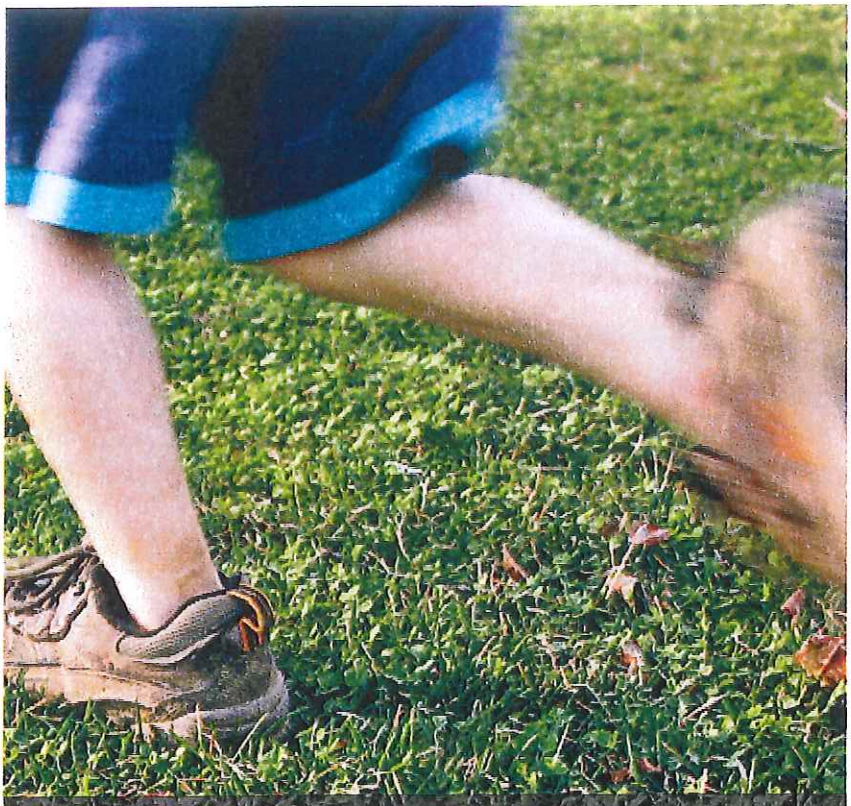

Attention Deficit/ Hyperactivity Disorder

Does your child have trouble paying attention?

Does he or she talk nonstop or have trouble staying still?

Does your child have a hard time controlling his or her behavior?

For some children, these may be symptoms of attention deficit/ hyperactivity disorder, or ADHD.

Attention Deficit/ Hyperactivity Disorder

What is attention deficit/hyperactivity disorder, or ADHD?

ADHD is a common childhood disorder, and it may affect children differently. It makes it hard for a child to focus and pay attention. Some kids may be hyperactive or have trouble being patient. ADHD can make it hard for a child to do well in school or behave at home.

ADHD can be treated. Doctors and specialists can help.

Who can develop ADHD?

Children of all backgrounds can have ADHD. Teens and adults can have ADHD too.

What causes ADHD?

No one knows for sure. ADHD probably comes from a combination of things. Some possibilities are:

- **Genes**, because the disorder sometimes runs in families
- **Lead** in old paint and plumbing parts
- **Smoking and drinking** alcohol during pregnancy
- **Certain brain injuries**
- **Food additives** like artificial coloring, which might make hyperactivity worse.

Some people think **refined sugar causes ADHD**. But most research does not support the idea that sugar causes ADHD.

ADHD has many symptoms. Some symptoms at first may look like normal behaviors for a child, but ADHD makes them much worse and occur more often. Children with ADHD have at least six symptoms that start in the first five or six years of their lives.

Children with ADHD may:

- Get distracted easily and forget things often
- Switch too quickly from one activity to the next
- Have trouble with directions
- Daydream too much
- Have trouble finishing tasks like homework or chores
- Lose toys, books, and school supplies often
- Fidget and squirm a lot
- Talk nonstop and interrupt people
- Run around a lot
- Touch and play with everything they see
- Be very impatient
- Blurt out inappropriate comments
- Have trouble controlling their emotions.

Your child's doctor may make a diagnosis. Or sometimes the doctor may refer you to a mental health specialist who is more experienced with ADHD to make a diagnosis. There is no single test that can tell if your child has ADHD.

It can take months for a doctor or specialist to know if your child has ADHD. He or she needs time to watch your child and check for other problems. The specialist may want to talk to you, your family, your child's teachers, and others.

Sometimes it can be hard to diagnose a child with ADHD because symptoms may look like other problems. For example, a child may seem quiet and well-behaved, but in fact he or she is having a hard time paying attention and is often distracted. Or, a child may act badly in school, but teachers don't realize that the child has ADHD.

If your child is having trouble at school or at home and has been for a long time, ask his or her doctor about ADHD.

How do children with ADHD get better?

Children with ADHD can get better with treatment, but there is no cure. There are three basic types of treatment:

1. Medication. Several medications can help. The most common types are called stimulants. Medications help children focus, learn, and stay calm.

Sometimes medications cause side effects, such as sleep problems or stomachaches. Your child may need to try a few medications to see which one works best. It's important that you and your doctor watch your child closely while he or she is taking medicine.

2. Therapy. There are different kinds of therapy. Behavioral therapy can help teach children to control their behavior so they can do better at school and at home.

3. Medication and therapy combined. Many children do well with both medication and therapy.

How can I help my child?

Give your child guidance and understanding. A specialist can show you how to help your child make positive changes. Supporting your child helps everyone in your family. Also, talk to your child's teachers. Some children with ADHD can get special education services.

How does ADHD affect teens?

Being a teenager isn't always easy. Teens with ADHD can have a tough time. School may be a struggle, and some teens take too many risks or break rules. But like children with ADHD, teens can get better with treatment.

What can I do for my teen with ADHD?

Support your teen. Set clear rules for him or her to follow. Try not to punish your teen every time he or she breaks the rules. Let your teen know you can help.

Can adults have ADHD too?

Many adults have ADHD and don't know they have it. Like ADHD in children and teens, ADHD in adults can make life challenging. ADHD can make it hard for adults to feel organized, stick with a job, or get to work on time. Adults with ADHD may have trouble in relationships. The disorder can also make adults feel restless.

ADHD in adults can be diagnosed and treated. For some adults, finding out they have ADHD can be a big relief. Being able to connect ADHD to longtime problems helps adults understand that they can get better. If you're an adult and think you may have ADHD symptoms, call your doctor.

Contact us to find out more about ADHD.

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Stimulant ADHD Medications: Methylphenidate and Amphetamines

Stimulant medications (e.g., methylphenidate and amphetamines) are often prescribed to treat individuals diagnosed with attention-deficit hyperactivity disorder (ADHD). ADHD is characterized by a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development. This pattern of behavior usually becomes evident in the preschool or early elementary years, and the median age of onset of ADHD symptoms is 7 years. For many individuals, ADHD symptoms improve during adolescence or as age increases, but the disorder can persist into adulthood. In the United States, ADHD is diagnosed in an estimated 8 percent of children ages 4–17 and in 2.9–4.4 percent of adults.[1,2,3]

How Do Prescription Stimulants Affect the Brain?

All stimulants work by increasing dopamine levels in the brain—dopamine is a brain chemical (or neurotransmitter) associated with pleasure, movement, and attention. The therapeutic effect of stimulants is achieved by slow and steady increases of dopamine, which are similar to the natural production of the chemical by the brain. The doses prescribed by physicians start low and increase gradually until a therapeutic effect is reached. However, when taken in doses and routes other than those prescribed, stimulants can increase brain dopamine in a rapid and highly amplified manner—as do most other drugs of abuse—disrupting normal communication between brain cells, producing euphoria, and increasing the risk of addiction.

What Is the Role of Stimulants in the Treatment of ADHD?

Treatment of ADHD with stimulants, often in conjunction with psychotherapy, helps to improve the symptoms of ADHD, as well as the self-esteem, cognition, and social and family interactions of the patient. The most commonly prescribed medications include amphetamines (e.g., Adderall—a mix of amphetamine salts) and methylphenidate (e.g., Ritalin and Concerta—a formulation that releases medication in the body over a period of time). These medications have a paradoxically calming and "focusing" effect on individuals with ADHD. Researchers speculate that because methylphenidate amplifies the release of dopamine, it can improve attention and

focus in individuals who have dopamine signals that are weak.[4]

One of the most controversial issues in child psychiatry is whether the use of stimulant medications to treat ADHD increases the risk of substance abuse in adulthood. Research thus far suggests that individuals with ADHD do not become addicted to their stimulant medications when taken in the form and dosage prescribed by their doctors. Furthermore, several studies report that stimulant therapy in childhood does not increase the risk for subsequent drug and alcohol abuse disorders later in life.[5,6,7] More research is needed, however, particularly in adolescents treated with stimulant medications.

Why and How Are Prescription Stimulants Abused?

Stimulants have been abused for both "performance enhancement" and recreational purposes (i.e., to get high). For the former, they suppress appetite (to facilitate weight loss), increase wakefulness, and increase focus and attention. The euphoric effects of stimulants usually occur when they are crushed and then snorted or injected. Some abusers dissolve the tablets in water and inject the mixture. Complications from this method of use can arise because insoluble fillers in the tablets can block small blood vessels.

What Adverse Effects Does Prescription Stimulant Abuse Have on Health?

Stimulants can increase blood pressure, heart rate, body temperature, and decrease sleep and appetite, which can lead to malnutrition and its consequences. Repeated use of stimulants can lead to feelings of hostility and paranoia. At high doses, they can lead to serious cardiovascular complications, including stroke.

Addiction to stimulants is also a very real consideration for anyone taking them without medical supervision. This most likely occurs because stimulants, when taken in doses and routes other than those prescribed by a doctor, can induce a rapid rise in dopamine in the brain. Furthermore, if stimulants are used chronically, withdrawal symptoms—including fatigue, depression, and disturbed sleep patterns—can emerge when the drugs are discontinued.

How Widespread Is Prescription Stimulant Abuse?

Monitoring the Future Survey†

Each year, the Monitoring the Future (MTF) survey assesses the extent of drug use among 8th-, 10th-, and 12th-graders nationwide. For amphetamines and methylphenidate, the survey measures only past-year use, which refers to use

at least once during the year preceding an individual's response to the survey. Use outside of medical supervision was first measured in the study in 2001; nonmedical use of stimulants has been falling since then, with total declines between 25 percent and 42 percent at each grade level surveyed. MTF data for 2008 indicate past-year nonmedical use of Ritalin by 1.6 percent of 8th-graders, 2.9 percent of 10th-graders, and 3.4 percent of 12th-graders.

Since its peak in the mid-1990s, annual prevalence of amphetamine use fell by one-half among 8th-graders to 4.5 percent and by nearly one-half among 10th-graders to 6.4 percent in 2008. Amphetamine use peaked somewhat later among 12th-graders and has fallen by more than one-third to 6.8 percent by 2008. Although general nonmedical use of prescription stimulants is declining in this group, when asked, "What amphetamines have you taken during the last year without a doctor's orders?" 2.8 percent of all 12th-graders surveyed in 2007 reported they had used Adderall. Amphetamines rank third among 12th-graders for past-year illicit drug use.

Other Information Sources

For more information on treating ADHD, visit the Web site for the National Institute of Mental Health, National Institutes of Health, at **www.nimh.nih.gov.**

For street terms searchable by drug name, street term, cost and quantities, drug trade, and drug use, visit **www.whitehousedrugpolicy.gov/streetterms/default.asp.**

Data Source

† These data are from the 2008 Monitoring the Future survey, funded by the National Institute on Drug Abuse, National Institutes of Health, Department of Health and Human Services, and conducted annually by the University of Michigan's Institute for Social Research. The survey has tracked 12th-graders' illicit drug use and related attitudes since 1975; in 1991, 8th- and 10th-graders were added to the study. The latest data are online at **www.drugabuse.gov.**

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Comorbidity: Addiction and Other Mental Disorders

What Is Comorbidity?

The term "comorbidity" describes two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Comorbidity also implies interactions between the illnesses that can worsen the course of both.

Is Drug Addiction a Mental Illness?

Yes. Addiction changes the brain in fundamental ways, disturbing a person's normal hierarchy of needs and desires and substituting new priorities connected with procuring and using the drug. The resulting compulsive behaviors that weaken the ability to control impulses, despite the negative consequences, are similar to hallmarks of other mental illnesses.

How Common Are Comorbid Drug Addiction and Other Mental Illnesses?

Many people who are addicted to drugs are also diagnosed with other mental disorders and vice versa. For example, compared with the general population, people addicted to drugs are roughly twice as likely to suffer from mood and anxiety disorders, with the reverse also true.

Why Do These Disorders Often Co-occur?

Although drug use disorders commonly occur with other mental illnesses, this does not mean that one caused the other, even if one appeared first. In fact, establishing which came first or why can be difficult. However, research suggests the following possibilities for this common co-occurrence:

- *Drug abuse may bring about symptoms of another mental illness.* Increased risk of psychosis in vulnerable marijuana users suggests this possibility.
- *Mental disorders can lead to drug abuse,* possibly as a means of "self-medication." Patients suffering from anxiety or depression may rely on alcohol, tobacco, and other drugs to temporarily alleviate their symptoms.

These disorders could also be caused by shared risk factors, such as—

- *Overlapping genetic vulnerabilities.* Predisposing genetic factors may make a person susceptible to both addiction and other mental disorders or to having a greater risk of a second disorder once the first appears.
- *Overlapping environmental triggers.* Stress, trauma (such as physical or sexual abuse), and early exposure to drugs are common environmental factors that can lead to addiction and other mental illnesses.

- *Involvement of similar brain regions.* Brain systems that respond to reward and stress, for example, are affected by drugs of abuse and may show abnormalities in patients with certain mental disorders.
- *Drug use disorders and other mental illnesses are developmental disorders.* That means they often begin in the teen years or even younger—periods when the brain experiences dramatic developmental changes. Early exposure to drugs of abuse may change the brain in ways that increase the risk for mental disorders. Also, early symptoms of a mental disorder may indicate an increased risk for later drug use.

How Are These Comorbid Conditions Diagnosed and Treated?

The high rate of comorbidity between drug use disorders and other mental illnesses calls for a comprehensive approach that identifies and evaluates *both*. Accordingly, anyone seeking help for either drug abuse/addiction or another mental disorder should be checked for both and treated accordingly.

Several *behavioral therapies* have shown promise for treating comorbid conditions. These approaches can be tailored to patients according to age, specific drug abused, and other factors. Some therapies have proven more effective for adolescents, while others have shown greater effectiveness for adults; some are designed for families and groups, others for individuals.

