CHAPTER THREE

The "Addictions Shuffle"

Other Chemical and Behavioral Addictions

The addict, including the self-injurer, may keep running from one temporary fix to another, be it alcohol, drugs, or some other self-destructive behavior. Addiction substitution is more common than not, particularly when the recovering alcoholic or addict begins to face the difficult emotions that were previously suppressed. The initial impulse is to run away, once again.

Often, people who are in early recovery start using another chemical or behavioral substitute, typically one which they perceive to be "not as bad." For example: "I only drink beer now, not hard liquor," or "I only smoke marijuana now; I don't do real drugs," or "I don't use razor blades anymore; that was too dangerous. Now I only use my fingernails or car keys." The goal of escaping or getting high is still the same. Shuffling from one addiction to another, along with the process of denial or trying to justify continuing destructive behavior, functions only to keep people locked in an addictive cycle.

Many self-injurers have problems with alcohol and/or drugs. Even if they are not using right now, it is likely that they have in the past and are definitely at risk in the future.

There is an even higher correlation between self-injury and eating disorders, which many describe as behavioral addictions. Eating disorders include anorexia, bulimia, and compulsive overeating/obesity.

Self-injurers and other addicts are also vulnerable to other unhealthy behavioral addictions. Some of the more common ones include compulsive exercise; sexual addictions (including compulsive Internet sexual behavior); compulsive shopping, debting, and spending; workaholism; and codependency and addictive relationships.

Alcohol, Drugs, and Self-Injury

Favazza and Conterio (1989), in their study of 240 female habitual self-mutilators, found that 28 percent reported that they are concerned about their drinking; 18 percent consider themselves alcoholics; and 30 percent have used street drugs (mainly marijuana, "speed," cocaine, and "downers"). Forty-one percent of respondents reported that their self-mutilative behavior occurs while under the influence of alcohol or drugs: sometimes (26 percent), often (12 percent), and always (3 percent). Seventy-one percent consider their self-mutilative behavior to be an addiction.

Researchers Zlotnick et al. (1997) assessed 85 substance-abusing and substance-dependent inpatients who had histories of distressing traumatic events versus those who did not. Traumatic events included natural and man-made disaster; physical or sexual assault; rape; witnessing family physical violence; serious accident; robbed/mugged/physically attacked. The patients who had experienced traumatic events reported (1) more self-mutilative acts, (2) higher levels of dissociation, and (3) a greater degree of impulsivity than did patients without such histories. Impulsive behavior was defined as "any act that disregarded the action's long-

term negative effects" and include behaviors such as binge eating, shoplifting, sexual disinhibition, and gambling. (By this definition, impulsive behavior can also include substance abuse/dependence and self-mutilative acts. However, for the purposes of their research, the authors used these categories for comparative purposes.)

In a study of data collected from hospital records of children and adolescent self-mutilators (age five to nineteen years old) in a psychiatric hospital setting, Simpson and Porter (1981) found that "many subjects compulsively ate, abused alcohol and drugs, and sliced, burned, or pulled hair from their bodies." Most of these children and adolescents had a history of physical and/or sexual abuse by family members. The authors state in conclusion, "It is suggested that self-mutilation may be a plausible and effective, if somewhat sensational, defense that is designed to handle stress by reducing painful emotional trauma."

Friedman (1989) found in his study of adolescents in the United Kingdom that those who had come from an unhealthy or inadequate environment *and* were lacking in self-esteem were more likely to develop behaviors that were dangerous to their health. These include "precocious and unprotected sexual behavior; the use of tobacco, alcohol, and other drugs; injuries arising accidentally from risk-taking behaviors, especially when combined with alcohol or drugs; intentional injury whether self-inflicted or inflicted by others; and poor eating and habits of hygiene." The responsibility for making positive choices, for health-enhancing behaviors, ultimately lies with the adolescents.

Thus, we see that self-injury very often happens concurrently with alcohol and/or substance abuse, as well as along with other maladaptive, and especially impulsive, behaviors. Self-injury while "under the influence" is extremely dangerous; like drunk driving. The self-injurer may get more

than she bargained for, getting into an "accident" with her self-injury, which although unintentional, can result in her death. Like a drunken race-car driver, she could easily crash and burn.

