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HELPING THOSE WHO HELP OTHERS

An All-too-Common Occurrence

Violence in Nursing Homes is Spreading

By Sharon Palmer

For families of the estimated 1.5 million elderly who reside in the nation's nursing homes, the evening news coverage on escalating violence in long-term care facilities is more frightening than a Hollywood thriller. Just look at these recent headlines:

- In Olympia, Washington, a licensed nurse was charged with sexually assaulting a comatose patient in a South Sound nursing home.
- At Beechwood Senior Living in Rhode Island, a resident allegedly stabbed one female resident to death and raped another one.

And then there's this: Twenty years ago, Matilda Anticevich, 77, was admitted to a reputable nursing home in California. By the time Matilda was transferred to a hospital for emergency surgery 18 months later, family members had filed many complaints with the nursing home staff for repeated failures to receive prescribed medication, bones broken under suspicious circumstances, mental and physical abuse, and bedsores. Matilda did not survive the surgery. After a long battle over Anticevich's case, Carole Herman, her niece, founded FATE, the Foundation Aiding the Elderly.

It seems that family members like Herman have had a large role to play in the emerging concern over nursing

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Nursing Home Violence *Continued from page 1*

home abuse in the past few decades. And it's no wonder. A congressional report in 2001 found that nearly one-third of all nursing homes had been cited for abuse, a statistic that had more than doubled since 1996. This investigation found physical, sexual and verbal abuse with such actions as punching, choking, and kicking by staff and other residents. Maybe even more disturbing was the discovery that more than 40% of the abuses uncovered in this investigation were only reported after formal complaints were made in a resident's behalf, leaving one to wonder just how many cases of abuse go unreported.

According to the Nursing Home Reform Act in 1987, all residents in nursing homes are entitled to receive quality care and live in an environment that improves or maintains the quality of their physical and mental health, free from neglect, abuse, and misappropriation of funds.

Abuse is defined as causing intentional pain or harm and it includes physical, mental, verbal, psychological and sexual abuse, corporal punishment, unreasonable seclusion, and intimidation. This can include acts like hitting, pinching, shoving, force-feeding, scratching, spitting, berating, ignoring, ridiculing, threatening, improper touching, immobilization, dehydration, pressure sores, depression, and rough handling.

With a growing number of elderly requiring long-term care, safety in nursing homes is a looming concern in our society. The federal government's General Accounting Office claims that more than 43% of all American over the age of 65 will reside in a nursing home at some point in their lives.

Why Rampant Abuse in Nursing Homes?

Take a group of residents who may not be able to adequately speak up for themselves, and provide them with stressed staff that usually experience poor working conditions, salaries and benefits, and it should be no surprise to find that abuse has been thriving in long-term care facilities for decades. Nursing home workers are typically overworked and undervalued, prompting high turnover rates which are directly related to resident care. Throw in factors like physical and chemical restraints and a history of inadequate resident rights and you can start to visualize the culture that pervades nursing homes across America.

In addition, the background of workers is under fire — and it seems rightly so. Two studies conducted by the office of Attorney General Mike Cox three years after Michigan's first criminal background check law for residential care facility employees revealed that nearly 10% of the employees caring for the state's vulnerable adults have criminal backgrounds that include homicide, criminal sexual conduct, weapon charges, and drug offenses.

And more attention has been cast on residents recently, prompting this haunting question: how much does a nursing home administrator know about the resident down the hall? In Richardson, Texas, a 3-year-old child who regularly visited a relative was molested by a resident. When the resident was moved to another nursing home, another child molestation occurred, after which the resident was imprisoned. The nursing home watchdog group A Perfect Cause discovered more than 90 sex offenders living in Texas nursing homes.

Finding a Safe Haven for Your Loved One

Thanks in part to the news media shedding light on nursing home abuse, some action has been taken to improve conditions. The federal government has increased its scrutiny of nursing homes, and litigation has made an impact on the nursing home industry, as well. Also, several organizations have cropped up with the mission of ending nursing home abuse. Organizations like the American Health Care Association are striving to improve quality in long-term care facilities. And family members, who have patiently and consistently called for better care, are now playing a larger role. Recently, family council laws have become effective in five states (California, Maryland, Massachusetts, Minnesota, and New