Effective medications exist for treating opioid, alcohol, and nicotine addiction and for alleviating the symptoms of many other mental disorders, yet most have not been well studied in comorbid populations. Some medications may benefit multiple problems. For example, evidence suggests that bupropion (trade names: Wellbutrin, Zyban), approved for treating depression and nicotine dependence, might also help reduce craving and use of the drug methamphetamine. More research is needed, however, to better understand how these medications work, particularly when combined in patients with comorbidities.

Other Information Sources

For more information on comorbidity between drug use disorders and other mental illnesses, see—

- NIDA's *Research Report* Series: *Comorbidity: Addiction and Other Mental Illnesses* at **www.drugabuse.gov/ResearchReports/comorbidity**
- NIDA's *Topics in Brief: Comorbid Drug Abuse and Mental Illness* at **www.drugabuse.gov/tib/comorbid.html**
- National Institute of Mental Health, National Institutes of Health, at **www.nimh.nih.gov**

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National Institutes of Health – U.S. Department of Health and Human Services

Association for the Advancement of Behavior Therapy
Fact Sheet on Aging

Myths and realities about old age

The number of Americans age 65 and older is projected to comprise about 20% of the nation's population by the year 2030. With a growing elderly population, greater attention has been devoted to the lives of seniors and toward ensuring the physical and mental health of individuals as they move toward later life.

Unfortunately, beliefs typically ascribed to older persons about their mental health tend to be myths. For example, the elderly are assumed to experience greater psychological problems in comparison to younger adults, and are thought to be plagued by sadness and loneliness, tormented by fears of death and dying. It is also commonly assumed that American families abandon their older relatives and that the elderly almost always suffer from dementia. Given that none of these assertions are substantiated, debunking common myths about old age is a necessary first step to gain a better understanding of psychological disorders among the elderly and within the context of aging.

The vast majority of older people are happy and satisfied with their lives. Some surveys show that older people display less fear of and more acceptance of death in comparison to younger and middle-aged people. Families also typically remain geographically and emotionally close to their older relatives -- even when they live in nursing homes. While dementia is more common in old age than in youth, it is not typical. Changes in thinking that occur with normal aging are largely harmless, characterized by mild forgetfulness and word-finding difficulty in conversational speech.

Thus, when older people experience marked psychological distress and impairment, the aging process itself cannot be held accountable. Rather, changes in the social or physical surroundings, the absence of supportive relationships, or long-standing difficulties should be considered as contributing factors to the development and maintenance of distress among the elderly. Appreciating the normal changes that occur in the aging process paves the way to proper assessment and treatment when problems do arise.

General Overview

In general, psychological disorders are less common in old age than middle age. The incidence of major depression, anxiety, and drug abuse all *decrease* with age. Some core symptoms of chronic psychological disorders may even improve with age. For example, hallucinations and delusions among individuals with schizophrenia tend to decrease with age.

Unfortunately, older people who do suffer from psychological distress are far less likely than younger people to receive effective treatment for mental health problems. They are less likely to seek treatment and, if they do, their problems are less likely to be treated aggressively. Older persons are more likely to receive diagnoses of intractable conditions and pharmaceutical rather than behavioral treatment. These facts highlight the importance of understanding the various treatment options available for older people who experience mental health problem.

Specific Disorders

Depression.

While temporary feelings of sadness, grief, and loss are typical in old age, persistent depression that interferes significantly with functioning is not a normal part of aging. In fact, recent studies have found the incidence of major depression to be relatively low among the elderly. Nevertheless, it is the most common psychological disorder in old age and the principal reason for psychiatric hospitalization in the elderly. Estimates of major depression in the elderly population living in the community range from about 1 percent to about 5 percent. These estimates rise to approximately 13.5 percent among elderly persons who require home healthcare and to 11.5 percent in elderly hospital patients. In addition, about 5 million older people have subclinical depression, symptoms that fall short of meeting the full diagnostic criteria for the disorder.

The risk of depression in the elderly increases when other medical problems are present including heart disease, stroke, diabetes, and cancer. Other risk factors for depression in the elderly include certain medications or combinations of medications, being female, single status (especially if widowed), social isolation, chronic or severe pain, stressful life events, lack of a supportive social network, past suicide attempts, and personal or family history of depression.

Left untreated, depression can seriously reduce quality of life. When depression co-occurs with a physical illness, depression can delay recovery from or worsen the course of other illnesses. The risk of suicide is also a serious concern among elderly patients with depression. Untreated depression can be deadly as demonstrated by the fact that Americans over the age of 65 are disproportionately likely to die from suicide, accounting for an estimated 18 percent of suicide deaths in the year 2000. Elderly white men are particularly at risk, with suicide rates in people ages 80 to 84 more than twice that of the general population.

Unfortunately, only about 10% of elderly persons with depression receive treatment.
Given that older persons tend to have medical illnesses and face other problems, health care providers sometimes erroneously assume that depression is a normal consequence of these problems or overlook depression. This misunderstanding is one of the many factors that contribute to underdiagnosis of depression among the elderly.

Proper assessment is critical when depression is suspected. A correct diagnosis is beneficial because elderly persons with depression typically respond well to treatment. Antidepressant medications or psychotherapy, or a combination of the two approaches, can be effective treatments for depression later in life. For older adults who are in good physical health, psychotherapy in conjunction with medication appears to be the most successful treatment approach. If medication is clinically indicated, consulting with a geriatric specialist about the most appropriate medication(s) is recommended.

There are a variety of medications for depression including antidepressants, tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs). It is important to note that different medications work for different people. Typically, medications take about four to eight weeks to work. If one medication is not helpful, research findings indicate that another might. Those who are taking medication for depression the first time should discuss with their health care physicians about continuing medication even if symptoms disappear because there is some evidence that older adults who continue to take their medications even after symptoms remit are less likely to relapse.

In psychotherapy, people work with a trained professional to deal with symptoms of depression, thoughts of suicide, and related problems. Research shows that certain types of psychotherapy are effective treatments for late-life depression.

Dementia.

Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities. The most common form of dementia in senior citizens is Alzheimer's disease, also referred to as senile dementia/Alzheimer's type (SDAT). SDAT currently affects about 5 million Americans. This number is expected to triple by the year 2050 because people are living longer. The number of people with SDAT doubles with every decade past the age of 70. Approximately 5 percent of people ages 65 to 74 have SDAT, and nearly half of those age 85 and older may have the disease. While the risk of SDAT increases with age, it is important to keep in mind that this disease is not a normal part of the aging process.

SDAT is a degenerative brain disease with a slow, progressive course. Although memory impairment is the core feature for the diagnosis of dementia, this disease also affects language, judgment, attention, emotions, decision-making, and other behaviors. In the early stages, the symptoms of SDAT may be more subtle and resemble characteristics that are often mistakenly attributed to the aging process with symptoms initially involving disruptions in thought, memory, and language. Early symptoms include repeating questions, misplacing personal items, having difficulty finding objects, getting lost in familiar places, losing interest in activities that used to be enjoyable, and experiencing difficulty performing tasks such balancing a checkbook or playing games. Later, disorientation, wandering, and profound memory loss characterize the disease. During advanced stages of the illness, symptoms include forgetting details about current events, forgetting aspects of personal history and identity, experiencing hallucinations, delusions, feeling agitated, difficulties selecting appropriate clothing, and difficulties performing daily tasks such as cooking. Eventually, victims do not recognize long-time friends and relatives, no longer understand language, and lose the capability to perform basic self-help skills such as bathing and dressing.

There are two types of SDAT, which are distinguished by the timing of disease onset. In early-onset SDAT, the less common version, symptoms appear before the age of 60 and the disease tends to progress rapidly. In late-onset SDAT, the symptoms typically emerge and progress at a slower rate.

The cause of SDAT is unknown but it is believed to result from both genetic and environmental factors. Genes are hypothesized to play a causal role in early-onset SDAT, but late-onset dementia appears unrelated to family history. Neuropsychological testing can be highly valuable in the differential diagnosis of reversible conditions, like depression, from dementia. It is extremely important to rule-out drug side-effects as the cause when dementia is in question.

The rate of disease progression is different for different people. However, some research suggests that SDAT will continue to progress at the same rate at which it develops. Thus, rapid development of the disease will likely lead to rapid progression of the illness and slow development will likely be followed by a slower progression of deterioration in memory, language, and other areas of impairment.

When elderly persons exhibit signs of SDAT, the first step is to establish the presence of dementia. Health care physicians should be consulted for a diagnosis of the type of dementia experienced. Physicians will help to determine whether the cause of the dementia is treatable. For example, conditions such as thyroid deficiencies, brain tumors, chronic infections, anemia, and depression may sometimes lead to dementia.

There is no known cure for SDAT. Both pharmaceutical and behavioral treatments have had limited success. Thus, treatment focuses on slowing the progression of the disease, managing problems such as confusion, changing the home environment to control problematic behavior, and supporting caregivers course of deterioration. The treatments with the most promise and success are medications that affect the neurotransmitter acetylcholine, lifestyle changes, and antioxidant supplements (i.e., ginkgo biloba and vitamin E). As with any medical condition, it is recommended that individuals interested in taking medication consult with a physician. Lifestyle changes may include incorporating regular activities such as walking into the daily routine, practicing relaxation techniques, using bright light therapy, and listening to calm music. Although research has not substantiated the effect of antioxidant supplements such as ginkgo biloba and vitamin E, these supplements have demonstrated some promise in reducing dementia symptoms. Individuals taking blood-thinning medications or monoamine oxidase inhibitors (MAOIs) should consult with their doctors prior to taking these supplements.

Caregivers and family members of individuals with SDAT should be prepared to provide both support and supervision in the home as the disease progresses. It can also be helpful to simplify the environment of those with this illness by providing reminders, notes, lists of tasks, directions for activities.

Summary

Aging per se does not increase the incidence of psychological disorders. If anything, the prevalence of most psychological disorders decreases with the aging process. It is essential to appreciate that most older people are psychologically resourceful and competent. When mental health problems do occur in the elderly, however, these problems are often overlooked. Thus, only a fraction of elderly persons with psychological distress receive effective treatment despite evidence that interventions can be effective for the elderly. It is important to be aware of mental health symptoms, particularly depression and dementia, and to be knowledgeable about the various treatment options available and effective for adults in later stages of life.

What Is Cognitive Behavior Therapy?

Behavior Therapy and Cognitive Behavior Therapy are types of treatment that are based firmly on research findings. These approaches aid people in achieving specific changes or goals.

Changes or Goals might involve:

- a way of acting - like smoking less or being more outgoing;
- a way of feeling - like helping a person be less scared, less depressed, or less anxious;
- a way of thinking - like learning to problem-solve or get rid of self-defeating thoughts;
- a way of dealing with physical or medical problems - like lessening back pain or helping a person stick to a doctor's suggestions; or
- a way of adjusting - like training developmentally disabled people to care for themselves or hold a job.

Behavior Therapists and Cognitive Behavior Therapists usually focus more on the current situation and its solution, rather than the past. They concentrate on a person's views and

beliefs about their life, not on personality traits. Behavior Therapists and Cognitive Behavior Therapists treat individuals, parents, children, couples, and families. Replacing ways of living that do not work well, with ways of living that work, and giving people more control over their lives are common goals of behavior and cognitive behavior therapy.

The Association for Behavioral and Cognitive Therapies (ABCT) is an interdisciplinary organization committed to the advancement of a scientific approach to the understanding and amelioration of problems of the human condition. These aims are achieved through the investigation and application of behavioral, cognitive, and other evidence-based principles to assessment, prevention, and treatment.

For more information, please contact ABCT at
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Anger

In response to being criticized or ignored, or when overwhelmed with daily hassles, people often feel irritated, annoyed or angry. This is a normal reaction. In fact, when anger is experienced and expressed appropriately, it can lead to healthy coping and constructive change. On the other hand, frequent, intense, and enduring anger can be quite harmful.

Anger is not limited to shouting and yelling. Angry individuals may become intimidating and aggressive. They may hurt themselves, others, or property. Extreme anger may lead to problems with the law. Also, some individuals feel badly about their anger leading to guilt reactions. Angry individuals may not show their anger outwardly. Rather, it remains inside and they harbor fantasies of "getting even." Uncontrolled and excessive anger causes problems in all areas of life. It can result in relationship problems with friends, family, or coworkers.

Some reactions to angry are immediate. For example, others may avoid angry individuals since it is unpleasant to be the recipient of anger. Angry individuals may themselves suffer from headaches, stomach problems, and so on. Other consequences of anger may emerge over the longer term. Angry individuals may develop habit of withdrawal, sulking, and brooding. They may experience anguish and inner turmoil. They tend to develop lower self-esteem, more anxiety, and more alcohol and drug abuse than people who are less angry. Uncontrolled anger may eventually lead to heart disease, elevated blood pressure, and cancer, as well as to relationship and work problems.

Anger Treatment

Counseling or psychotherapy can help you (or others in your life) deal with an anger problem. In seeking therapy, you may wish to consider several general issues. First, realize that anger is a common and sometimes normal human emotion. It is sometimes appropriate to be angry. But, when exaggerated, uncontrolled, or linked with dysfunctional behavior anger becomes a problem that can affect all areas of life. Second, note that angry behavior patterns are habits that are developed and repeated over a lifetime. Fortunately, these habits can be changed. Much anger is an automatic emotional response and with practice it can be reduced. Thus, it is important to ask prospective therapists how techniques for anger management will be learned and practiced. Third, if you have concerns regarding the confidentiality of treatment, discuss these issues with your therapist. Since laws vary from state to state, your therapist would be in the best position to explain the doctor-patient privilege. You should be aware that therapists, to prevent harm, may warn a potential victim of aggression if a client intends to hurt someone. This is a normal professional procedure.

Approaches to Anger Therapy

There are many different approaches a therapist may use to help an individual control anger. For example, some people may benefit from exploring their family backgrounds and others may be helped with medication. Of importance, you should know that cognitive behavior therapy techniques have been shown to be highly effective for anger reduction and often represent the treatment of choice. Not everyone, of course, will find every technique to be useful. Therapists base the use of each technique on a careful evaluation of the client's circumstances and characteristics.
Several effective cognitive behavioral techniques are outlined below:

Enhanced Personal Awareness

Angry individuals often do not have a clear sense of their anger. They don't understand where it comes from, and what is happening to them when they are angry. There are many

ways you can learn about the elements of anger episodes. These include detailed discussions with your therapist, role-playing of anger causing situations, and self-monitoring (making a record of) anger in day-to-day living. Whatever approach is chosen, the goal is to help you become more aware of the anger in your life, by addressing the following issues:

Where and when does the anger occur?
Why does anger occur (what events or situations lead to the anger)?
What kinds of memories or images trigger the anger?
How do you feel when you become angry (emotionally and physically)?
What are you thinking when you are angry?
How do you handle the aversive situation?
Do you always behave the same way? If not, why not?
What do others do when you become angry?