The authors Zlotnick et al. state that it is important for those treating patients with substance abuse to know whether dissociation, impulsivity, and self-mutilative behavior are a reaction to trauma or a result of substance abuse. Research about cause and effect is surprisingly lacking. All of these areas should be appropriately addressed in treatment. For instance, the alcoholic self-injurer absolutely must address both her alcoholism and her self-injury addiction. Although one of these may presently be more life threatening, the other can soon take its place. When she is ready to deal with her emotions from the trauma of the past, she needs to move forward with this. However, she must at all times keep her addictions in check, maintain abstinence, and be aware of the potential for *addiction substitution.*

Sandra, a brilliant girl in her early twenties who dropped out of her Ivy League law school on the East Coast because she could not keep up, was found by the police lying down on a park bench in the snow. She was rushed to the hospital, this time with cardiac arrhythmia brought on by her bulimic episodes. With medical monitoring and intensive outpatient therapy, which addressed her depression, mania, borderline personality disorder (with some episodes of self-mutilation), and numerous issues with trauma and sexuality due to having been sexually abused as a child and then raped as a young adult, Sandra improved significantly. Her bulimia was well under control—but she was soon brought into the hospital emergency room again, after being found by the police on a park bench, this time passed out from an overdose of prescription drugs and alcohol. Her consulting psychiatrist, who was initially not aware of the severity of

her alcohol and drug problems, made the referral to Alcoholics Anonymous. Sandra began attending AA meetings on a daily basis and continued with her intensive outpatient therapy for trauma as well as with medical follow-up as required. All of this contributed greatly to her recovery.

Eating Disorders and Self-Injury

Self-injurers are at high risk for eating disorders (anorexia nervosa, bulimia nervosa, and obesity/compulsive overeating), and vice versa. According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV* edition, American Psychiatric Association 1994), eating disorders are characterized by severe disturbances in eating behavior. There are two specific diagnoses: anorexia nervosa and bulimia nervosa. The majority of anorexics and bulimics are female, and most symptoms start during adolescence.

Anorexia nervosa is characterized by a refusal to maintain a normal body weight (less than 85 percent of that which is expected for one's height and weight) or a refusal to make expected weight gain during a period of growth (especially during puberty), which results in a weight that is less than 85 percent of that which is expected. Although underweight, the anorexic has a distorted sense of body image and sees herself as "fat." The anorexic has an intense fear of gaining weight and typically is in denial of the seriousness of her deteriorating physical condition, no matter what other people say (including doctors). Menstrual periods are absent (amenorrhea) due to the effects of her physical disease.

There are two types of anorexia: *binge-eating/purging type,* in which one regularly goes on eating binges (eating massive amounts of food) and then either throws up or uses laxatives, diuretics, or enemas to get rid of the food; and

restricting type, in which one does *not* regularly engage in binge-eating or purging behaviors. Many anorexics also engage in compulsive strenuous physical exercise, sometimes to the point of injury or exhaustion, as an attempt to promote weight loss.

Bulimia nervosa is when one engages in repeated episodes of binge-eating, followed by inappropriate behaviors to try to get rid of the food and thus prevent unwanted weight gain. Such inappropriate behaviors to compensate may include throwing up, using laxatives, diuretics, or enemas; or fasting; or excessive exercise. There is a sense of "going out of control" with eating during an episode, usually followed by extreme feelings of depression, guilt, and worthlessness. To meet the *DSM-IV* diagnostic criteria, the food binges and compensating behaviors must both occur on the average of at least twice a week for three months.

However, as a clinician, I have known of teens and young adult women who would force themselves to vomit several times in one day, as many as three to eight times, every day. Debbie, an attractive, friendly sixteen-year-old girl of average weight with a nice figure, was one of them. She did not consider herself pretty, although everyone else did. She "looked good," so much so that when admitted to a hospital inpatient eating disorders unit for adolescents, a nurse commented, "What's she doing here? She seems like a normal, healthy teenager!" Although Debbie appeared to excel rapidly in the hospital's treatment program, as she did with school, sports, and other activities, no real progress in recovery had been made.