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RESOURCES

Association for Protection of the Elderly
www.apeape.org

Nursing Home Abuse and Neglect Information Center **www.nursinghomeabuse.com**

California Advocates for Nursing Home Reform
www.canhr.org

Coalition to Protect America's Elders
www.protectelders.org

Foundation Aiding the Elderly **www.4fate.org**

National Citizens' Coalition for Nursing Home Reform **www.nccnhr.org**

National Nursing Home Watch List
www.memberofthefamily.net/usmap.htm

Caregiver's Dilemma

Coping with Incontinence

By Lori Ritchie

Urinary incontinence is a frustrating and embarrassing condition that afflicts nearly a third of all our elderly living in a non-institutional setting, leaving family caregivers with the sometimes awkward and often unpleasant task of caring for their incontinent loved one.

Not only must caregivers deal with the sanitation issues surrounding an incontinent loved one, but also their own distress as they watch their loved ones struggling with embarrassment, limited trips outside of the home, and withdrawal from family and friends. Ultimately, the sanitation worries about odors and awkward "accidents" become the unspoken concerns of both elders and caregivers alike.

There are two main types of incontinence. Stress incontinence occurs during certain activities such as coughing, sneezing, laughing, or exercise. Urge incontinence involves a strong sudden need to urinate followed by instant bladder contraction and involuntary loss of urine. Individuals who struggle with this type of incontinence don't have enough time to react between the point they recognize the need to urinate and when they actually do urinate.

If you are among the millions of caregivers who deal with elderly incontinence every day, how can you deal with the issue gracefully while making your loved one more relaxed with the condition?

The first step is to acknowledge the problem and schedule an appointment with a family healthcare provider. Early intervention can prevent some of the condition's physical effects—from rashes and pressure sores to skin and urinary tract infections—and the natural inclination to reduce outside social activities. Don't be tempted to turn prematurely to the use of absorbent products, such as adult diapers and bed pads, for the person you care for without first having their situation properly diagnosed and medically treated.

Here are some tips to help caregivers more effectively care for those struggling with incontinence.

1. The following information and health history compiled by the caregiver will assist the healthcare professional provide an accurate assessment and diagnosis:

- Describe the problem
- When does incontinence occur?
- How long has incontinence been a problem?
- How much of a problem has the condition become?
- How many times does incontinence occur each day?
- Is the individual immediately aware that they have passed urine?
- Are incontinence products such as absorbent liners or briefs used in case of accidents? Occasionally? All of the time?
- Does the individual avoid social situations when accidents occur?
- Is there a history of urinary tract infections?
- Does incontinence commonly occur when coughing, sneezing, straining, laughing, or walking?
- What medications is the individual currently taking?
- What is the degree of use of coffee, soft drinks, or alcohol?
- Is your loved one on a special diets or have there been changes in diet?

2. Discuss the possibility of using the following interventions for incontinence management with the individual's doctor:

- *Kegel or pelvic muscle exercises* – These are simple toning exercises that strengthen the muscles that help control urine flow. The exercises can be learned quickly and can be done anywhere.
- *Biofeedback* – This is a type of training that helps the incontinent person recognize their body's signals. They learn how to "tune in" to the sensations of the muscles that control the bladder.
- *Bladder Retraining* – This is the process of restoring a normal pattern of voiding by slowly increasing the amount of time between trips to the bathroom.

3. Avoid items that irritate the urethra or bladder.

Some of these may include liquids that tend to increase urination (coffee, alcohol), diuretics (water pills), some antispasmodic medications, antidepressants and antihistamines, cough/cold medications, and ventolin (albuterol) or other beta agonists. Check with your doctor or pharmacist for specific concerns about medications. Spicy foods, carbonated beverages, and citrus fruits and juices can be irritating to the urethra or bladder.

4. Modifications to the home environment

Remove barriers that hinder an incontinent person around the house by

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Conditions that can contribute to incontinence

- Dementia, mental confusion or psychological factors
- Cancer
- Restricted mobility
- Urinary tract or prostate enlargement or infection
- Side effects of medications
- Impaired nervous system
- Pelvic muscle weakness
- Nerve or muscle damage after pelvic radiation
- Developmental problems of the bladder
- Pelvic, prostate, or rectal surgery
- Bladder spasms

Medications that can contribute to incontinence

Diuretics commonly used for water retention and blood pressure increase the amount of urine produced and can cause urgency.