Answering such questions will help you become aware of the nature, reasons, and results of anger. The answers will also eventually help you develop a greater sense of self-worth and personal control, and the ability to use anger management and problem solving skills. Although enhanced personal awareness is rarely all that is needed, it is often very helpful.

Anger Disruption by Avoidance and Removal

These techniques lead to interruption of anger by removing you, mentally or physically, from the situation. For example, it might be wise to simply get up and leave a situation when anger develops. This might even be negotiated with a spouse, friend, or business associate in advance. It might be wise to delay responding by asking for time to think about angering issues or to gather additional information before responding. It might be wise to seek an alternative mode of response, such as a written or email answer, instead of an immediate spoken one. These techniques may decrease or even prevent the anger altogether.

Doing a distracting non-angry activity is also an alternative. One mother, with an anger problem, chose to plan meals and do the laundry instead of arguing and insulting her teenage daughter about homework. Other individuals may count to ten, or may provide themselves with a brief, nondamaging physical distraction such as pressing their fingers together very firmly or leaving to take a shower or work in the garden.

Although these are only a few examples, they are simple strategies that can disrupt anger and give the individual some time and distance to calm down. They can then approach the situation differently at a later time. As with enhanced self-awareness, these strategies are rarely sufficient alone, but are an important part of treatment.

Relaxation Coping Skills

Anger is often marked by increased emotional and physical excitement. Relaxation coping skills target this excitement and can help you learn how to calm down when angered. You can learn to become aware of the triggers for anger and relaxation can be used to lower it. Relaxation skills include slow deep breathing, slowly repeating a calm word or phrase, picturing a personal relaxation image, or focusing on muscle tension and consciously letting it go. These skills are practiced at home until you can relax quickly. Then, as you become better at using relaxation, it can be used to lower anger within the therapy session. For example, the therapist may ask you to imagine an angering event, experience the anger, and then assist you to use relaxation skills to lower the anger. Over the course of a few sessions, as the therapist's

assistance decreases, you can learn to handle increasing levels of anger. If successful in the therapy sessions, you can begin to use relaxation for anger management in daily living, freeing yourself to approach situations more calmly.

Attitude and Cognitive Change

When angry, people often make bad situations worse by the way they think about them. For example, angry individuals tend to *demand* that things should be, ought to be, or have to be, their way - rather than just *wanting* or *preferring* them to be a certain way. Often, they call other people insulting and sometimes obscene names. The problem situation is often seen as *awful* or *catastrophic*, rather than simply *difficult, frustrating*, and truly *disappointing*. By thinking about bad situations in this way, natural frustrations, hurts, and disappointments seem much larger than actually are, leading to increases in anger.

Attitude and cognitive change techniques focus on identifying anger producing thoughts and replacing them with more reasonable ways of thinking. As with relaxation skills, many different techniques may be employed. For example, careful exploration of thinking errors, role-playing, self-monitoring and self-debating strategies, and trying out new behaviors are some of the techniques available to therapists. Whatever specific strategies are chosen, you and your therapist work together in session to become aware of, and change, attitudes and images that increase anger. Then, the new and more reasonable thought patterns (habits) for anger reduction are practiced in the real world.

Silly Humor

Another cognitive change technique is silly humor. This does not mean that you will be taught to laugh away problems. Instead, the goal is to use silly humor, rather than hostility, as a partial cure. This is particularly helpful with certain types of angering thoughts. For example, adult drivers may make themselves angrier by calling other drivers "asses." The client might be asked to define this term correctly. This usually leads to a definition of burro. Then, they might be asked to draw a picture of this definition and to picture this image when they use the term. Rarely is silly humor the primary therapy technique, but it often helps people chuckle at themselves, take a mental step back, and approach the situation in a less angry way.

Acceptance and Forgiveness

Many things that others do simply can not be helped. For example, because of poor motor control children do often spill drinks at a restaurant. As part of their natural development, they commonly argue with each other, then and pout or shout. In industry, realistic economic conditions do sometimes lead to layoffs, which even management does not want. Marital partners do sometimes forget about issues that are important to their spouses, because of personal medical or work preoccupations. Thinking that others have intentionally or purposely set out to cause problems is often wrong. Thinking that they could have acted differently if they really wanted to, ignores other causes of behavior. Sometimes, for example, spouses or colleagues just don't hear what you say because of hearing loss. Thinking that the bad behavior of others is always intentional just increases anger and does little to solve problems. Understanding that some behaviors are caused by biology or genetics, or normal development, or economic stressors, is more realistic. Acceptance and forgiveness interventions help you to understand these realities. The goal is to improve relations with others, while reducing needless and repetitive lecturing and blaming.

Skill Enhancement

Some people experience anger because they do not have the necessary skills to negotiate common interpersonal hassles and conflicts. They may fight with a spouse because

they don't know how to communicate well about family budgets; become furious and yell at a child because they don't know how to handle the child's misbehavior; or become angry and intimidating when dealing with coworkers because they don't know how to be assertive. Anger escalates because of insufficient skill at resolving the situation.

Although the needed skills vary greatly from individual to individual, skill training can help you approach negative situations in a calm, direct, problem-solving manner. You and your therapist identify the needed skills and rehearse them during therapy sessions until you are comfortable with them. Then, you work together to transfer these skills from the office into the real world. Over time, you will learn general principles and strategies that can be adapted to many anger causing situations. This leads to a reduction in anger because the skills stop or lessen conflict and tension with others.

Summary

Although frustration and a degree of anger are inevitable parts of life, individuals don't have to be victims of uncontrolled, intense or frequent anger. A number of effective cognitive-behavioral techniques are available for anger management. No one is likely to need all of them. However, psychotherapy can identify how these strategies might be combined to reduce anger, in order to help you and others in your life deal with this troublesome emotion.

What Is Behavior Therapy?

Behavior Therapy is a particular type of psychological treatment that is based firmly on research findings. It aids people in achieving specific changes or goals.

Goals might involve:

- An improved way of acting: like trying not to shout or push others;
- An improved way of thinking: like understanding that most bad situations aren't catastrophic, learning to problem-solve and get rid of self-defeating thoughts, rather than to blame others;
- An improved way of dealing with physical or medical problems: like controlling the advance reactions due to pain or helping a person stick to a doctor's suggestions; or
- A way of coping: like training people to see the cause of their anger before becoming angry and to accept the, sometimes, negative reality of life.

Behavior Therapists and Cognitive Behavior Therapists usually focus on the current situation, rather than the past. They concentrate on a person's views and beliefs about their life, not on personality traits. Behavior Therapists and Cognitive Behavior Therapists treat individuals, parents, children, couples, and whole families.

Replacing ways of living that do not work well with ways of living that do work, and giving people more control over their lives are common goals of behavior therapy. The development of goals and improved habits is done collaboratively, so that clients and therapists agree on the best course of action.

How to get help

If you are looking for help with anger, either for yourself or someone else, you may be tempted to call someone who advertises in a local publication or who comes up from a search of the internet. You may, or may not, find a competent therapist in this manner. It is wise to check on the credentials of a psychotherapist who you might consider seeing. It is expected that competent therapists hold advanced academic degrees and are trained in anger management techniques. They should be listed as members of professional organizations such as the Association for Behavioral and Cognitive Therapy, the American Psychological Association, and

so on. Of course, they should be licensed to practice in your state. You can find competent anger management specialists who are affiliated with local universities or mental health facilities, or who are listed on the web sites of professional organizations.

What Is Cognitive Behavior Therapy?

Behavior Therapy and Cognitive Behavior Therapy are types of treatment that are based firmly on research findings. These approaches aid people in achieving specific changes or goals.

Changes or Goals might involve:

- a way of acting - like smoking less or being more outgoing;
- a way of feeling - like helping a person be less scared, less depressed, or less anxious;
- a way of thinking - like learning to problem-solve or get rid of self-defeating thoughts;
- a way of dealing with physical or medical problems - like lessening back pain or helping a person stick to a doctor's suggestions; or
- a way of adjusting - like training developmentally disabled people to care for themselves or hold a job.

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Anxiety Disorders

Anxiety is a normal emotion and common experience, and it represents one of the most basic of human emotions. At one time or another, all of us are likely to be "stressed out," worried about finances or health or the children, fearful in certain situations (such as when on a ladder or just before an operation), and concerned about what other people think. In general, anxiety serves to motivate and protect an individual from harm or unpleasant consequences.

For many people, however, constant or excessive anxiety disrupts their daily activities and quality of life; for others, panic, which seems to come out of nowhere, can cause terrible physical symptoms, such as faintness, chills, and even extreme chest pains. Anxiety disorders are so common that more than 1 in every 10 Americans will suffer with one at some point in their lives. Fortunately, anxiety disorders can be treated, generally with short-term, effective, and cost-efficient methods.

Types of Anxiety Disorders

There are a number of different disorders that fall under the category of anxiety. They include Panic, Generalized Anxiety, Obsessive-Compulsive Disorder (or OCD), various Phobias (including Social Phobia and Agoraphobia), and Posttraumatic Stress Disorder (or PTSD). Each of these is described below.

Panic Disorder: On his way home from work, John is driving through his neighborhood when suddenly a child darts out into the street in front of the car. John slams on the brakes and swerves, just missing the child. As he pulls over, John's heart is beating furiously, and he is breathless, sweating, and shaking. He could have killed that child. It is several long minutes before he is able to continue home. This is a normal reaction to a potentially catastrophic situation. Our nervous systems are equipped with an alarm system, much like a fire alarm, that alerts us to danger. This system is triggered by impending danger, and it instantaneously prepares our body to "fight or flee" and ultimately protects us from harm.

For some individuals, the alarm system rings at inappropriate times, when there is no danger present. Imagine sitting at home, watching television, and, from out of nowhere, this alarm reaction occurs. A panic attack is the physical sensations of the alarm system and includes sensations such as a racing heart, rapid breathing, tingling or numbing sensations, hot or cold flashes, sweating, trembling, and similar sensations. Individuals who experience unexpected alarms develop a fear of these sensations, and often attribute the attacks to major medical problems, such as a heart attack or stroke. When no physical cause is identified, the individual

begins to fear losing control, or even think that he or she is going crazy. The more a person fears these intense sensations, the more aware he or she becomes of the sensations. The fear of the panic attacks ultimately can cause the attacks to be become more intense and frequent. Fear of panic attacks, then, often becomes the cause of the panic attack.

Social Phobia: Giving a talk in front of a group, walking into a room full of strangers, or meeting with the boss can make anyone somewhat anxious, but for the person with social phobia, such situations cause intense fear and even panic attacks. Individuals with social phobia fear being evaluated negatively by others, and worry excessively about embarrassing themselves. This overwhelming fear often leads the person to avoid social situations. Social phobia is not the normal nervousness a person has before meeting new people, it is an intense fear that causes that person to avoid that situation, significantly disrupting the person's life. Social phobia is one of the most common forms of anxiety disorder, and is often accompanied by depression. In addition, some individuals with social phobia develop alcoholism or other substance abuse problems. Social phobia may be present in all social situations or it may appear in only certain situations, such as speaking in public.

Generalized Anxiety Disorder (GAD): Everyone worries from time to time about finances, the job, health, or family matters. For individuals with GAD, the worry is excessive, difficult to control, and unrealistic. In addition, GAD is accompanied by a range of physical symptoms, such as muscle aches, tension, soreness, sleepless nights, irritability, concentration difficulties, and restlessness. The worry and physical symptoms of GAD can persist for six months or longer, thus reinforcing the person's feelings of helplessness and anxiety. Individuals with GAD are also more likely to develop additional anxiety disorders and depression.

Specific Phobias and **Agoraphobia:** Dogs, spiders, injections, small rooms, thunderstorms, blood, elevators, crowds, driving, heights, and deep water can all cause a certain degree of unease in most individuals. It is relatively easy for most individuals to think about a particular situation or object that they would prefer to avoid. However, when that fear is persistent, or the individual's life is disrupted when trying to avoid the cause of that fear, this is considered a specific phobia. Although individuals with specific phobias recognize that their fear is way out of proportion to the actual threat of the situation, they are unable to control the fear and may experience an anxiety attack when encountering the feared situation or object. As an example, individuals with a specific phobia of blood often faint when they see blood; the anxiety and, especially, fainting, make simple medical or dental procedures overwhelming. Agoraphobia, which is closely linked with panic attacks, is particularly disruptive because the person fears most any open space, thereby making simple tasks, such as grocery shopping, or even seeing

a therapist, anxiety-provoking.

Obsessive-Compulsive Disorder (OCD): Ever wonder if you locked the doors or left the stove on? Ever have the feeling that something terrible was about to happen? Do you have certain routines that you follow in the morning or evening? These thoughts and simple routines are not unusual. However, for the person with OCD, these thoughts and routines occur repeatedly, and the individual feels unable to stop them. Moreover, these thoughts and behaviors cause significant distress and interference in the individual's life. When "checking behavior" or other compulsions take hours, not minutes, of a person's day, therapists consider this to be OCD. Typical obsessions include fears of contamination or poisoning, religious themes, doubts, and thoughts of sex. Compulsions are often desperate attempts to "neutralize" the obsession and anxiety, and involve repeating some behavior such as washing, checking, counting, tapping or touching things repeatedly.

Posttraumatic Stress Disorder (PTSD): Terrible events can cause extreme feelings of helplessness, horror, and fear. These events might include physical or sexual assault, car accidents, natural disasters, robbery, and war. People with PTSD develop anxiety and intrusive thoughts about the event, and may feel at times as though the event were happening again. Classic symptoms of PTSD include nightmares, being easily startled, anger outbursts, feelings of detachment, and hopelessness about the future. PTSD can occur within one month of the event, or may be delayed for many years after the trauma.

How Can Cognitive and Behavior Therapy Help People With Anxiety Disorders?

There is hope for individuals with anxiety disorders, because these problems can be effectively treated with cognitive therapy and behavior therapy. In some cases, treatment of a specific phobia takes only one session, while most programs for the other anxiety disorders take, on average, 12 to 18 sessions. Cognitive behavioral treatments typically involve four main components.

Education about the nature of anxiety helps the individual understand his or her responses and teaches the individual ways to more effectively cope with anxiety. ***Somatic management skills*** teach relaxation and breathing techniques, which help the individual manage the physical symptoms and discomfort of anxiety. ***Cognitive skills*** address the individual's beliefs and thoughts, and focus on teaching more adaptive, realistic thinking styles. And, all treatments for anxiety involve some form of ***behavioral exposure***, a gradual, step-by-step confrontation of the fear with mastery and skill.

For many people, behavior therapy and cognitive therapy alone will be enough to overcome or manage the various anxiety disorders. For some individuals, however, medication, in

combination with cognitive behavioral therapy, can foster a return to a full and satisfying life. Programs combining pharmacology and behavior therapy are available for the range of anxiety disorders.

What Is Cognitive Behavior Therapy?

Behavior Therapy and Cognitive Behavior Therapy are types of treatment that are based firmly on research findings. These approaches aid people in achieving specific changes or goals.