Until . . . one day a hospital counselor found Debbie collapsed on the bathroom floor after dinner, in a state of medical emergency. Somehow, Debbie managed to continue to hide her numerous bulimic episodes, which she finally admitted to staff had been occurring two or three times a day

(usually after meals), even while in the hospital. On being found by the counselor, she commented: "I didn't lock the door 'cause I wanted someone to find me. It's better if somebody comes in, like you did."

Debbie eventually completed the hospital treatment program and returned home to her parents, who both faithfully participated in family therapy during her hospital stay. She continued treatment for her eating disorder in outpatient therapy in her hometown, with the continued dedication and support of her family.

For the bulimic, feelings of self-worth are unduly influenced by body shape and weight. Bulimics are typically not underweight, and they do not meet the criteria for anorexia—their weight is usually at, or somewhat above, average.

The *purging type* bulimic regularly engages in self-induced vomiting or the misuse of laxatives, diuretics, or enemas. The *nonpurging type* bulimic does not do these things, but instead uses other inappropriate behaviors to prevent weight gain, such as fasting or excessive exercise.

Obesity or *compulsive overeating* are not in the *DSM-IV* because it has not been established that these are consistently associated with a psychological or behavioral syndrome. However, simple obesity is included in the *International Classification of Diseases (ICD)* as a general medical condition. Obesity and compulsive overeating have been discussed extensively in the clinical literature in terms of having psychological factors, especially regarding what the causes are.

A common point of view is that some people use food and overeating as a way to escape from their difficult or uncomfortable emotions. The focus is on food instead, which can become an obsession, or even an addiction, that overshadows one's thoughts and feelings. There are Twelve Step

groups such as Overeaters Anonymous (OA) for compulsive overeaters to deal with their food problems, like Alcoholics Anonymous is for alcoholics to deal with alcohol problems. Many times anorexics and bulimics also attend Overeaters Anonymous meetings, because their "drug of choice" also happens to be food. There are even OA meetings with specific focus on anorexia and bulimia, as these are considered the "flip side" of the same disorder.

The psychological and medical literature over the years frequently mentions the coexistence of self-mutilation and eating disorders. The literature mostly focuses on anorexia and self-injury and bulimia and self-injury.

In the 1989 study of 240 female habitual self-mutilators (ages fourteen to seventy-one), researchers Favazza and Conterio found that eating disorders were reported by 61 percent of the subjects surveyed.

In a 2000 study of 236 patients from an outpatient eating disorders unit, consisting of patients with restricting anorexia and binge-eating/purging anorexia and bulimia, researchers Favaro and Santonastaso found a very high frequency of self-injurious behaviors. These behaviors included skin cutting/burning; suicide attempts; substance/alcohol abuse; hair pulling; and severe nail biting. "Any" of the aforementioned forms of self-injury was reported by 59 to 76 percent of the patients. Skin cutting/burning was reported by 13 to 27 percent of patients; hair pulling by 31 to 44 percent of patients; and severe nail biting by 31 to 50 percent of patients.

Reasons Why: Eating Disorders

A person can become caught in an addictive cycle with anorexia, bulimia, or compulsive overeating/obesity for a number of different reasons. Developing an obsession with

food and with one's physical body in order to suppress difficult emotions is primary.

Teenagers and young women who already have low self-esteem and perfectionist strivings are especially vulnerable to buying into what is supposed to be beautiful and fashionable, according to what is portrayed in the media and in society. Models in fashion magazines as well as movie stars are often too thin for their own good, to the point of being physically unhealthy. There is a major focus in society on losing weight and being thin, especially in terms of the rampant advertising for weight-loss centers, health spas and exercise clubs, faddish diets, and low-calorie diet foods. One study showed that 60 to 70 percent of American women are on some sort of a diet at any given time.

Control issues are another big reason, especially in anorexia. Sometimes a bright, accommodating teenager, for example, feels trapped by other people's expectations and thus seeks to define her individuality and independence. She therefore seizes control of the one thing she can that is uniquely hers—her own physical body. The more people criticize her about her eating habits and express concern and distress over her deteriorating physical condition, the greater her sense of autonomy and achievement. It's a feeling of power.