Antihistamines (this includes over-the-counter sleep medications and Tylenol PM), especially when taken by older men with prostate problems, can cause urinary retention, overflow incontinence, sedation and delirium.

Tricyclic antidepressants and antipsychotics can cause urinary retention and sedation as well.

Benzodiazepines (such as Valium or Xanax) can cause sedation, delirium and muscle relaxation.

Narcotic pain relievers can cause urinary retention, delirium and sedation.

Alpha-blockers (used for blood pressure or prostate problems) can cause relaxation of the urethra. This can be a problem for women who experience stress incontinence.

Alpha-agonists (over the counter decongestants) can cause urinary retention in men.

Calcium Channel Blockers (usually used for blood pressure—sometimes migraine headaches) can cause urinary retention.

Alcohol can increase the amount of urine produced, causing frequency, urgency and sedation

Incontinence *Continued from page 3*

designing a safe and easy-to-navigate path to the bathroom. Leave a light on in the bathroom so the person you are caring for can easily locate the bathroom at night. Perhaps some type of ambulation aid is needed to improve mobility such as a rolling walker, cane, or wheelchair. Consider placing a bedpan, bedside toilet, or urinal close to the bed at night to minimize nighttime incontinence.

5. Bathroom issues
Consider a toilet seat extender, which is an adaptive device that raises the seat to a more comfortable level. Wall handrails may offer additional support for the individual having difficulty getting on and off of the commode. Provide time and privacy in the bathroom so the individual feels comfortable enough to completely empty their bladder. Consider encouraging men to sit on the toilet to urinate to cut down on problems with an inaccurate aim. Try a toileting routine that includes bathroom trips every two hours, which is about how long it takes the bladder to fill with one cup of urine.

6. Skin care
Urine is very irritating to the skin and can easily damage it. Examine your loved one daily for signs of skin breakdown, redness, rashes, or sores. Any of these symptoms should be promptly reported to the healthcare provider. Early intervention can prevent the problem from worsening. If the incontinent person wears briefs, change them as soon as they become wet to keep the skin as dry as possible. Wipe the skin with a mild soap, rinse with warm water, pat dry with a soft cloth, and apply a thin layer of moisture barrier ointment according to package directions. Consult your doctor or pharmacist for a recommendation of an effective ointment. Avoid powders because they trap moisture into skin folds. A regular bathing routine is key for keeping the skin free from irritants. Remove wet clothing immediately after an accident. To cut down odor, rinse soiled items immediately.

7. Travel tips
Look for bathroom locations ahead of time when you are in a public place with your loved one. Try to find a unisex handicapped restroom if the individual requires assistance with toileting. If traveling on a plane, request aisle seats so access to the bathroom will be quicker and less of a hassle. If you are going on a long car ride, reassure the person with incontinence that it isn't a problem to stop for bathroom pit stops. Bring along a change of clothing and extra incontinence products in case of accidents. Encourage your loved one to wear loose comfortable clothing for the trip so changes will be easier to pull off. Double protection can be offered by using a brief with an absorbent liner.

8. Caregiver support
Consult support groups to network with others who have first-hand experience with incontinence and their loved ones. They may be able to offer additional suggestions that have worked for them. There are many online discussion boards designed for caregiver support, if you are unable to attend meetings within your community.

Dr. Adina Schneider, an internist at Columbia Presbyterian Medical Center in New York City, advises: "As a caregiver, it may be necessary for you to take the lead in addressing this problem. Help your loved one realize that this condition need not be a cause for shame, but rather should be viewed as a treatable medical problem. Helping your loved one deal with their incontinence can improve the quality of life for both of you." n

RESOURCES

http://caregiver.depend.com/ offers caregiver support, feature articles, discussion boards, expert advice, and an interactive assessment to determine if a loved one is experiencing related symptoms of incontinence.

The National Association For Continence (NAFC). **http://www.nafc.org.**
This is the homepage of the world's largest consumer advocacy organization that contains informational articles, message boards, product selection guide, and links to additional information.

http://www.caregiver911.com/caregiver_newsletter/2005/weekly_newsletter052605.htm has several articles on the topic of incontinence and caregivers.

Relocation or Dislocation?