Changes or Goals might involve:

- a way of acting - like smoking less or being more outgoing;
- a way of feeling - like helping a person be less scared, less depressed, or less anxious;
- a way of thinking - like learning to problem-solve or get rid of self-defeating thoughts;
- a way of dealing with physical or medical problems - like lessening back pain or helping a person stick to a doctor's suggestions; or
- a way of adjusting - like training developmentally disabled people to care for themselves or hold a job.

Behavior Therapists and Cognitive Behavior Therapists usually focus more on the current situation and its solution, rather than the past. They concentrate on a person's views and beliefs about their life, not on personality traits. Behavior Therapists and Cognitive Behavior Therapists treat individuals, parents, children, couples, and families. Replacing ways of living that do not work well, with ways of living that work, and giving people more control over their lives are common goals of behavior therapy.

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What Is Assertiveness?

Have you ever been to a party and found yourself avoiding someone because you did not know what to say? Have you ever realized, after the fact, that you had been unfairly criticized or taken advantage of? Are you hesitant to express your thoughts or opinions? Do you find dealing with authority figures difficult?

These are examples of situations that involve assertive behavior. Assertiveness can be defined as communication in which one expresses oneself in a direct and honest manner in interpersonal situations, while simultaneously respecting the rights and dignity of others.

What Is Assertiveness Training?

Assertiveness training can be an effective part of treatment for many conditions, such as depression, social anxiety, and problems resulting from unexpressed anger. Assertiveness training can also be useful for those who wish to improve their interpersonal skills and sense of self-respect.

The Reasons for Assertiveness Training

Assertiveness training is based on the principle that we all have a right to express our thoughts, feelings, and needs to others, as long as we do so in a respectful way. When we do not feel like we can express ourselves openly, we may become depressed, anxious, or angry, and our sense of self-worth may suffer. Our relationships with other people are also likely to suffer because we may become resentful when they do not read our minds for what we are not assertive enough to be telling them. There are no hard-and-fast rules of what assertive behavior is; rather, it is specific to the particular time, situation, and cultural context. In other words, behavior that is appropriately assertive for one person in one situation may be either excessively passive or too aggressive for someone else in a different situation. Finally, assertiveness training is based on the idea that assertiveness is not inborn, but is a learned behavior. Although some people may seem to be more naturally assertive than others are, anyone can learn to be more assertive.

Although these ideas may sound simple and straightforward, behaving assertively can sometimes be difficult for almost anyone, and is often impossible for some people. For this reason, assertiveness training focuses on not only talking about the importance of assertiveness, but also on learning assertive behaviors and practicing these behaviors with the help of a professional therapist.

What Is the Difference Between Assertiveness and Aggression?

People sometimes confuse assertiveness with aggression, believing that assertiveness training might make them pushy or inconsiderate of others. In fact, assertiveness can be thought of as a middle point between passivity and aggression. In interpersonal situations, passive behavior occurs when you focus on the needs and desires of another person, but ignore your own needs and wishes. In contrast, aggressive behavior occurs when you force your own needs on others. Assertive behavior involves expressing your own way of seeing things, but in a way

that is respectful of the other person. Although no one can guarantee that the other person will like what you do or say, assertive behavior requires that the other person be treated with respect. Assertiveness training can help not only those who tend to be overly passive in interpersonal situations, but also those who tend to be overly aggressive.

What is the Difference Between Assertiveness and Passive-Aggression?

Passive-aggressive behavior includes pieces of both aggressive and passive styles. Rather than speak or act directly, passive-aggressive behavior involves masking aggression to avoid accepting responsibility for the consequences of one's behavior. Consider this example: On a busy weekday morning your spouse asks you at the last minute to mail an overdue bill on your way home from work. You do not want to do this, as you know you are going to have an unusually busy day. So rather than skipping your lunch break to mail it without saying anything to your spouse (passive), shouting at him or her (aggressive), or explaining how busy you are (assertive), you simply leave work after the post office closes. You get your way, your spouse is upset, yet you can deny any responsibility for your behavior. Sometimes such things really do happen and people have legitimate excuses. Behavior becomes passive-aggressive if at some level one really wished for the bad outcome. Appropriate assertiveness can help alleviate negative feelings that build up from constantly letting others down.

How Is Assertiveness Training Done?

Therapists help clients figure out which interpersonal situations are problems for them and which behaviors need the most attention. In addition, therapists help to identify beliefs and attitudes the clients may have developed that lead them to become too passive. Therapists take into account the clients' particular cultural context in this process. Therapists may use a combination of interviews, tests, or role-playing exercises as part of this assessment.

Therapists help clients understand what assertiveness is and how behaving assertively may be helpful. Inaccurate or unproductive attitudes and beliefs about assertiveness are discussed. Once clients understand the importance of assertive behavior for their situation, therapists help them develop more assertive behaviors. For example, using a technique called behavioral rehearsal, a specific situation is described and then role-played by the client and the therapist. Initially, the therapist may play the role of the client and model assertive behavior. The client and therapist then switch roles, and the client practices the new behavior. The therapist gives supportive, honest feedback after each role-play exercise in order to help the client improve his or her skills. Assertiveness training focuses on both verbal and nonverbal behavior. Verbal behavior is the content of a communication — in other words, what is actually said. This includes expressing requests, feelings, opinions, and limits. Nonverbal behavior refers to the style of communication: eye contact, posture, tone and volume of speech, interpersonal distance, and listening.

Examples of Assertiveness Techniques

There are several specific strategies that can be useful when trying to develop assertiveness. One, called the broken-record technique, is useful for situations in which another person will not acknowledge or accept your message. For example, suppose a salesperson is attempting to pressure you to buy something you do not want. You respond, "Thank you, but I am not interested in buying anything today." If he or she continues pushing, you simply repeat the same statement, keeping your tone of voice constant, without becoming upset. Eventually, the person will be forced to accept your refusal. Another technique, sometimes called fogging, is a method for denying requests or disagreeing with someone while showing them that you nevertheless recognize and respect that person's position. You begin by summarizing the other person's feelings, and then explain why you cannot, or choose not to, comply with that person's request. For example, your husband is warm and asks you to turn down the heat, but you are cold. You respond, "I'm sorry you feel warm, but I've got on a sweater and long underwear, and I'm still freezing. I do not want to turn down the heat any more. Maybe you could dress more lightly or go for a walk." These are only two of many behavioral techniques that can help develop better assertiveness skills.

In addition to teaching specific assertiveness skills, the therapist can work with clients to help reduce depression, anxiety, worry, and stress through exposure-based interventions, cognitive interventions such as cognitive therapy or rational-emotive behavior therapy, acceptance and mindfulness interventions, or other techniques.

Can Therapy Help?

All of us can learn to improve our assertiveness skills. Some people are able to improve their skills by reading books on assertiveness training and practicing the exercises outlined in the books. Such books are widely available in libraries and bookstores. For many others, however, professional help is necessary to make real and lasting improvements in assertiveness skills. This is especially true if one's interpersonal problems are associated with strong feelings of anxiety or depression. If you or someone you know might benefit from assertiveness training, it is important to find a therapist or counselor who is an expert with this approach. Ask directly about the professional's training and experience with assertiveness training. Your family doctor may be able to refer you to a competent professional.

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What Is Chronic Fatigue Syndrome?

Chronic fatigue syndrome (CFS) is an illness characterized by a combination of symptoms and signs that have lasted six months or longer. Characteristics of this syndrome include disabling fatigue, fever, sore throat, painful lymph nodes, muscle weakness, muscle pain, after-exercise fatigue, headaches, joint pain, sleep disturbance, and neuropsychological symptoms (such as forgetfulness, confusion, irritability, depression, and trouble concentrating). The strength of the illness can vary from severe to lesser symptoms.

What Causes CFS?

The cause of CFS is unknown. It is probably triggered by several factors, including infection, surgery, stress, and others. These factors may act individually or together to trigger CFS. However, no trigger or abnormality has been identified that is shared by everyone with CFS. Long after the triggering factors have occurred, the illness continues.

Chronic Fatigue Syndrome Is a "Diagnosis of Exclusion"

Because the cause of CFS is unknown, there is no laboratory test to prove or disprove the presence of CFS. A number of other illnesses with symptoms like those of CFS must be ruled out before CFS is diagnosed. Self-diagnosis with CFS should be avoided; consideration of a CFS diagnosis requires comprehensive, sophisticated medical and psychological evaluations.

Other illnesses to be ruled out include neuromuscular diseases (such as multiple sclerosis), autoimmune diseases (such as systemic lupus erythematosus), cancers, and diseases from parasitic infections (such as giardia), to name a few.

Because emotional problems such as depression have symptoms similar to CFS, some professionals have thought that CFS was a "hidden" depression or anxiety problem. However, emotional problems do not account for some CFS signs and symptoms, such as fevers and swollen lymph glands, which make it hard to support emotional problems as a cause. On the other hand, when a person has fewer or more symptoms than the list of CFS symptoms, other diagnoses, including psychological ones, must be considered.

What Role Do Psychological Factors Play in CFS?

A person's response to the illness is important in determining its course. Similarly, family's, friends', physician's, and co-workers' responses affect how a person copes with symptoms. For example, some people react to illness by denying that it exists and underrespond to their symptoms. This may not be in their best interest, as they are likely to overexert themselves and make their symptoms worse or set unrealistically high goals that they cannot achieve, leading to depression and/or anger.

On the other hand, other people may respond to symptoms with fear and pessimism and unnecessarily limit their activities. Further problems can result from this sort of response, such as a loss of muscle tone and therefore of strength. Behavior therapists can help a person learn to cope effectively and flexibly with symptoms.

How Is CFS Treated?

Gather your treatment team. The treatment of CFS is symptomatic and supportive. Because its cause is not known, treatments cannot be directed at the underlying cause but are directed at its symptoms. Management and treatment of CFS involves both medical and psychological professionals, and may include other professionals, such as physical therapists.

It is very important that one physician be designated as the doctor in change. This physician acts as the overseer. Many people with CFS obtain consultation with multiple professionals, and

having one doctor in charge helps to keep an eye on the "big picture" and to manage recommendations from other consultants, which can be conflicting and confusing.

Medication

Symptomatic relief is sometimes obtained from medications. Anti-inflammatory drugs such as ibuprofen help relieve headaches and muscle and joint aches and pains. Antidepressants are sometimes prescribed to help with depressive symptoms and pain. These drugs have other effects useful for people with CFS, such as anti-inflammatory effects or sedation to help with sleep. Antiviral drugs have been tried without good results. Many other drugs have been tried to treat CFS. No single drug helps all people with CFS.

Exercise and Physical Therapy

People with CFS often avoid exercise altogether as it can seem to make symptoms worse. This can lead to a sense of mistrust of one's body. For these reasons, a gradual physical activity program can be helpful. It is important to begin with activities that can be achieved. For example, if a person suffers from dizziness and loss of balance, a program of stretching exercises done from a seated or lying position would be more safe and comfortable than those that involve standing or balancing.

For many people with CFS, programs of strenuous aerobic exercise may make symptoms worse. If this is the case, daily, gentle exercise should be directed toward goals of maintaining flexibility, mobility, and accomplishment, and of gradually increasing strength and endurance (e.g., walking, bicycle riding, and swimming).

Cognitive Behavior Therapy

Behavior therapy is used to treat both direct symptoms of CFS and the consequences of having a chronic illness (such as depression, anxiety, job loss, or relationship conflict). When treating CFS symptoms, the therapist will help the patient analyze what makes the symptoms worse or better. This is usually done by asking the person with CFS to keep detailed records.

Take, for example, if the symptom of fatigue is the target, the person might be asked to rate the severity of fatigue on an hourly basis throughout the day and keep track of what else is going on in his or her life; when he or she sleeps, rests, lies down, takes a medication, eats, exercises, does a social activity, works, and so forth. Over time, a pattern may emerge that will lead to a specific treatment. For example, if symptom tracking reveals that exhaustion begins in the late afternoon, a scheduled rest period before this time of day may prevent symptoms from increasing. Record keeping also lets the therapist and the person with CFS know if they are making progress or not.

How a person thinks about CFS affects his or her mood and ability to cope. Tracking symptoms and identifying patterns increases the person's sense of control. Other ideas, like "activity causes illness," may not be completely correct, and may have negative effects, such as leading the person to avoid all activity. Behavior therapy helps identify and modify detrimental thoughts as well.

When treating the consequences of CFS, such as depression, anxiety, or relationship conflict, cognitive behavior therapists use well-established techniques but modify them to take into account the special circumstances of people with CFS. For example, behavior therapy for depression often involves increasing a person's activity level. A person who was depressed about having CFS may be depressed exactly because it is more difficult to be active. Prescribing more activity would need to be done with creativity and flexibility to identify enjoyable, but not physically strenuous, activities that the person could do without making his or her symptoms worse. Cognitive behavior therapy plays an important role in the overall treatment of CFS by helping the person be as active and productive as possible.

Support Groups

Some people enjoy and benefit from attending support groups; other do not. Support groups can be a forum for sharing information and ideas, and participation can counteract the sense of isolation ("I'm the only one who's ever had to deal with this...") that can occur with CFS.

CFS is a recently defined diagnosis, and both medical and psychological scientists are working to understand and treat it. Recovery is impossible to predict. However, multidisciplinary care that is overseen by one physician can help the person with CFS learn to decrease symptoms and cope with them more effectively.

What Is Cognitive Behavior Therapy?

Behavior Therapy and Cognitive Behavior Therapy are types of treatment that are based firmly on research findings. These approaches aid people in achieving specific changes or goals.

Changes or Goals might involve:

- a way of acting - like smoking less or being more outgoing;
- a way of feeling - like helping a person be less scared, less depressed, or less anxious;
- a way of thinking - like learning to problem-solve or get rid of self-defeating thoughts;
- a way of dealing with physical or medical problems - like lessening back pain or helping a person stick to a doctor's suggestions; or
- a way of adjusting - like training developmentally disabled people to care for themselves or hold a job.

Behavior Therapists and Cognitive Behavior Therapists usually focus more on the current situation and its solution, rather than the past. They concentrate on a person's views and beliefs about their life, not on personality traits. Behavior Therapists and Cognitive Behavior Therapists treat individuals, parents, children, couples, and families. Replacing ways of living that do not work well, with ways of living that work, and giving people more control over their lives are common goals of behavior and cognitive behavior therapy.

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Depression

Depression is a common psychological problem, experienced by many people at some time during their lives. One member of most families has experienced an episode of depression severe enough to require formal treatment. Depressed mood is costly to individuals and society as a whole, both economically as well as in terms of quality of life.

Major Characteristics

The primary feature of depression is a sad mood state, which, in its most severe form, is experienced as a feeling of helplessness, hopelessness, and despair. When people experience depressed mood, it is common for them also to experience a decrease in social activities, problems with relationships, and an increase in crying or "a desire to cry even if you cannot get the tears out" (called dry tears depression).