As a clinician, I have also seen very young children go on "hunger strikes," refusing to eat or being extremely finicky about what they will and won't eat, oftentimes sending their parents into a frantic tailspin. In each of three cases that come to mind (all girls, ages five, six, and eight), the children were extremely angry and felt that they had no control over, or were entrapped by, some horrible event or situation that occurred in their young lives. (Janie, the five-year-old, was temporarily taken away from her mother and put into the foster care system when her mother made a

suicide attempt and was placed in a mental institution. Julie, a six-year-old from Taiwan, had already endured several surgeries in her young life and was on an extended trip to America with her grandmother and aunt to see a world-famous neurosurgeon. Ling, the eight-year-old, had come over to America from Cambodia with relatives after her father had been shot. At the time of his death, she was holding his hand.) Two of the girls were also selectively mute (they could talk, but refused to talk to anyone—even family members). One thing that each of these children had in common was a shy but mischievous smile (as if to say, "Good, it worked!") when their mothers, teachers at school, and other concerned adults became frantic and at their wit's end when trying to get their child to eat.

One alternative explanation for anorexia is that the anorexic feels threatened by the process of physical maturation. The biological and physical changes, including menstruation and the surfacing of sexual feelings, are frightening. She strives to avoid it. By merciless dieting, the anorexic ensures a preadolescent figure. She prefers to remain childlike, or even utterly unappealing, to potential romantic suitors. Oftentimes, anorexic and compulsive overeater/obese women who were physically or sexually abused in childhood attempt to take control of the appearance of their physical bodies, trying to make them unattractive as a protection against further abuse.

There are similar biophysiological processes that connect anorexia, bulimia, self-injury, and other addictions. Although it is not the effect that is initially sought after, at least on a conscious level, anorexics, bulimics, and self-injurers eventually come to discover remarkable fringe benefits to their self-destructive behavior as their condition worsens to the point of becoming an addiction. These might include getting high and emotional escape. Bulimics often

describe a "high" that comes on with repetitive vomiting, as do self-injurers with repetitive episodes of cutting and burning. This is due to a release of endorphins, as well as feeling a sense of profound psychological relief. Anorexics, and particularly those who engage in compulsive exercise, often describe feelings of high energy, increased physical and mental well-being, and feeling high. "The manic pursuit of exercise and creating a lean, taut body, so commonly seen among restrictor anorexic patients, purveys a sense of freedom, of invincibility, of physical lightness—almost like flying" (Cross 1993).

In a writing exercise that all clinical and medical staff members were required to do and share with each other during initial staff training before coming to work on an adolescent eating disorders unit (most of us had recovered from some sort of eating disorder), I described my battle with and successful recovery from anorexia nervosa as a teenager. I was twenty-eight years old, in graduate school, and working at the time.

I wrote: "I did go on eating binges, but not very often. My main thing was starving—i.e., having 'competitions' with myself to see how long I could go without food, which would last sometimes for several days. What I did seem to strive for with the starvation trip was going into different (non-chemically induced) mind states. After not eating for long periods of time, strange things happened, like getting an extreme 'high' or 'rush.' A lot of this was brought on in conjunction with extremely strenuous non-stop exercise. But the feeling I liked best was 'blanking out,' just going away and feeling nothing. I lived for it."

Self-injury brought on the exact same feelings and occurred very often between the ages of eleven and fifteen when I was struggling with anorexia. Self-injury seemed to intensify the feelings of high and escape brought on by the

eating disorder, and vice versa. For me, the self-injury was ultimately much harder to give up, probably because I got away with it for so long. It was easy enough to hide the scars on my arms by wearing long sleeves all the time.

What's the Connection?

A number of similarities exist between eating disorders and self-injury. First of all, both disorders most frequently occur in females (although they do occur in males, who typically have more severe cases), beginning during adolescence. Both eating disorders and delicate self-mutilation symptoms have an "emotionally cathartic, self-purifying function in that they modulate states of anxiety, sexual tension, anger or dissociated emptiness, and they bring about a tremendous quasi-physical sense of relief" (Cross 1993).