Think Long & Hard Before Moving to Care for Mom

By Paula S. McCarron

> **"Nothing could have prepared me for the loss of personal freedom that I felt. It's what you want to do but you can't realize how hard it will be."**
>
> **— Fran Harton, who relocated from New Jersey to Maine to care for her mother**

In 2002, Sue Taylor made a life-changing decision. She left a great job, many friends and a much-loved home in Atlanta to move to Ohio to become the live-in caregiver for her aging parents.

According to a study by the University of Illinois, adult children make up 26% of all caregivers living in the same home as an elderly care recipient, whereas spouses comprise 62%. But there is little information available about the numbers of family caregivers who actually relocate from one community to another in order to live closer to, or live with, their aging loved ones.

"I do know it's a much less common scenario," says Bonnie Lawrence, spokesperson for Family Caregiver Alliance (FCA), a California-based agency that provides support to family caregivers on a local, statewide and national basis. She says it is much more common for an older adult to relocate than for the caregiver to make the move. Lawrence advises family caregivers who are considering such a move to do so carefully. "We sometimes hear from family caregivers who have made this kind of move thinking they'd help out for six months or maybe a year, but five years later, they're still there."

That description seems to fit Taylor, who says, "I envisioned being with my parents for about a year and probably helping to move them into a nursing home. That was three years ago." As Taylor was to learn, caring for her father, who had lung disease and diabetes, along with a mother with Alzheimer's disease, proved to be more complicated than she had anticipated.

First, Taylor's plan for nursing home placement crumbled when she was confronted by the financial realities of facility-based care, as well as the lack of facilities in her immediate area prepared to meet the special needs of Alzheimer's patients. She tried hiring helpers to come into the home, but found that few workers were trained adequately and that the cost was prohibitive. She looked into adult day services but found it an impractical option as it was 20 miles from her home. In the end, she relied heavily on her two brothers who lived about two hours away, a cousin, and friends of her parents.

Fran Harton and her husband moved from New Jersey after spending 5-1/2 years of driving every five or six weeks to Maine in order to provide assistance to her mother. Harton's mother, who was experiencing difficulties due to an Alzheimer's–like dementia brought on by a series of small strokes, needed help with the day-to-day chores that come with living independently. Harton says, "We were lucky to have a neighbor who checked in on her every single day, but we'd drive up to help her write checks, get to the bank, do food shopping, and take care of things around the house. Every time we visited, we saw changes."

Harton, like Taylor, found that help in caring for her mother was both expensive and difficult to locate. She says, "We found it would cost about $2,600 a month to have my mother in a care facility, but even if we could afford it, we couldn't use the nearest facility because they couldn't keep my mother from wandering out the door. And home care would have cost us about $100 a day. Medicare has limits on what they will do, and she did not qualify for Medicaid because of her income." Beyond concerns for her mother, Harton also was dealing with her own diagnosis of breast cancer.

Both Harton and Taylor found themselves immersed in the maze of health services, reimbursement issues, financial concerns, medical and legal decisions. "It was a lot more work than I thought it would be," says Taylor.

It's because of concerns like these that FCA's Lawrence suggests that family caregivers delay a move until they have taken a long, hard look at all of the available options and answer questions such as these:

- Are there services for your loved one where you live, or are there better services in the in the community where your loved one resides? How will the cost of care be covered?

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Relocation *Continued from page 5*

- Will you need to maintain employment? If so, what can you expect in terms of finding work? What will you do for health coverage if you are not employed?
- What is the cost of living compared to where you now reside?
- What losses will you experience in retirement benefits, eligibility for pension plans, or Social Security benefits if you stop working to care for a loved one?
- How will the move impact other family members?
- What kinds of legal or financial agreements need to be made for sharing a home?
- What modifications will be made to the home and at whose expense?

And those concerns don't even begin to address the emotional dimension of caring for a frail loved one. "I had no idea how hard it would be," says Taylor who finally made the decision to place her mother in a care facility following her father's death in January 2004. "I was at the point where I was pretty burned out."

As for Harton, she says "nothing could have prepared me for the loss of personal freedom that I felt. It's what you want to do but you can't realize how hard it will be."

While Taylor says her father thanked her every day for being there and that she gained a deeper relationship with him, Harton says her relationship with her mother was sometimes strained or diminished due to the symptoms of her mother's advancing dementia which sometimes led to outright hostility.