Cognitive Characteristics

There are also several cognitive features of depression that may include a loss of concentration and memory; a belief that you are becoming worthless; a belief that things cannot be made better, have gotten bad, and will get worse; and a focus on negative things about yourself without enough attention on positive things about yourself.

Biological Characteristics

The biological characteristics of depression include disrupted sleep (especially trouble falling sleep and a pattern of waking up very early in the morning), loss of appetite, loss of sexual desire or lack of interest in sexual activity, and fatigue or tiredness during the day. It is also important to know that depression may happen along with increased anxiety and feelings of anger or hostility. In about 10% of cases, depression will be followed by problems with alcohol or drugs.

Frequency

Depression severe enough to require formal treatment occurs in about 6% of the women and 3% of the men in this country. Depression can occur, although at lower rates, among children. During adolescence, the rates gradually increase, so that by age 14 or 15 they equal those of adults. Among the elderly, the rates decrease slightly, but depression remains a frequent and serious problem among this age group.

Causes

Life Events

Although no definitive and final answer exists to the question of what causes depression, much is known. Depression may be caused by major negative life events – for example, the death of a loved one, a divorce, a severe financial setback, or even a move to a different neighborhood or part of the country. Other factors that may cause depression include trouble having and keeping social relationships and trouble keeping your everyday life in line with your values in life.

Thinking Patterns

Depression also may be related to faulty thinking patterns. These might include magnifying how badly things are going for you, drawing negative conclusions from life events even when it doesn't make good sense to do so, and generally having a negative view of oneself, the world, and the future.

Biochemical Imbalances

There are several types of biochemical imbalances that may occur in depression. Depression may develop when a biological predisposition to depression is activated by an event. This predisposition is activated when one experiences a major life event (or a sequence of more minor negative life events) and/or develops a negative cognitive pattern of evaluating oneself and one's life events. It is believed that the biological characteristics of depression (sleep disturbance, appetite loss, loss of sexual interest, and tiredness) are related to this biochemical imbalance.

Treatment

During the past few years, very effective treatments have been developed for depression. The majority of people experiencing depression can expect to experience considerable relief from depression within 3 or 4 weeks of effective treatment, and long-lasting relief within 3 to 6 months of treatment.

Behavioral and Cognitive Behavioral Therapies

Behavior therapy and cognitive behavior therapy are among the treatments that have been most extensively evaluated and that have been shown through research to be effective. Behavioral treatments help a person to engage in healthy life activities, particularly activities that are consistent with one's life values. Behavior therapy also helps people to develop skills and abilities to cope with major life events and to learn social relationship skills when these are missing. Cognitive behavior therapy includes the development of behavioral skills, but focuses more on correcting the faulty thinking patterns of depression. Most people experiencing depression will profit from participating in cognitive behavioral therapy that is widely available from mental health professionals.

Some severe depressions, especially those involving severe biological symptoms, may require antidepressant medications. Such medications are available, and many produce quick and effective relief of depression. When antidepressant medication is necessary, it may be combined with behavior therapy or cognitive behavior therapy to produce effective and long-lasting treatment results.

Some people believe that depression will gradually go away, or that if you "just get yourself in gear" you can get over it yourself. Indeed, in some small percentage of cases that may be true. Unfortunately, depression usually does not go away without treatment. Therefore, if you are experiencing a severe, acute depression or a chronic lower level depression, it is best and wise to seek and participate in therapy. Fortunately, there are treatments available to lessen depression and the life difficulties that come along with it.

What Is Cognitive Behavior Therapy?

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What is dual diagnosis?

Dual diagnosis is a term used to describe people with mental illness who also have problems with drugs and/or alcohol. The relationship between the two is complex, and the treatment of people with co-occurring substance abuse (or dependence) and mental illness is more complicated than the treatment of either condition alone. This is unfortunately a common situation many people with mental illness have ongoing substance abuse problems, and many people who abuse drugs and alcohol also experience mental illness.

Certain groups of people with mental illness (e.g., males, individuals of lower socioeconomic status, military veterans and people with more general medical illnesses) are at increased risk of abusing drugs and alcohol. Recent scientific studies have suggested that nearly one-third of people with all mental illnesses and approximately one-half of people with severe mental illnesses (including bipolar disorder and schizophrenia) also experience substance abuse. Conversely, more than one-third of all alcohol abusers and more than one-half of all drug abusers are also battling mental illness.

What is the relationship between substance use and mental illness?

The relationship between mental illness and substance abuse/dependency is complex. Drugs and alcohol can be a form of *self-medication* for people with mental illness experiencing conditions such as anxiety or depression. Unfortunately, while drugs and alcohol may feel good in the moment, abuse of these substances does not treat the underlying condition and, almost without exception, makes it worse. Drugs and alcohol can worsen underlying mental illnesses during both acute intoxication and during withdrawal from a substance. Additionally, drugs and alcohol can cause a person without mental illness to experience the onset of symptoms for the first time.

Abuse of drugs and alcohol always results in a worse prognosis for a person with mental illness. Active users are less likely to follow through with their treatment plans. They are more likely to experience severe medical complications and early death. People with dual diagnosis are also at increased risk of impulsive and violent acts. Those who abuse drugs and alcohol are more likely to both attempt suicide and to die from their suicide attempts.

Individuals with dual diagnosis are less likely to achieve lasting sobriety. They may be more likely to experience severe complications of their substance abuse, to end up in legal trouble from their substance use and to become physically dependent on their substance of choice.

What treatments are available for individuals with dual diagnosis?

Treatment of individuals with dual diagnosis is also complicated. Of primary importance is addressing any life-threatening complications of intoxication. The following situations would require immediate care in a hospital: severe cases of alcohol intoxication; heart problems or stroke caused by use of amphetamines, crack, cocaine and other drugs; overdose on benzodiazapines (e.g., diazepam [valium], clonazepam [klonopin]), opiates (e.g., oxycodone, oxycontin) and other downers. Untreated, any of these conditions can lead to death.

Drug and alcohol withdrawal can also lead to medical emergencies requiring immediate treatment. Alcohol withdrawal can result in heart problems (e.g., arrhythmias), seizures or *delirium tremens* (an acute delirious state), all which can be potentially fatal. Benzodiazapine withdrawal can result in tremors (shakes), seizures and potentially death. Opiate withdrawal is not thought to be life-threatening in most cases but can be a very traumatic and painful experience.

Many people seek assistance in going through the process of stopping their drug and alcohol abuse. This may include inpatient detoxification involving admission to a hospital either a general hospital or a detoxification facility and treatment with the appropriate medications to avoid serious complications of acute drug and alcohol withdrawal.

Multiple scientific studies have shown that psychiatric treatments are more effective in people who are not actively abusing drugs and alcohol. Many options exist for people who are newly sober or who are trying to avoid relapse on drugs and alcohol. These can include inpatient rehabilitation centers or supportive housing. Some people find therapy to be a helpful part of maintaining their sobriety. This can include individual therapy (e.g., cognitive behavioral therapy) as well as self-help groups such as Alcoholics Anonymous, Narcotics Anonymous or Smart Recovery.

Certain medications to help maintain sobriety have been safely tested in multiple studies. For alcoholism, available medications include disulfiram (*Antabuse*), acamprosate (*Campral*) and naltrexone (*Revia*). For opiate abuse, available medications include naltrexone (*Revia*, *Vivitrol*), methadone and buprenorphine (*Subutex*, *Suboxone*). Given how complicated these choices may be, it is necessary for any individual with dual diagnosis and their loved ones to discuss medication management strategies with their doctors.

Families, friends and others can be most helpful in providing empathic and non-judgmental support of their loved one. This can be critically important as a significant majority of people will relapse into drug and alcohol abuse at some point in their lives, even if they are eventually able to achieve long-lasting sobriety. With this support, the proper medical treatment and effective psychosocial treatments, many people with dual diagnosis will be able to actively participate in their journey to recovery.

Reviewed by Ken Duckworth, M.D., and Jacob L. Freedman, M.D., January 2013

Eating Disorders

We eat to live and eating is an important focus for our family and social lives. In a wealth country like the United States, there are large amounts of food available. These large amounts of food seem to put us at risk for the three major eating disorders: obesity, bulimia, and anorexia nervosa. This fact sheet will discuss the role of behavior therapy in the treatment of these disorders.

Obesity

Characteristics

A recent report from the National Institutes of Health suggested that people who are more than 20% over their ideal weight should seek treatment. Over one quarter of all women in the United States fall in this category. Also, just under a quarter of men in the United States fall into this category. Obesity is related to health risks. Some risks include high blood pressure, adult-onset diabetes, and gall bladder disease. At very high levels of obesity, life expectancy is shortened. People should lose weight for health reasons and not for beauty reasons.

We do not understand all the causes of obesity. Recent research suggests that both family genetics and the environment are involved. Some environmental factors include living in a place where there are large amounts of food available and having lower activity levels.

Treatment

For people who have up to about 50 pounds to lose, behavior therapy has been a successful approach to treatment. It is better than medicines that curb the appetite and dietary treatments. Treatment is usually done in groups of 8 to 12 people. It consists of learning to look at and change key behaviors. Keeping records of eating activity forms the basis of treatment. The records are used:

1) to help change the way one eats, for example, eating in fewer places and eating more slowly;
2) to change to a heart healthy diet by decreasing the amount of fat one eats and increasing dietary fiber; and
3) to increase activity levels.

Losing weight and keeping it off is hard work. People who manage to change these key behaviors and continue to practice them over the years are the ones who lose the most weight at first and who keep it off. Weight loss of about a pound a week can be expected with this treatment. In addition, the lost weight is usually kept off for at least a year.

People who have more weight to lose should try a combination of behavior therapy and a very-low-calorie diet (less than 800 calories). The diet should be done under medical supervision. The combination has been shown to be more successful than using the very-low-calorie diet alone. These treatment programs are usually available in specialized centers, such as eating disorders clinics. These clinics are usually found at major medical centers.

Should overweight children be treated?

Overweight children at any age have a greater risk of becoming obese adults than normal-weight children. These children tend to have higher blood pressure and cholesterol levels than normal weight children do. High blood pressure and cholesterol are risk factors for heart disease in later life. This is why overweight children should be treated. Behavior therapy programs tailored to the child's age have both short-term and long-term success in helping children lose weight. These programs usually involve parents.

Bulimia
Characteristics
Social standards for body shape change over time. This is especially true for women. In the United States, a thin body shape is expected for women. Most women diet from time to time. However, a few restrict their diet in a major way. These women tend lose control of their eating and begin to binge-eat. Binge eating leads to the possibility of weight gain. As a result, individuals begin to purge. Some ways people purge include vomiting or using laxatives or diuretics. Less often, people purge by not eating for several days.

Over time, an extreme concern about body shape develops. This fosters more severe dieting and increases the frequency of purging when diet rules are broken. These behaviors are known as bulimia. Bulimia carries several health risks. These risks include an increase in dental problems and a loss of potassium, which may lead to problems such as abnormal heart rhythms. Psychological problems also occur in this condition. Some problems include irritability and depression. The vast majority of bulimics are women, although a few men do develop this problem.

Treatment
Over the last few years, cognitive behavior therapy has been shown to be helpful in overcoming bulimia. Treatment consists of careful record keeping. This can be used to help the patient form new behaviors including:

1) eating three or more balanced meals each day;
2) delaying and then stopping purging;
3) looking at and changing false beliefs about food, dieting, and body shape; and
4) learning that things other than body shape are important to developing a good self-image.

The length of treatment depends on how severe the bulimia is. The average number of treatment sessions is between 15 and 20. Cognitive behavior therapy has some benefits for people who are bulimic. Most people have increased self-control of binge eating and purging. Also, about two-thirds of are able to return to normal eating patterns. Weight gain after treatment is the exception rather than the rule. When people do gain weight, these gains are usually small. Behavior therapy for bulimia nervosa is available at a number of eating disorders centers. When choosing a treatment program, it is important ask about the therapist's experience in treating patients with bulimia. Antidepressant medications have also been shown to be useful. Such medication may be especially helpful for patients who do not get better with to behavior therapy.

Should bulimics be hospitalized?
Unless there are major medical problems, or a related severe mental health problem, hospitalization is not usually necessary for the treatment of bulimia. Hospitalization takes people out of the environment in which the problem occurs. This may make recovery from the disorder harder because bulimics must learn to eat normally in their own environment.

Anorexia Nervosa
Characteristics
Anorexia is the rarest of the three eating disorders. Anorexia is characterized by a large loss of body weight. People often fall to 20% to 30% below ideal weight. Anorexia nervosa may become a chronic illness. It usually begins in early adolescence. It can require frequent hospitalization for the medical problems of starvation. About 5% of anorexic patients die because of the disorder. About half of those die from the complications of the disorder and

about half from suicide. Most patients with this disorder need to be hospitalized, preferably in a unit designed for the treatment of eating disorders. Early cases, in which weight loss has not reached high levels, can be treated on an outpatient basis.

Treatment
Behavior therapy forms the basis of modern treatment of anorexia nervosa. Most patients with this disorder are worried about gaining weight. They know they need to gain weight be healthy and to have normal social functioning. However, weight gain and changes in body shape can be frightening for the anorexic. These people feel "fat" even though they are often very thin.

A rewarding environment that helps the anorexic want to gain weight is set up to help them overcome their problems. Within such an environment, weight gain leads to access to pleasant activities. This rewards weight gain. As the patient gains weight, the family is usually involved. This helps to find ways in which family members can help the patient return to a normal social life. In addition, the anorexic is helped to build up behaviors that will aid in the process.

Research has shown that about three quarters of anorexics treated with behavior therapy will gain a reasonable amount of weight. In addition, they will return to reasonably normal activities. Some anorexics will relapse and will need to be rehospitalized. A few patients will not get better with this treatment.

Much progress has been made in understanding and treating the eating disorders over the past twenty years. Because of strong research efforts, behavior therapy has become either the treatment of choice or a major part of treatment for these problems. If support for research continues, we should expect to keep improving our ability to treat these disorders.

What Is Cognitive Behavior Therapy?
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Hoarding Disorder

What is hoarding disorder?
Hoarding disorder includes ALL three of the following:

1. A person collects and keeps a lot of items, even things that appear useless or of little value to most people, and
2. These items clutter the living spaces and keep the person from using their rooms as they were intended, and
3. These items cause distress or problems in day-to-day activities.

How is hoarding different from collecting?
- In hoarding, people seldom seek to display their possessions which are usually kept in disarray.
- In collecting, people usually proudly display their collections and keep them well organized.