Both those with eating disorders, particularly anorexia, and those who self-injure have intense control issues—wanting and attempting to be in control of their own bodies, minds, rights as a person, and life in general. Many have "perfectionist" strivings. One severely anorexic teenage patient who was an A student in school, captain of her cheerleading team, and exceptionally beautiful stated, "I'm not really that good in anything, so at least I can be good at anorexia."

Those with eating disorders (including anorexia, bulimia, and obesity/compulsive overeating) and those who self-injure often have a history of abuse in childhood. Most often it is child sexual abuse, including incest. This is especially true when both an eating disorder and self-injury are present, which may occur simultaneously or at different times. Those with eating disorders and those who self-injure tend to come from dysfunctional, if not horrendous, family backgrounds. Anorexics and self-injurers tend to have alcoholic

fathers and mothers who are absent or at least emotionally distant, have emotional problems, or have a high number of psychosomatic complaints. Bulimics often have mothers who are unhealthily overweight or obese. Self-injurers and those with eating disorders, especially anorexia and bulimia, have a high occurrence of alcohol and/or drug addiction, as well as other behavioral addictions, and problems with interpersonal relationships.

Issues with sexuality are typically present and oftentimes seriously problematic. This usually results from having been abused as a child, particularly if one was sexually abused by a trusted adult. The subsequent fear of being controlled or "attacked" by another person, albeit on a subconscious level, takes over. The feelings that are especially hard for self-injurers and those with anorexia to tolerate are

1. dependency
2. anger
3. sexual arousal
4. mixed messages from other people, which cause confusion and frustration

When these feelings occur at the same time or in reference to a particular situation or person (for example, in an unhealthy romantic relationship), the combination is overwhelming. The ultimate goal for the struggling anorexic or self-injurer is that these feelings must somehow be kept underground. In eating disorders, especially in anorexia, there is a suppression of sexual feelings because the body is too busy doing something else.

At the very least, sexuality is confusing or unduly stressful.

Anorexics and obese/compulsive overeaters tend to avoid sexually intimate relationships, either by making their bodies appear prepubescent and unattractive or by creating a large protective barrier of body fat between themselves and

other people. Self-injurers disfigure their bodies and prefer to spend a lot of time alone, in isolation from other people. Romantic relationships are sometimes avoided because of the fear of scars, wounds, and hidden self-injurious behaviors being discovered. Many bulimics tend to act out sexually and often exhibit sexually promiscuous behaviors, have multiple partners with no emotional connection, have a high level of impulsivity, and use poor judgment. Generally speaking, bulimics are having (a lot of) sex. Anorexics are not having sex.

In particular, those who indulge in self-injurious behavior and purging behavior together can't recognize and identify emotions or sensations of hunger and safety. Self-injury in eating-disordered patients not only serves as an alternative tension releasing method to binge eating, but allows them to experience their bodies and seek a sense of reality and identity. In general, more serious psychiatric problems may be found in patients with eating disorders who purge than in those who only restrict their food intake without purging. In anorexics who engage in purging behaviors, both suicide attempts and self-injurious behavior are much more common than with those who practice food-restricting behaviors only. Those who employ more than one purging behavior, in both anorexia and bulimia, report a greater frequency of self-injurious behavior. Specifically, impulsive self-injurious behaviors such as skin cutting and burning are more frequent.

Self-injurious behavior is reported to occur at higher rates for bulimics than for anorexics. Compulsive self-injurious behaviors such as hair pulling are habitual, repetitive, and characterized by greater resistance to treatment. Among bulimics, compulsive self-injurious behavior is strongly associated with low awareness of one's internal emotional states and dynamics, and high obsessionality.

Because of the coexistence of and high associations among these disorders, the researchers/authors Favazza, DeRosear, and Conterio (1989) have proposed that the *DSM-IV* should list self-mutilation as an associated feature or complication of anorexia nervosa/bulimia nervosa. It is further stated in their article that the combination of self-mutilation, anorexia, bulimia, and other symptoms may be manifestations of an impulse control disorder known as the deliberate self-harm syndrome.