Given all the difficulties, one might wonder whether Taylor or Harton would make the same decision again to uproot their lives in order to care for their parents. While difficult to predict unless faced with the option, each woman does admit there is one thing she would do differently. And they both give the exact same answer, using the exact same words: "I would have done it sooner." n

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Not Two Peas in a Pod

The Key Differences Between Medicare + Medicaid

By Ursula Furi-Perry

If your loved one needed government assistance with long-term care, would you turn to Medicare or Medicaid?

What if it were income-based aid you needed: which of the two government-sponsored medical programs would you seek out?

Which of the two would cover your loved one's long-term care?

Is it possible to be helped by both programs at the same time?

If you can't answer these questions correctly, you're not alone. But as a caregiver, the answers to these questions and many others regarding Medicare and Medicaid are important to you.

Both programs were established in 1965 through the Social Security Act, and both exist to make healthcare more affordable all around. Yet Medicare and Medicaid differ significantly in many ways: eligibility requirements, coverage, and even the purposes they serve.

Consider the following key differences between the two programs:

Who provides and administers it?

While Medicare is a federally-sponsored program, "Medicaid is a state-federal partnership program," says Mary Kahn, spokesperson for the Centers for Medicare and Medicaid Services (CMS). As such, Medicaid programs can differ entirely by state. "Each state gets to set its own eligibility," Kahn explains. Because programs can vary, it's a good idea to visit your state's officials for Medicaid information and paperwork.

Who can get it?

"Medicare is for people with disabilities or over 65…those receiving medical benefits under Social Security or disability," says Peter Ashkenaz, another CMS spokesman. In addition, Medicare also serves those with permanent kidney failure with dialysis or a transplant. Medicaid, on the other hand, determines its eligibility through 25 categories specified by federal statute. These include low income and few resources, disability, blindness, and some other factors such as underage children or pregnancy in a family.

While the two programs are very different, it is possible to be enrolled in both at the same time: for example, someone who is over 65 and considered a low-income citizen may be placed on both Medicare and Medicaid. In those situa-

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COMING UP IN AUGUST

n **You've had enough.** This marriage is on the rocks. I'm outta' here. But then it happens: your spouse becomes ill, your help is needed—and you are suddenly a "reluctant caregiver." How it happens and how to deal with it.

n **As if caregiving itself weren't enough to contend with,** our elderly hoard everything from junk mail and catalogs to canned goods and other "essentials." How can you deal effectively with this very real problem?

n **The illness is devastating, and you need help.** Mom can't stay at home—or with you. How long-term care insurance can help, if you plan ahead.

n **Medication mistakes happen all the time.** Sometimes our elderly dodge a bad reaction, but other times the worst happens. What a caregiver needs to know to guard against this potentially deadly situation.

tions, Medicare is usually considered the primary form of assistance by most care providers.

What is covered?

"With Medicare, some doctor services are covered," says Ashkenaz. Some in-patient and out-patient hospital services, as well as some medical equipment and supplies, may also be covered. "Beginning next year, there will be a new drug benefit," Ashkenaz added, noting that more information about the new plans will be available later this year, and that those dually on Medicare and Medicaid will automatically be enrolled.

With Medicaid, while certain basic services must be offered by federal law, states largely get to decide exactly what their programs will cover. That means hospital in-patient and out-patient services, physician assistance, and laboratory and X-ray services must be provided by all states to those eligible for Medicaid. However, a state may or may not provide other types of care, including dental and optical services, prosthetic devices, mental health services, and prescription drug coverage.

Is there a long-term care benefit?

"People think that Medicare will cover long-term care, but that's not true," says Kahn, citing one of the most popular misconceptions about the program. In fact, Medicare is limited to 100 days and only covers certain types of long-term care, and even that comes only after a hospital stay.

Medicaid programs, however, will often cover long-term care—again, the details are state-specific and vary greatly. It's important for caregivers to note that Medicaid may cover at-home care, nursing home care, and hospice care in many situations.

What purpose do they serve?

While Medicare is essentially a health insurance program sponsored by the government, Medicaid is a social-health welfare program that provides comprehensive coverage to those eligible. Medicare is an entitlement program: those who have paid into the program and fall into the classes of people for whom Medicare is intended may use it.

Medicare is meant to be there as a form of insurance for certain medical treatments and services, while Medicaid is meant to help those who have low income and few resources with all medical costs provided by federal statute.

What about costs to the consumer?