What are the signs of hoarding?
- Difficulty getting rid of items
- A large amount of clutter in the office, at home, in the car, or in other spaces (i.e., storage units) that makes it difficult to use furniture or appliances or move around easily
- Losing important items like money or bills in the clutter
- Feeling overwhelmed by the volume of possessions that have 'taken over' the house or workspace
- Being unable to stop taking free items, such as advertising flyers or sugar packets from restaurants
- Buying things because they are a "bargain" or to "stock up"
- Not inviting family or friends into the home due to shame or embarrassment
- Refusing to let people into the home to make repairs

What makes getting rid of clutter difficult for individuals who hoard?
- Difficulty organizing possessions
- Unusually strong positive feelings (joy, delight) when getting new items
- Strong negative feelings (guilt, fear, anger) when considering getting rid of items
- Strong beliefs that items are "valuable" or "useful," even when other people do not want them
- Feeling responsible for objects and sometimes thinking of inanimate objects as having feelings
- Denial of a problem even when the clutter or acquiring clearly interferes with a person's life

Who struggles with hoarding behavior?
Hoarding behaviors can begin as early as the teenage years, although the average age of a person seeking treatment for hoarding is about 50 years of age. Without effective treatment, individuals who hoard often endure a lifelong struggle with hoarding. They tend to live alone and may have a family member with the problem. It seems likely that serious hoarding problems are present in at least 1in 50 people, but they may be present in as many as 1 in 20.

Are hoarding and obsessive compulsive disorder (OCD) related?
Hoarding was commonly considered to be a type of OCD. Some estimate that as many as 1 in 4 people with OCD also have hoarding. Recent research suggests that only 1 in 5 individuals who hoard have non-hoarding OCD symptoms, and that hoarding is a distinct disorder. The American Psychiatric Association is considering establishing a separate disorder for hoarding in the new *Diagnostic and Statistical Manual* (*DSM-V*). Hoarding is currently considered a feature of obsessive compulsive personality disorder (OCPD) in *DSM-IV*, but may be removed in *DSM-V*. Hoarding also may develop along with other mental illnesses, such as dementia and schizophrenia.

What kinds of things do people hoard?
Most often, people hoard common possessions, such as paper (especially mail, newspapers), books, clothing, and containers (e.g., boxes, paper and plastic bags). Some people hoard garbage or rotten food. More rarely, people hoard animals or human waste products. Often the items collected are valuable but far in excess of what can reasonably be used.

What are the effects of hoarding?
- Severe clutter threatens the health and safety of those living in or near the home, causing health problems, structural damage, fire, and even death
- Expensive and emotionally devastating evictions or other court actions can lead to hospitalizations or homelessness
- Conflict with family members and friends who are frustrated and concerned about the state of the home and the hoarding behaviors

Is compulsive hoarding caused by past poverty or hardship?
Many people who hoard may call themselves "thrifty." They may also think that their behavior is due to having lived through a period of poverty or hardship. Research does not support this idea. However, experiencing a traumatic event or serious loss, such as the death of a spouse or parent, may lead to a worsening of existing hoarding behavior.

Can hoarding be treated?
Yes, hoarding can be treated. Unfortunately, it has not responded well to the usual treatments that work for OCD. Some strategies used to treat hoarding include:

- Challenging the hoarder's thoughts and beliefs about the need to keep items and about collecting new things
- Going out without buying or picking up new items
- Getting rid of and recycling clutter. First, by practicing the removal of clutter with the help of a clinician or coach and then independently removing clutter
- Finding and joining a support group or teaming up with a coach to sort and reduce clutter
- Understanding that relapses can occur
- Developing a plan to prevent future clutter.

How can I help a hoarding friend or family member de-clutter?
Attempts by family and friends to help with de-cluttering may not be well received by the person who hoards. It may be helpful to keep in mind:

- Until the person is internally motivated to change, the person may not accept, or even welcome, your offer to help.
- Motivation cannot be forced.
- Everyone, including people who hoard, has a right to make choices about their objects and how they live.
- People who hoard are often ambivalent about accepting help and throwing away objects.

Can't hoarding be solved by simply cleaning out the home?
No. Attempts to clean out the homes of people who hoard without treating the underlying problem usually fail. Families and community agencies may spend many hours and thousands of dollars clearing a home only to find that the problem recurs, often within just a few months. Individuals who hoard often experience extreme distress and may become further attached to their possessions if their homes are cleared without their consent. This may lead to them refuse future help.

How do I have a conversation with my friend of family member who is ready to talk about hoarding?
When a person seems willing to talk about a hoarding problem, these guidelines may be useful to follow:

- Respect. Acknowledge that the person has a right to make their own decisions at their own pace.
- Have sympathy. Understand that everyone has some attachment to the things they own. Try to understand the importance of their items to them.
- Encourage. Come up with ideas to make their home safer, such as moving clutter from doorways and halls.
- Team up with them. Don't argue about whether to keep or discard an item; instead, find out what will help motivate the person to discard or organize.
- Reflect. Help the person to recognize that hoarding interferes with the goals or values the person may hold. For example, by de-cluttering the home, a person may host social gatherings and have a richer social life.
- Ask. To develop trust, never throw anything away without asking permission.

Are there medicines that can help reduce hoarding?

- Medicine alone does not appear to reduce hoarding behavior.
- Medicine may help reduce the symptoms.
- Medicine can be used to treat conditions, like depression and anxiety, that may make hoarding worse.

Where can I find further information and help?
International Obsessive Compulsive Disorder Foundation (www.ocfoudation.org)
Boston University School of Social Work (www.bu.edu/ssw/research/hoarding)
San Francisco Mental Health Association (www.mha-sf.org/programs/ichc.cfm)
Smith College Department of Psychology (www.science.smith.edu/departments/PSYCH/rfrost)
The Institute of Living /Hartford Hospital (www.harthosp.org/InstituteOfLiving/AnxietyDisordersCenter)

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OCD

Far more common than previously thought, obsessive-compulsive disorder (OCD) now receives widespread attention from the general public. Reports in the media are frequent, but not always correct. The terms "obsession" and "compulsion" are sometimes incorrectly applied to various psychological difficulties, such as gambling or overeating, which are in fact quite different from OCD. Since the treatment methods used for OCD are not necessarily useful for other types of problems, it is important to understand exactly what OCD is.

What Are Obsessions?

Obsessions are ideas, thoughts, images, or impulses that are senseless and "get in the way." They continue even though a person may try to ignore or forget about them. They are experienced as unpleasant and unwanted and may provoke anxiety, guilt, shame, or other uncomfortable emotions.

The most common obsessions are concerns that objects or other people might be "contaminated" by contact with germs, disease, dirt, chemicals, or some other source. The feeling of contamination is accompanied by an urge to wash or to clean. Other obsessions focus on fears that doors or windows have been left unlocked, appliances have been left on, important papers have been thrown away, mistakes have been made, and so forth.

Frightening thoughts about burglary, fire, and other losses often accompany these fears, forming part of the obsessive ideas. Some obsessive thoughts concern accidents or unfortunate events that might occur unless one superstitiously repeats particular actions or thoughts to prevent the disaster. Other obsessions take the form of unwanted urges or impulses to do something harmful, such as to stab one's child with a kitchen knife. Some people experience horrific or upsetting images having to do with religious figures.

Obsessions can take many forms. Ordinary people are concerned by many of the ideas, thoughts, images, or impulses underlying obsessive fears. Most of us are concerned about AIDS and other diseases, and about harmful chemicals in the environment. However, for those with OCD, the fear and guilt or other unpleasant emotions are out of proportion to the actual risk of danger or harm, driving them to carry out compulsions to rid themselves of the worry.

What Are Compulsions?

Compulsions, also called rituals, are usually actions that are repeated, but sometimes are thought patterns that are performed to rid oneself of a disturbing obsession. Rituals are usually carried out according to certain rules or in a rigid fashion and are clearly excessive. The person recognizes that the rituals are not reasonable but feels unable to control them. Most compulsions are logically related to the type of obsessive ideas they attempt to reduce or prevent, although this is not always true. Because they temporarily reduce discomfort, rituals become habitual, and the person with OCD often has difficulty controlling them to the point that they interfere in the person's life and functioning at school, home, or work.

Examples of compulsions include hand-washing, showering, or cleaning to remove "contamination"; checking to prevent feared dangers such as theft, fire, or loss of important things; repeating actions or thoughts to prevent a catastrophic event from happening; having to arrange objects in a particular way before beginning an activity; or needing repeated reassurance from others that a feared event has not or cannot happen.

Some compulsions are performed mentally without any behavioral manifestation. Examples include praying to relieve guilt about an unwanted idea and repeating phrases or images in one's mind to prevent a catastrophe.

Common Characteristics

Those who suffer from obsessions and compulsions vary widely in their personality characteristics, life circumstances, and the degree to which their lives are disrupted by these symptoms. Thus, it is difficult to make general statements about their habits. Some researchers have suggested that those with OCD tend to come from more perfectionistic and possibly more moralistic upbringings. They are more concerned with avoiding mistakes than are people who do not get so anxious.

Many OCD sufferers appear to overestimate the risk involved in their obsessive concern, and some dislike taking even small risks of any type. Many doubt their own decision-making ability and request reassurance from others to confirm their choices. On the other hand, many people with OCD do not exhibit these traits, but appear to be quite normal in their social and work lives.

Treatment

The most widely accepted form of psychological treatment for OCD is cognitive behavioral therapy, using procedures known as "exposure and response (ritual) prevention." In this treatment method, the therapist first helps the patient develop a list of obsessively feared and avoided situations (or thoughts) and a list of all compulsive rituals. Then the list of obsessive situations is put into order according to the amount of discomfort provoked. Exposure begins with the client being asked to confront situations that trigger some anxiety for an extended period of time. With prolonged exposure while not engaging in the compulsion or ritual, the anxiety begins to dissipate on its own. As therapy continues, the client works toward dealing with the more difficult situations until all the feared items on the list have been faced and no longer provoke more than mild discomfort.

Often times, exposure is carried out naturalistically, with the therapist and the patient going to each situation (e.g., a public restroom, a restaurant) on the list and remaining as long as necessary for anxiety or discomfort to be reduced substantially. In some cases, exposure may be conducted in imagination, with the person visualizing him- or herself going step by step through a scene designed to imitate the type of situation that provokes obsessive fear.

At the same time that the patient is being exposed to obsession-inducing situations, rituals must also be prevented. If the compulsive behaviors continue, they reinforce (or feed into) obsessive fears, making exposure a useless exercise.

In some programs compulsions are reduced gradually: As the person is exposed to each new feared situation, he or she is asked not to perform any rituals after that or other similar situations. In other programs compulsions are blocked altogether. The therapist does not use force but relies on the patient's motivation to improve to overcome the urge to ritualize.

Many studies of exposure and ritual prevention have been conducted. Results have shown that about 65% to 75% of those treated with this method improve substantially, and most have maintained their improvement years later. Cognitive behavioral therapy alone is less successful for patients who have obsessive thoughts but perform no or few compulsive rituals.

Drug Treatment

Many medications have been tried for OCD, and recent studies suggest that a particular group of drugs that affect the serotonergic system (SSRIs) are most successful in relieving obsessions and compulsions. In particular, the drug clomipramine (Anafranil) has been subjected to much research and has been shown to be an effective anti-obsessive agent, reducing the symptoms of about two-thirds of those who have tried it. The degree of symptom reduction ranges from nearly symptom-free to mild improvement, with most patients reporting 30% to 60% improvement .

Most people are able to tolerate the common side effects of clomipramine (such as dry mouth, dizziness on sudden standing, tremor, or constipation). For some, the side effects make

the drug unusable. Another serotonergic drug that may be helpful for OCD is fluoxetine (Prozac). So far, however, there have been fewer studies of its effectiveness.

Drug treatment appears to be a valid option for many with OCD. However, since relapse often occurs when patients are taken off these drugs, those who use medication should probably undertake behavior therapy as well to achieve stable improvement.

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Phone (212) 647-1890

Panic Attack

A panic attack is an alarm reaction. When real danger is present (such as when one's life is being threatened), the alarm is a "true" alarm. In panic disorder, the panic attacks are "false" alarms, because the feeling of the alarm occurs even though there is no real danger.

A panic attack is defined as a sudden rush of intense fear or dread, which usually goes along with several of the following physical symptoms and thoughts: shortness of breath or smothering feelings, dizziness, feeling faint or unsteady, racing or pounding heart, trembling or shaking, sweating, choking sensations, nausea or abdominal distress, feelings of being detached or things seeming unreal, numbness or tingling sensations, hot flashes or cold chills, chest pain or discomfort, fears of going crazy, fears of losing control, and fears of dying. In a panic attack these symptoms are not the result of a real medical condition, such as illness, too much caffeine, or alcohol or drug intoxication.

Features of panic attacks are the suddenness with which fear is experienced - panic attacks usually occur and peak in a very short time (1 to 10 minutes), and the peak lasts on average only 5 to 10 minutes. This makes it very different from other types of anxiety; the strong urge to escape and reach safety - (also know as the fight or flight response); the beginning of an attack "out of the blue," with no obvious outside cause - however, over time, most attacks become connected with specific situations (such as traveling long distances from home).

Panic attacks are common

Six to twelve percent of the general population reports an unexpected surge of fear or panic at some time during a given year. According to the latest survey, from 2% to 6% of the general population suffer from panic disorder in any given 6-month period. Thus, as many as 14 million Americans have panic disorder.

Panic disorder is distinguished from other anxiety disorders by the unexpected nature of the alarm reactions as well as the continuing anxiety about their return. Worry about the return of panic often leads to the avoidance of situations in which help may not be available or from which escape is difficult, should a panic attack occur. The types of situations avoided may include crowded shopping malls, theaters, highway driving, elevators, walking alone, or traveling far from home. This is known as agoraphobic avoidance. In contrast, the occasional panic attack experienced by people with other types of anxiety problems is rarely a major source of concern, and rarely lead to significant avoidance behaviors.

Other results of an untreated panic disorder may include depression, reliance on alcohol and drugs to take some of the edge off the nervous tension, missed work, and social disability.

Characteristics of panic disorder

Panic attacks may occur as early as 10 years of age, but panic attacks typically begin in the mid to late twenties. The average age at which treatment is sought is 34. Many panic sufferers seek medical treatment before seeking psychological help. More women than men are diagnosed with this condition.

What causes panic disorder?

Stressful life events often come just before an individual's first panic attack. Approximately 80% of people who panic can relate their first panic attack to stressful life circumstances. This might be positive, such as having a child, getting married, or moving to a new city, or negative, such as a bad drug experience, or losing someone close. Conditions that may add to the chances of having an attack under stressful conditions include certain physical and psychological vulnerabilities.

Physical vulnerabilities refer to aspects of body functioning that may make panic symptoms or paying attention to panic symptoms more likely. The biological basis for this susceptibility can be shown by panic attacks occurring in several members of the same family. However, the notion of physical vulnerabilities should not be misunderstood to mean that certain physical aspects "guarantee" the development of panic disorder. Panic disorder seems to develop from a combination of psychological and physical factors.