Addiction Similarities: Anorexia, Bulimia, and Self-Injury

Self-injury and abnormal eating habits both have the potential to become addictive. As so proficiently stated by clinical and research psychologist Dr. Lisa Cross in her article "Body and Self in Feminine Development: Implications for Eating Disorders and Delicate Self-Mutilation" (1993):

> The preoccupation with the physical self takes a more ego-alien form when the self-cutting or abnormal eating habits become addictive. These acts, which originally were aimed at erasing the existence of the body and at establishing self-control, now take control themselves. The world narrows to an obsessive preoccupation with the body and its products and the next meal, the next purge, the next self-cutting. Every plan for the day revolves around finding an opportunity to carry out these rituals.

Dr. Cross further states in her conclusion:

> The body, of course, comes to resent its taskmaster, in a way quite similar to the development of an addiction. The more the addicts attempt to control their emotional

world with drugs or alcohol, the more substance-dependent and out of control they become. Similarly, the body of the eating disorder or self-cutting patient escapes control and inflicts its own persecution: Vomiting leads to remorseless hunger; overuse of laxatives leads to intransigent constipation and laxative addiction; weight loss leads to an escalating compulsion to lose even more weight; self-cutting is never as fully satisfying an emotional catharsis and leads to a strong temptation to cut more frequently and more injuriously.

Hence, an addict of any type is an addict. Some types of addictions and "drugs of choice" (or "behaviors of choice") are more closely related than others. There are remarkably similar dynamics between anorexia and bulimia and self-injury. An addict is more likely to shift to something most closely related to her primary addiction. What particular drug or behavior this will be depends on what core internal dynamics are present and on what effect is being sought.

Behavioral Addictions

There are numerous behavioral addictions that are prevalent in today's society. New behavioral addictions (and literature and Twelve Step groups to address them) are springing up all the time. Today, there are Internet addictions, including Internet dating and cybersex. Even young children are becoming addicted to playing video games, which sometimes interferes with doing their homework and appropriately socializing with their peers. These things were not even around until a few years ago.

Many people are looking for some sort of relief from the stresses of everyday life or for something to fulfill an emptiness inside. It is easy for one to accidentally fall prey to one

or more various obsessions and compulsions. It is when some type of obsessive or compulsive behavior becomes more important than, or interferes with, one's health, work or school, finances, interpersonal relationships, and/or responsibilities that it becomes problematic or addictive, and thus should be appropriately addressed.

Claudia got into an almost daily habit of stopping at the local mall on her way home from work. Although shopping was her favorite way to escape and relax after teaching special education high school students all day, her compulsive shopping and spending caused her to rack up a lot of credit card debt, which she could not pay. Claudia came to avoid the responsibility of paying her other bills on time, such as the rent, telephone, and electricity. She sometimes did not even open her mail and screened her phone calls to avoid creditors. Replacing something as uninteresting as the tires on her car, even when they became worn down to the point of jeopardizing her safety, was not a consideration of hers. She was constantly borrowing money from her mother, who was sometimes sympathetic and sometimes angry about it. This greatly added to the dysfunction in their already dysfunctional relationship. Claudia's behavioral addiction of shopping and spending thus interfered with her finances, other responsibilities, and an interpersonal relationship (with her mother). This only added significantly more stress in her life.

Too much of anything is not good. For instance, food is a good thing, it is necessary for survival, and exercise is good for one's physical health and psychological well-being. However, these and other things can easily become addictions if used excessively or inappropriately. The key is to have a healthy *balance* in one's life.

Some of the most common behavioral addictions among self-injurers, next to eating disorders, are exercise addiction,

compulsive shopping and spending, and sex and love addiction.

Exercise Addiction

Exercise addiction occurs when the frequency, duration, and intensity of exercising becomes damaging to one's physical health and/or fits the criteria for addiction, in terms of interfering with other important areas of one's life. Exercise addiction is also closely correlated with anorexia and bulimia, and is quite common especially among food-restricting anorexics.

An exercise addict becomes preoccupied with the act of exercising, as well as with body image. Anorexics and bulimics are focused on losing weight and being thin; body builders and power lifters are focused on attaining muscle mass and physical strength. Those who are especially prone to exercise addiction include dancers, gymnasts, competitive athletes, wrestlers, and long-distance runners.

