake their concerns, even though they usually realize that much of their anxiety is unwarranted. People with GAD also seem unable to relax and often have trouble falling or staying asleep. Their worries are accompanied by physical symptoms, especially trembling, twitching, muscle tension, headaches, irritability, sweating, hot flashes and feeling lightheaded or out of breath.

Many individuals with GAD startle more easily than other people. They tend to feel tired, have trouble concentrating and may suffer from depression. GAD may involve nausea, frequent trips to the bathroom or feeling like there is a lump in the throat.

When their anxiety level is mild, people with GAD can function socially and hold down a job. Although they don't avoid certain situations as a result of their disorder, people with GAD can have difficulty carrying out the simplest daily activities if their anxiety is severe.

GAD affects about 6.8 million American adults, including twice as many women as men. The disorder develops gradually and can begin at any point in the life cycle but usually develops between childhood and middle age. There is evidence that genes play a modest role in GAD.

Other anxiety disorders, depression, or substance abuse often accompany GAD, which rarely occurs alone. GAD is commonly treated with medication or cognitive-behavioral therapy, but co-occurring conditions must also be treated using the appropriate therapies.

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