With Medicare, consumers pay a yearly deductible and some services can come with co-payments. Medicaid is meant to be free for those eligible, although some states may charge small fees for certain services. As for participants dually on Medicare and Medicaid, many states allow them to rely on Medicaid for the payment of certain Medicare fees and co-payments.

To curb confusion about the two programs, caregivers are encouraged to become familiar with Medicare and Medicaid through free information provided by the federal government. "Anyone with Medicare should receive the *Medicare and You Handbook*," says Ashkenaz. The government's website on Medicare, www.Medicare.gov, allows users not only to find answers to questions, but also to log into a feature called My Medicare and access personalized information.

For information on Medicaid programs, caregivers should turn to their loved one's state officials. "Start at your county social services office; that's the entry point," Kahn advised, adding that Area Agencies on Aging are also a great resource for caregivers. n

RESOURCES

Centers for Medicare and Medicaid Services, **www.cms.hhs.gov** or (877) **267-2323**

The Official US Government Site for People with Medicare, **www.medicare.gov**

Comprehensive State Medicaid Programs, **www.cms.hhs.gov/medicaid/statemap.asp**

National Association of Area Agencies on Aging, **www.n4a.org** or **(202) 872-0888**

Nursing Home Violence *Continued from page 2*

York). Under this program, family members of residents can work together in so-called family councils to play a crucial part in improving care.

So, let's take this dilemma down to a personal level: what can you, as a caregiver, do to make sure your loved one is safe and sound in a residential care facility?

Probably the most important step is to make a good home selection. Looking for a facility that meets your loved one's needs with an eye for quality of care is essential. The government's Nursing Home Compare website (www.medicare.gov/NHcompare/home.asp) provides data by the federal government on nursing homes, such as inspection reports, staffing levels, and quality measures. By contacting your state or local ombudsman and/or citizen advocacy group, you can gain valuable assistance in selecting a nursing home. (Find your local long-term care ombudsman or citizen advocacy group at www.nursinghomeaction.org.)

Once you have placed your loved one in a facility, be ever-diligent to ensure they are receiving the best care. Understand the Residents' Rights, which are guaranteed under federal law (see www.protectelders.com for the Residents' Rights). Visit the home frequently at different times of the day and week. Get involved in family council meetings at the facility and attend care plan conferences focused on your loved one's care. Make sure that you get to know the staff.

Watch for signs and symptoms of abuse, such as wounds, bruises, cuts, weight loss, soiled clothing, dehydration, changes in behavior, agitation, or confusion. And if you're loved one reports abuse, believe them and report it immediately. Follow up on any concerns; don't just assume they are resolved. Document any problems that occur for future investigation. A report may be filed with the nursing home administrator, ombudsman, police, advocacy group, and state health agency (and don't forget to keep a copy for yourself).

Finally, keep this fact in mind: these days, finding a safe shelter for your loved one may require a lot of work on your part. n

Parkinson's Drugs Linked to Gambling, Sex Addictions

Many drugs have common side effects, but scientists at the Mayo Clinic were startled when they closely monitored people taking drugs for Parkinson's disease. They concluded that the drugs, called dopamine agonists, can lead patients to become addicted to food, sex, and even gambling.

In a study prepared for the September issue of *Archives of Neurology*, researchers called their findings very unusual, not at all what they expected.

They cited specific examples, including a 41-year old computer programmer who had never gambled in his life and suddenly began spending hours gambling on the Internet. In another case, a middle-aged clergyman became making daily trips to a local casino, hiding his mounting losses from family members.

The drugs in question are designed to help regulate movement and balance in patients suffering from Parkinson's disease. But researchers say it also affects the brain's pleasure and reward centers. They say dopamine is released in times of pleasure, and could serve as a reinforcement of compulsive behavior.

That's why someone being treated for Parkinson's might suddenly begin acting "out of character." In the latest study, 11 patients were taking a dopamine agonist drug. Nine patients were taking the drug pramipexole, sold under the brand name Mirapex. In two cases, it was ropinirole, sold as Requip.

Researchers say seven of the nine patients developed pathological gambling habits within one to three months of treatment. Four others began compulsive gambling 12 to 30 months after starting the therapy.

More than half the patients in the study also developed other problems, including compulsive eating, increased alcohol use, and hyper-sexuality. They say at least one patient developed an obsession with pornography and engaged in extramarital affairs.

Home Companion partner ConsumerAffairs.com provided this article.