The psychological vulnerabilities include beliefs that the physical symptoms of anxious arousal (e.g., shortness of breath or dizziness) are harmful or threatening, and a sense that they are difficult to predict or control. These beliefs seem to form the basis of continuing worry about the return of panic attacks. Chronic worry is characterized by focusing on and searching for any bodily sensations that may mark another panic attack, and by high levels of physical tension in general. Because such tension produces frequent physical symptoms, worrying about panic can lead to the experience of more panic attacks.

The panic attack itself can be viewed as the combination of physical sensations and the frightening thoughts about these sensations ("The chest pain that I am feeling must mean that I am having a heart attack."). In other words, panic attacks are in many ways like phobias, but instead of being afraid of a specific object or situation, panic sufferers are afraid of their own bodily sensations. Therefore, harmless changes in physical state linked with routine activities (such as walking up stairs), certain substances (such as caffeinated coffee), or other mood states (such as anger), might lead the person to become panicky. The sensations are likely to be mistaken as signs of immediate physical or mental danger, such as losing control, dying, fainting, or going crazy.

Because these thoughts are frightening, the nervous system is turned on (as would occur under conditions of real danger). As a result, more physical symptoms are likely to be experienced, which in turn may be thought of as further evidence of physical or mental danger. That is, an increasing cycle of fear and physical symptoms occurs. The urge to escape may increase the cycle even further, particularly if escape is difficult or impossible. The attack cycle is interrupted when the physical activation has run its course, or when safety factors come into play (such as the arrival of a reassuring friend or doctor).

Persistent overbreathing or hyperventilation (taking in more air than is needed) may contribute to panic attacks. It is certainly natural to breathe more quickly and more deeply when afraid. However, overbreathing does not explain all panic attacks; it is important for some but not for others.

Cognitive behavioral treatment for panic disorder

Several researchers from different centers around the world have developed new treatment methods, but all tend to include the same four components: (1) re-education about the physical symptoms of anxiety and fear, to correct misinterpretations of them as being harmful or dangerous, (2) training in methods for reducing physical tension, usually by breathing retraining or relaxation, (3) repeated exposure to feared and avoided physical situations, and (4) repeated exposure to feared and avoided sensations.

Exposure to physical sensations is the most recently developed procedure. Specific exercises are used to produce the various symptoms that characterize panic attacks. For example, aerobic exercise might be used to produce shortness of breath and a pounding heart, and overbreathing might be used to produce lightheadedness and dizziness. Systematic exposure to these sensations reduces the person's fear of them, and teaches the person that the sensations are not dangerous. Activities that were avoided are practiced to establish that they are not dangerous. These activities might include climbing flights of stairs for aerobic effects, eating certain foods, drinking coffee, and so on.

When fear of the body sensations is lessened so is the fear of the return of a panic attack. These new behavioral treatments eliminate panic attacks in most clients. This favorably

compares to the use of prescription medications to reduce panic attacks. Research has shown that two years following cognitive behavioral treatment, most patients remain panic-free. In contrast, patients treated with prescription medications often experience a return of panic when the medications are discontinued.

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Phobia

A phobia can be defined as a fear and/or avoidance of an object, activity, or situation that the individual knows is out of proportion to the actual dangers that that object, activity, or situation poses. Phobias are one of the most widespread mental disorders, with estimates ranging from 10% to 30% of the population reporting a fear severe enough to disturb some aspect of their functioning.

According to the *Diagnostic and Statistical Manual* phobic disorders fall into three types, based on the nature of the object or situation that produces the fear:

1) Simple phobias involve a fear of particular objects or situations, such as heights, the dark, moths, or small spaces.

2) Social phobias involve a fear of being watched or evaluated by others and a belief that the individual will appear foolish. This results in avoidance of such situations as eating in front of others or going to parties or meetings.

3) Agoraphobia involves a fear of being unable to escape quickly or reach help in the event of sudden incapacitation, commonly a panic attack. Specifically, therefore, agoraphobia involves a fear of a wide variety of situations that the individual believes will either increase the likelihood of incapacitation or reduce the chance of reaching help should incapacitation occur. These situations include going to malls, using public transport, and generally being alone.

Agoraphobia is usually thought to be the most crippling phobic disorder and simple phobia the least. People suffering with phobias can also have problems with chronic anxiety and depression. Simple phobias often begin in childhood; social phobias in the late teens; and agoraphobia in the mid-20's. Phobias appear to be more common in females than in males, although social phobia seems to be fairly evenly divided.

Causes

The cause of the various phobia disorders is still under considerable dispute. Traditionally, psychologists have believed that phobias are the result of experiencing a traumatic event in the presence of a specific situation or object (conditioning); being bitten by a dog, for example. However, recent research suggests that this is likely to be the case in only a certain portion of phobic cases, especially cases of simple phobia and some social phobias, such as fear of eating, drinking, or writing in front of others.

Other ways in which many simple phobias and some social phobias are probably acquired include the passing of false or exaggerated information (e.g., being told dogs are dangerous) or seeing or hearing of someone else being injured or distressed in a particular situation (e.g., seeing someone being bitten by a dog).

Some social phobias appear to be worsening of lifelong behaviors and personality factors. In other words, some people who are afraid of going to parties or formal meetings may report that they have always been "basically shy," but only since they took on new responsibilities has this become severe enough to be considered a problem.

The immediate cause of agoraphobic fear and avoidance involves an unexpected panic attack. This first panic attack is reported to occur "out of the blue." The agoraphobic then begins to fear the occurrence of another such attack and avoids those situations that they believe may cause or worsen a future attack.

The reasons why an individual may begin to associate certain situations with panic attacks are not yet known. In addition, the cause of the initial panic attack is only just beginning to be investigated. Some factors that might be responsible for causing the first panic attack include life stressors, earlier experience with loss of control, a tendency to breathe too fast, or fluctuations in brain chemicals.

Treatment

The basic treatment of choice for the phobic disorders involves what is called graduated exposure to the phobic stimulus. This means that the person is slowly brought into contact with the avoided object or situations until he or she "gets used to" it. Repeated investigations have demonstrated the value of exposure-based techniques for all types of phobias.

For maximum improvement in most cases of social phobia, it also appears to be necessary to teach people to re-evaluate some of their thoughts and beliefs; to learn, for example, that "everyone is not watching me" or that "if I say the wrong thing, people will not think I am stupid." Some form of social skills training may also be of value, because it may produce new skills and/or increase confidence.

While exposure to the feared object or situations is of immense value for the avoidance component of agoraphobia, maximum improvement is unlikely to occur without some attempt being made to deal with the unexpected panic attacks.

Treatment for panic attacks has traditionally involved the use of medications such as imipramine (Tofranil) or alprazolam (Xanax). More recently, psychological techniques are proving to be just as effective.

The specific components of psychological treatments for panic attacks, which are necessary for treatment effectiveness, have not yet been conclusively determined, but some possibilities may include teaching people to slow their breathing; teaching people that their symptoms are harmless; and doing gradual exposure to the actual physical symptoms of a panic attack.

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What Is Schizophrenia?

Schizophrenia is a chronic, severe, and disabling mental illness that affects approximately 1 out of every 100 people in the world's population. The first symptoms of schizophrenia are typically seen in late adolescence or early adulthood, although they occasionally develop after the age of 30. A variety of different symptoms may occur when the illness first develops, including social isolation, unusual thinking or speech, having beliefs that seem strange and peculiar to others, seeing things that are not visible to others, and hearing voices when none are present. These symptoms often make it difficult for a person with schizophrenia to maintain interpersonal relationships, care for personal needs, work, and live independently.

How Long Does Schizophrenia Last?

For most people, schizophrenia is an episodic illness in which symptoms appear and subside at varying degrees of intensity over the course of one's lifetime. The frequency and severity of schizophrenia symptoms vary from person to person; some patients have only one or a few episodes of the illness while others experience symptoms continuously.

How Do People Talk About Different Aspects of Schizophrenia?

Since each person's experience with schizophrenia is different, certain terms help others understand the severity of one's illness and the length of time one has been sick (the *duration* of one's illness). **Subchronic** refers to the time during which a person first begins to show signs of the schizophrenia on a somewhat regular basis. This phase typically lasts from 6 months to no more 2 years in duration. **Chronic** schizophrenia refers to an illness that has been present for at least 2 years. **Acute** schizophrenia refers to the reemergence or intensification of psychotic symptoms in a person who previously had no symptoms or whose symptoms had not changed for a significant amount of time.

Other terms are used to describe the degree to which schizophrenia has developed across a person's life. There are three basic phases to the illness. Overlapping symptoms in each of these phases make them hard to distinguish clearly, but they offer a general understanding of whether the illness is just developing or has been cycling through subchronic, chronic, and acute phases for some time. The first phase is called the **prodromal** or pre-illness phase. This phase involves a clear deterioration of functioning: social withdrawal, inappropriate affect (emotional responses to different situations), or increased impairment in personal grooming and hygiene. The second phase is called the **active** phase. In this phase, there have been continuous signs of disturbance for at least 6 months and occupational, social, academic, and personal functioning is considerably below the highest level of functioning before the illness began. During the active phase, people with schizophrenia experience difficulty telling the difference between reality and fantasy, frequently termed **psychosis**. Other symptoms that appear in the active phase (described in more detail below) are delusions, hallucinations, thought disturbances, or inappropriate affect. The third or **residual** phase follows the active phase and is indicated by a persistence of at least two of the symptoms experienced during the pre-illness phase. It is not uncommon for patients in the residual stage to experience periods when the prominent psychotic symptoms seen in the active phase reemerge for a brief period of time and then subside.

What Are the Main Symptoms of Schizophrenia?

Delusions are false beliefs that are not based in reality. These false beliefs commonly contain themes of persecution and grandeur. An example of a delusion is a belief that others are trying to harm or control the person to steal information vital to national security.

Hallucinations are false perceptions (seeing, hearing, smelling, tasting, and feeling) not experienced by others. Smelling the odor of rotting flesh and hearing voices in an empty room when there are no voices or odors are examples of hallucinations.

Thought disturbances are incidences in which the person is unable to concentrate, to "think straight or coherently," or to slow down racing thoughts. An example of a thought disturbance is when a person speaks in randomly connected thoughts using words that do not exist.

Inappropriate affect refers to showing an emotion that is inconsistent with the person's speech or thoughts. For example, the person may say that he or she fears being persecuted by the devil and then laugh. Sometimes a person with schizophrenia may exhibit a blunted or flat affect, which is a severe reduction in emotional expressiveness. Examples are the use of a non-changing tone of voice with few facial expressions.

Diagnosis

No laboratory tests exist to determine a diagnosis of schizophrenia. Like other mental and emotional disorders, a diagnosis of schizophrenia is made solely on the basis of the person's behavior, thoughts, and feelings. Through careful observation and interviewing, competently trained psychiatrists, psychologists, nurses, social workers, and therapists can detect major disturbances in a person's functioning, including the presence of psychotic symptoms. However, before a diagnosis of schizophrenia is made, medical factors such as a brain tumor or the effects of substance abuse are ruled out.

Myths About Schizophrenia

Despite common belief and usage of the term by the popular press, schizophrenia is not the same as the relatively rare disorder known as split personality (multiple personality: a Dr. Jekyll and Mr. Hyde switch in character). People also tend to equate schizophrenia with "insanity" or "madness." These are not psychiatric terms but are popular descriptions for strange, irrational behavior. Most people suffering from schizophrenia are not violent, although an occasional individual will have violent outbursts. There is also concern among some families that they might be the cause of schizophrenia. No conclusive scientific evidence exists that a family's actions cause schizophrenia. There is abundant evidence, however, that families may be able to help improve the outcome of the illness.

Causes of Schizophrenia

There are a number of factors that may cause schizophrenia. Some of these factors are genetic (inherited from the person's biological parents), some are biological (stemming from abnormalities in a person's body), and some are psychosocial (caused by the environment in which one was raised and in which one lives currently).

Structural abnormalities of the brain, biochemical deficiencies, or an imbalance of brain chemicals called neurotransmitters are considered potential biological causes of schizophrenia. The degree to which each factor *causes* schizophrenia, as opposed to being *caused by* schizophrenia, remains unclear. Studies show that if a close relative suffers from schizophrenia there is a 1 in 10 chance that another immediate family member may also experience the disorder, suggesting that there are genetic components of the disease as well.

Environmental stress also appears to be an important factor in the development of schizophrenia. Personal and family events such as an adolescent's leaving home, a young adult's entrance into a new career or peer group, a death in the family, or the breakup of a significant relationship are some of the stressors that may precede the onset of schizophrenia.

These stressors demand adaptive changes from the individual and challenge the individual's current coping and competence. Growing evidence exists that an individual's inability to cope with and handle certain stressors combines with structural, genetic, and biochemical vulnerabilities to result in schizophrenia.

Treatment Modalities

Although some individuals will always be subject to varied degrees of recurring symptoms of schizophrenia, studies show encouraging evidence that most people suffering from schizophrenia can be trained and supported to live productive, noninstitutionalized lives. There is no one best treatment for schizophrenia; a combination of treatment and support programs seems to provide the best way to help a person with schizophrenia maintain the highest degree of health and independence.

Antipsychotic medications have greatly improved the outlook for the person with schizophrenia. These drugs do not "cure" schizophrenia but typically reduce the intensity and frequency of the psychotic symptoms and usually allow the person to function more effectively and appropriately. Another beneficial aspect of drug therapy is that it may help to reduce such symptoms as poor concentration and social isolation. However, medications are only a necessary first step.

Psychiatric rehabilitation is a second important step that is often provided by day treatment centers and community support programs. Psychiatric rehabilitation enables the individual to acquire personal and instrumental skills as well as environmental supports which will enable the person to fulfill the demands of various living, learning, and working environments.

Family Support

Since many persons with schizophrenia live with their families, it is important for the family to have a clear understanding of the illness. Many psychiatric rehabilitation programs include the family in their work to reduce the family's stress and help make the family setting a more supportive environment for the person with schizophrenia. These programs also help families learn about the different kinds of outpatient and family support services that are available in the community.

Self-help groups are one such resource. Although they are usually not led by professional therapists, these groups are often helpful because members—usually family members of persons with schizophrenia—provide continuing support for each other. These groups have also become effective in advocating for needed research and treatment programs.

Other Sources of Information

Other useful resources for patients and families of patients with schizophrenia are:

The National Alliance for the Mentally Ill
2101 Wilson Blvd., Suite 302
Arlington, VA 22201
703.524.7600

National Mental Health Association
1021 Prince St.
Alexandria, VA 22314-2971
703.684.7722

The National Mental Health Consumer's Association
311 S. Juniper St., Room 902
Philadelphia, PA 19107
215.735.2465

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What Is Sexual Assault?