As with deliberate self-injury (for example, by cutting or burning), during strenuous physical exercise, the body's own natural endorphins are released in response to pain. Greater intensity, duration, and/or frequency of exercise may be needed over time to produce similar effects. The "runner's high," for instance, is experienced when the body pushes itself past its limits—however, taking it too far may lead to physical collapse or injury. Like other addicts, the exercise addict continues despite the consequences. Athletic performance may actually suffer. Physical withdrawal symptoms are rare but include changes in appetite, sleep, and increased sensitivity and decreased tolerance to pain. Psychological withdrawal symptoms may include depression, anxiety, or anger, hostility, and rage.

Additionally, exercise addicts are likely to also abuse

drugs. Anabolic steroids and growth hormones are sometimes used by weight lifters and body builders to produce rapid muscle and weight gain. Sometimes diuretics and anti-wasting HIV drugs are also inappropriately used. Other "performance enhancing" drugs and substances often abused by exercise addicts of all types include pain, muscle relaxant, and anti-inflammatory drugs; "speed"; beta blockers; and nutritional supplements and foods.

Compulsive Shopping and Spending

Compulsive shopping and spending is another addiction that a self-injurer may be likely to slip into, especially because this is most prevalent in females, especially teenagers and young women; women with eating disorders, especially bulimia; women who have a history of childhood sexual abuse; upper-middle-class teens and young women. All of these characteristics fit the profile of the typical self-injurer.

Compulsive shopping can easily become another highly *impulsive* behavior, which is fun, exciting, social, and a favorite pastime of many women. However, it typically leads to spending, frequently much more money than one actually has, and using poor judgment. Especially with the availability of credit cards, one can quickly get into significant financial debt or not have enough money to pay for the general necessities of life. Needless to say, this can cause significant stress and anxiety.

Teenagers and young adult women "shopaholics" who are into the fashion scene often buy a lot of clothes, sometimes that they do not even wear. Even on her moderate teacher's salary, Claudia, who was also a compulsive overeater, bought so many clothes on one shopping trip that she did not realize that she had bought two jeans jackets that were exactly the same. She ended up eating nickel-and-dime

vending-machine junk food, such as chips and licorice, for lunch every day until her next paycheck and had to borrow a few dollars from a co-worker to buy Pepto-Bismol. (No, she did not take any of her new clothes back to the mall!)

There is a notably high rate of compulsive shopping among the subgroups of "beauty and fashion conscious" young women with anorexia and bulimia, particularly for those who have bulimia. For the struggling bulimic, shopping serves the purpose of filling the internal emptiness and provides something else to focus on, something else to obsess about, instead of facing what is going on with oneself emotionally. For the same reasons, there is also a correlation with child sexual abuse and compulsive shopping, and hoarding of possessions, in later years.

Sex and Love Addiction

Sexual addiction can be understood as a physical, emotional, and spiritual illness. In their book *Sex, Lies, and Forgiveness,* Schneider and Schneider define *sexual addiction* as "the pursuit of the sexual high to the exclusion of one's primary relationships, jobs, and health."

Sex, love, and romantic relationships are oftentimes difficult for self-injurers, those with eating disorders (especially anorexia and bulimia), and for those who were sexually abused as children. When two or more of these preexisting conditions are present, the probability is much higher that problem behaviors, or at least bad feelings, regarding sexuality will eventually surface. And those with concurrent alcohol and/or substance abuse problems are even more likely to use poor judgment, be prone to indiscriminate acting-out behavior, or be easily taken advantage of by others who use their vulnerability for selfish opportunity.

For some, sexual issues become a preoccupation, and

sexual behavior may become inappropriate, compulsive, and eventually another problematic addiction. An extreme need for dependency, made worse by low self-esteem, often leads one to run from one romantic relationship to another, or to desperately "look for love in all the wrong places," or to stay in negative, or possibly even abusive, romantic relationships that lead to utter destruction of one's sense of self. Additionally, "love" and "lust" are often confused. Someone inevitably ends up getting hurt.

Others may avoid sex and romantic relationships, for reasons such as fear of emotional closeness, rejection, being out of control, or further abuse at the hands of another person.