Anyone — men, women, and even children — can be sexually assaulted. Sexual assault is usually defined as sexual activity between two or more people in which one of the people is coerced or threatened with harm. The sexual activity may include fondling, sexual intercourse, oral sex, and/or anal sex. The sexual aggressor can be a family member, like a husband or father, or a friend, date, acquaintance, or stranger.

Sexual assault is a crime that has become an epidemic problem. Sexual assault can be an extremely stressful, terrifying event and can severely disrupt the victim's lifestyle and coping patterns. During a sexual assault, the victim may have feelings of powerlessness and uncertainty about whether he or she will survive. Frequently the victim's life is directly threatened and the victim may be physically injured in a variety of ways. At the same time, the victim must remain alert, trying to protect him or herself from even more harm. Children who may be present are often threatened, adding to the terror and causing the victim to feel responsible for protecting them.

Studies show that the impact of sexual assault varies from person to person. Victims may no longer feel safe, may lose self-esteem, feel powerless, and lose the ability to trust others or develop intimacy. The more terrifying the assault, and the more the person's life is threatened, the more problems victims usually have afterwards. Having suffered previous traumatic events can also contribute to greater problems.

What Are the Problems?

After a sexual assault, victims can experience a range of responses. However, some patterns are especially common. Some victims report that they have repeated and frequent memories of the sexual assault that intrude on their thoughts and cannot be controlled; flashbacks, or a feeling as if they are reliving the sexual assault; nightmares; and difficulty sleeping. In addition, sexual assault victims may experience feelings of being "on edge," having trouble concentrating, feeling the need to continually watch over their shoulder, or being easily startled (for example, jumping at the sound of someone's voice from behind). Victims also report that they tend to avoid reminders of the sexual assault, including avoiding places that may resemble the place where they were assaulted; may feel less interested in things that they used to enjoy; and may feel emotionally numb. Victims may also withdraw from social interaction or settings. When these problems persist and disrupt daily life, mental health professionals call this group of symptoms posttraumatic stress disorder (PTSD).

In addition to PTSD, sexual assault victims frequently find that they feel depressed and hopeless about the future, which can lead to thoughts about suicide. Many victims also report that they feel like the sexual assault was somehow "their fault," resulting in feelings of self-blame and self-doubt. Frequently, sexual assault victims also say that they feel generally unsafe and often have difficulties with trust and intimacy. It is also common for sexual assault victims to have questions about their physical health and develop problems related to their sexual functioning. Lastly, sexual assault victims may resort to using drugs or alcohol to cope with their symptoms.

Studies have found that about 90% of sexual assault victims experience symptoms of PTSD 2 weeks after the assault and about 50% of sexual assault victims continue to experience symptoms of PTSD 3 months after the sexual assault. The symptoms of PTSD can begin a long time after the attack and can last much longer than just 3 months. Sometimes individuals

experience more than one sexual assault during their lifetime. Having multiple experiences increases the likelihood of developing PTSD.

Can Therapy Help?

Yes. Several short-term therapeutic techniques have been shown to reduce the PTSD symptoms. Although symptom response to the assault may vary from person to person, effective short-term treatments are available for PTSD and a variety of disorders that tend to be part of PTSD, including depression, panic, anxiety, and phobias. Regardless of a victim's specific symptoms, treatment should include two basic components: (1) development and maintenance of a trusting relationship with a therapist; and (2) recounting one's story about the assault in treatment so that the therapist can help the individual overcome the debilitating symptoms resulting from PTSD.

Telling one's story allows victims to feel more in control of their memories and the feelings that have arisen in response to them. With this increased sense of power, victims can look at other problems they are having and make the changes necessary to allow them to function better in everyday life.

PTSD symptoms do not tend to go away by themselves. The earlier victims begin therapy, the sooner they can begin addressing symptoms and turning their lives around. Victims who do not seek treatment often begin to avoid the painful thoughts, feelings, and situations that may trigger thoughts of the event; this prevents the memory from being understood and seen clearly, and so the individual does not regain a sense of control.

In behavior therapy, the therapist helps victims make sense of their memories. This reduces the emotional impact of the memories so the intrusive thoughts, flashbacks, and nightmares eventually go away. Although the memories will never be pleasant, the psychological pain and anxiety associated with them can be reduced. The therapist attempts to reduce the guilt and fear associated with the victim's response to the sexual assault. Using techniques such as relaxation training, the therapist will help the victim reduce the symptoms of PTSD. Therapists may also diminish the power of the memories or flashbacks by having the victim relive and re-experience them. The therapist can also explore the victim's thoughts about the assault and, where appropriate, help him or her understand when his or her beliefs are contrary to reality. The therapist can also teach the victim other skills, such as anger management, assertiveness training, and communication training, depending upon the person's needs.

Medication may be appropriate as an adjunct to behavior therapy for some victims of sexual assault, primarily individuals who are having a difficult time with PTSD-associated depression. When used in conjunction with behavior therapy, antidepressants have been found to be an effective tool in reducing trauma-related depression.

Victims of sexual assault should not suffer in silence. Behavior therapists offer effective treatments tailored to a victim's individual problems.

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Behavior Therapy and Cognitive Behavior Therapy are types of treatment that are based firmly on research findings. These approaches aid people in achieving specific changes or goals.

Changes or Goals might involve:

- a way of acting - like smoking less or being more outgoing;
- a way of feeling - like helping a person be less scared, less depressed, or less anxious;
- a way of thinking - like learning to problem-solve or get rid of self-defeating thoughts;
- a way of dealing with physical or medical problems - like lessening back pain or helping a person stick to a doctor's suggestions; or
- a way of adjusting - like training developmentally disabled people to care for themselves or hold a job.

Behavior Therapists and Cognitive Behavior Therapists usually focus more on the current situation and its solution, rather than the past. They concentrate on a person's views and beliefs about their life, not on personality traits. Behavior Therapists and Cognitive Behavior Therapists treat individuals, parents, children, couples, and families. Replacing ways of living that do not work well, with ways of living that work, and giving people more control over their lives are common goals of behavior and cognitive behavior therapy.

The Association for Behavioral and Cognitive Therapies (ABCT) is an interdisciplinary organization committed to the advancement of a scientific approach to the understanding and amelioration of problems of the human condition. These aims are achieved through the investigation and application of behavioral, cognitive, and other evidence-based principles to assessment, prevention, and treatment.

For more information, please contact ABCT at
305 7th Avenue, 16th Fl., New York, NY 10001
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Shyness, Social Anxiety Disorder, and Social Phobia

Shyness is a problem that is well known to many people. It is that all-too-familiar feeling of discomfort, tension, or anxiety that a person may experience when he or she has to interact with other people, or when he or she faces the prospect of doing something in front of others. Shyness can be troubling and very uncomfortable. Up to 80% of people report that they were shy at some time in their lives. Forty percent describe themselves as shy now. However, if you think of yourself as shy, it does not mean you have a problem that requires professional help. Most people feel some discomfort when thinking about social events (parties, for example), when preparing to take a social risk (asking someone for a first date), or when called upon to do something in front of others (public speaking). However, the typical shy person manages to get along reasonably well. These situations may not be comfortable and there may be great temptation to avoid them, but the shy person finds that he or she is still able to tolerate them and to get a great deal of satisfaction out of life.

However, these feelings can sometimes be severe. If they are sufficiently intense; if the person avoids doing things that are important to him or her because of these feelings; or if the person's ability to function at home, at school, at work, or in his or her social circle is curtailed by these feelings, the label of shyness is no longer appropriate. Then mental health professionals call it social anxiety disorder (it is also known as social phobia).

Social anxiety disorder is the fear of being observed and evaluated by others. A person may experience this fear in a single situation or in any interaction with other persons. Individuals with social anxiety disorder are afraid that they will do something to humiliate or embarrass themselves in social situations. They are afraid that other people will judge them negatively (that is, wonder what is wrong with them). At the bottom of these concerns is the fear that other people will reject them or conclude that they are incompetent. These fears may easily interfere with a person's ability to function in everyday life.

The Effects of Social Anxiety Disorder

Because of these concerns, individuals with social anxiety disorder may become extremely anxious in a number of situations or avoid them altogether. These situations may involve any or all of the following: public speaking; eating or drinking with others; writing, working, or playing while others are watching; initiating conversations with strangers; dating; parties; joining social groups; interacting with authority figures; or asserting oneself with others. The list of potential problem situations is long, because so much of what we do involves other people.

The effects of social anxiety disorder are varied, and many of the effects can be serious. Individuals with social anxiety disorder, often very bright, talented, and sensitive people may find themselves socially isolated and lonely because it is just too frightening to approach others. They may compromise their educational goals because of the social demands of education or because their classes may require them to speak in front of others. They may find themselves in unfulfilling jobs because the exciting ones are also frightening. Importantly, individuals with social anxiety may be vulnerable to depression if their anxieties persist over time. Similarly, they may find relief from their anxiety in alcohol or tranquilizing medications, and these may create serious additional problems.

What Causes Social Anxiety Disorder?

Scientists do not agree on the causes of social anxiety disorder, which afflicts more than 12% of the general population at some point during their lives. It occurs a bit more frequently in women than men, although men are more likely to seek treatment for this problem. This is different from other anxiety disorders, such as agoraphobia or panic disorder, which occur much more frequently in women.

Social anxiety disorder appears to run in families, but it is the environment in which one grows up that may contribute the most to the development of social anxiety disorder. Individuals with social anxiety disorder often report that one of their parents had significant social anxiety, that their families did not socialize often with other families, that their parents did not encourage them to interact with other children when they were growing up, and that there was a great emphasis on the opinions of others in their families.

What Can Be Done to Help the Person With Social Anxiety Disorder?

A number of treatments are available for social anxiety disorder, and the chances that a person with social anxiety disorder may find relief are very good. These therapies attempt to teach clients cognitive (thinking) and/or behavioral skills for dealing with the situations they fear. These treatments may be combined with each other to fit the needs of specific clients and may be offered in either individual or group therapy settings. These treatments are described below.

Exposure Therapy, in which clients are asked to confront the situations they fear, starting with the least frightening situations, mastering them, moving to more difficult situations, mastering them, and so on until the most difficult situations lose their ability to interfere with the client's life.

Cognitive Behavioral Therapy, in which clients are taught to examine their ways of thinking about feared situations. They do this by looking at whether their behavior is truly inadequate; looking at whether other people are really likely to evaluate them negatively, and, if they do, how important that is; and looking at their belief that feared negative consequences are likely to occur. Armed with new ways of thinking, they may act out these situations with their therapist or therapy assistants, or other group members. Thereafter, clients are encouraged to confront their real-life feared situations (just as in Exposure Therapy), using their new coping skills and relying on the successful experiences they have had in sessions.

Social Skills Training, which teaches new ways to act (like using eye contact and asking appropriate questions) in many different situations through practice and rehearsal; and

Applied Relaxation Training, which helps clients to learn to relax while in the situations they fear.

Several cognitive and behavioral therapies have effectively reduced the anxiety experienced by persons with social anxiety disorder, and these benefits have lasted for a number of years after treatment.

Medication Treatment

A number of medications have been scientifically studied; several classes of drugs have proven useful for social anxiety disorder. Consult your doctor about medication treatment for social anxiety disorder.

We strongly encourage you to seek treatment for your social anxiety disorder and wish you the best of luck in your efforts.

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What is sleep apnea?

Sleep apnea is a common medical illness affecting millions of Americans. Sleep apnea can be central (e.g., due to a neurological condition such as a stroke) and due to a lack of respiratory effort, obstructive (due to a closed airway in spite of normal respiratory effort), or the combination of both.

Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS) is the most common cause of sleep apnea and is caused by the repetitive closing of a person s airway (e.g., trachea or windpipe) while they are asleep. When a person goes to sleep, all of the body s muscles which are under voluntary control begin to relax, making it impossible to breath.

Apneas are the moments when breathing is stopped due to the obstructed movement of air (lasting more than 10 seconds) and *hypopneas* are moments of abnormal and decreased breathing due to obstruction. Snoring is common for many people with OSAHS. OSAHS causes poor sleep, excessive daytime sleepiness, and a number of other medical and psychiatric issues that comprise the syndrome.

How is it diagnosed?

OSAHS is diagnosed by a doctor who recognizes the combination of symptoms that are seen in people who have this syndrome. Specifically, many people with OSAHS may:

1) Experience poor sleep (e.g., waking up multiple times overnight)
2) Report excessive daytime sleepiness
3) Be aware of nighttime snoring
4) Have other symptoms such as unexplained high blood pressure, daytime headaches, or incontinence while sleeping (*nocturia*)

A definitive diagnosis of OSAHS is made using a test called a sleep study, or a *polysomnogram,* that measures for apnea and hypopnea events that are present when a person sleeps overnight in a hospital or another medical setting.

Who is at risk?

Men are at greater risk of developing OSAHS than women and younger people are less likely to develop OSAHS than older individuals. People who are overweight are also significantly more likely to be diagnosed with OSAHS.

What are some of the complications of OSAHS?

People with OSAHS are more likely to develop high blood pressure and diabetes which increases the risk of heart disease and heart attacks. People with OSAHS are also at increased risk when undergoing surgeries or other procedures that require general anesthesia.

OSAHS and Mental Illness

Getting a good night s sleep is very important for all people, but even more so for people with depression, anxiety, bipolar disorder and other mental illnesses. Many mental illnesses can disrupt sleep when untreated, but sometimes it is the other way around: poor sleep worsens mental illness and makes it harder to treat the symptoms of mental illness.

The poor sleep that is caused by OSAHS has been shown to significantly worsen the symptoms of depression in scientific studies. Furthermore, severe OSAHS can decrease the efficacy of certain treatments in depression. All of the scientific data shows the connection between medical and mental illnesses: good treatment for OSAHS is necessary for recovery or prevention in both types of conditions.

What is the treatment for OSAHS?

After a diagnosis is made, sitting down and talking with a physician is the first step in the treatment of OSAHS. A person s doctor will likely counsel them on smoking and alcohol use; both of these substances may worsen OSAHS. People can also expect to be counseled to lose weight as this will decrease the severity of symptoms associated with this condition. Some people, who are taking medications that increase sleepiness, including some benzodiazepines, may also be advised to stop these medications.

Some people may seek treatment with stimulant medications or non-stimulant medications but these are not effective in treating the underlying cause of OSAHS. These medications are only useful in decrease daytime sleepiness.

Continuous Positive Airway Pressure (CPAP) is a treatment of choice in OSAHS. This consists of a mask that people wear on their face while sleeping in bed. This mask is attached to a machine that blows air into a person s nose and mouth and helps to keep the airway open. Most people find that this treatment is very effective.

Some people might also seek surgery to cure their OSAHS. It is not generally recommended for most people with OSAHS because non-surgical methods have proven more effective.

Another treatment used is a Mandibular Repositioning Splint (MRS), a mouth guard or an oral device, which can help to open the airway and decrease apnea and hypopnea events.

Reviewed by Ken Duckworth, M.D., and Jacob Freedman M.D., July 2012