The Big Book of Alcoholics Anonymous *(Alcoholics Anonymous)* and other Twelve Step literature refer to problems with sex and relationships, and making amends to others who have been hurt by this behavior, as it is quite common among alcoholics. "If sex problems are bothersome, one must throw themselves all the more into helping others" (*Twenty-Four Hours a Day,* Hazelden 1975). Alcohol and drugs can cause people to lose their inhibitions when drinking or using. Drugs such as cocaine and stimulants can build a false sense of self-esteem and grandiosity. Designer drugs such as Ecstasy and nightclub drugs, intended for those who want to have a good time on the social scene, have often led young people to catastrophes such as date rape and death. The combination of alcohol or drugs and addictive sexual behavior is especially dangerous.

One of the main things that drive alcoholics and addicts to relapse is disappointment in romantic relationships—ask any therapist who works with alcoholics and addicts or any person who regularly attends AA or other Twelve Step meetings! Romantic relationships are an especially vulnerable area for self-injury addicts. Sex and love addiction will

most likely, if not inevitably, lead to disappointment and heartbreak. In combination or substitution for any other addiction, it can cause one to go around and around in a vicious cycle.

Child Sexual Abuse, Cross-Addictions, and Relapse

In an academic journal article, "The Role of Incest Issues in Relapse" (Young 1990), it is stated that relapse is often related to uncovering painful early childhood incest experiences that have been defended against through self-destructive addictive behaviors. Comprehensive studies have established that relapse has been the most common outcome of recovery programs that treat addictive behaviors. However, the possible existence of childhood sexual abuse issues as a predisposing factor of relapse, and the connection between cross-addiction and relapse, needs to be more fully explored.

Young further states that another aspect of relapse is the phenomenon of multi-addictions: Withdrawal from an identified addictive behavior will often lead to the unmasking of other addictive behaviors. Relapse may indicate the existence of additional addictions that must be identified and explored in order for recovery to proceed. Additionally, sex and love addiction is often found in conjunction with alcoholism, codependency, and compulsive overeating, and often comes to light through the emergence of incest memories. Treatment of this hidden addiction (that is, sex and love addiction) is called for.

Self-injury is another possible "hidden addiction" that should be explored, and treated if present. This is because it is highly correlated with child sexual abuse and incest, as well as with the above-mentioned addictions.

Relapse Prevention

Relapse is the recurrence of addictive behavior after a period of abstinence. There are variable opinions among scientists, clinicians, and treatment approaches, including the Twelve Step approach, as to what exactly constitutes a relapse. For example, some define an alcohol relapse as "when one drinks X amount of alcohol over X period of time after X amount of time abstinent" and others define relapse as "any alcohol at all—even one sip." This is a source of great controversy in the addictions field.

Rigorous honesty with oneself is essential in recovery. Commitment is sacred. Abstinence means honest, complete, and total abstinence. It is too easy to play games, even in one's own mind, with words and definitions about how much is too much. And addiction substitution is another danger always lurking in the background. Why play with fire?

However, if one does relapse, it is helpful to see the relapse as a "slip" or a "temporary setback" and not a failure. Whatever gains (for example, in treatment; in therapy; in a Twelve Step program) that have been made have *not* all been lost. It is like hitting a speed bump or a pothole (although maybe a big pothole) on the great road of life. It is important to get back on track as soon as possible.

It is important for a recovering addict to be aware of her own *internal danger signals* that may lead to a potential relapse. The self-injurer may recognize, for example, "I'm angry! I'm emotionally escalated! I'm in a *huge* fight with my boyfriend! Romantic relationships are my danger area!" She can then wisely choose positive alternatives instead of having another self-injury episode. This may include removing herself from the negative situation, seeking support, and using some of her tools for relapse prevention. In Alcoholics Anonymous, there is a popular saying: "Never

get too Hungry, Angry, Lonely, or Tired (HALT)." There are times when one needs to take positive action immediately, including seeking additional support.

Especially in early recovery, and at times when life becomes difficult for whatever reason, it is good for the recovering addict to have a game plan for *relapse prevention*. A therapist can be very helpful in devising such a plan that is specific to the individual's needs. Friends, significant others, Twelve Step program sponsors, and other concerned people in the addict's everyday life can help a recovering addict successfully carry out the relapse prevention plan.