An Invitation to Health: Build Your Future

DIANNE HALES

15TH EDITION
After studying the material in this chapter, you should be able to

- List the key structures of the brain and describe the role of neurons in communication within the brain.
- Discuss gender- and age-based differences in the brain.
- Explain the differences between mental health and mental illnesses and list some effects of mental illness on physical health.
- Identify risk factors in college students for mental health problems.
- List the symptoms of major depression and discuss the pros and cons of using antidepressants.
- Describe the major anxiety disorders, including symptoms and treatments.
- Discuss some of the factors that may lead to suicide, as well as strategies for prevention.
- List the criteria for considering therapy for a mental health problem.
For years, Travis put on his “happy face” around his friends and family. Popular and athletic in high school, he never let anyone know how desperately unhappy he actually felt. “Whatever I was doing during the day, nothing was on my mind more than wanting to die,” he recalls. On a perfectly ordinary day in his senior year, Travis tried to kill himself with an overdose of pills. Rushed to a hospital, Travis recovered, resumed his studies, and entered college. By the middle of his freshman year, he was struggling once more with feelings of hopelessness. This time he realized what was happening and sought help from a therapist. “I thought college was supposed to be the happiest time of your life,” he said. “What went wrong?”

This is a question many young people might ask. Although youth can seem a golden time, when body and mind glow with potential, the process of becoming an adult is a challenging one in every culture and country. Psychological health can make the difference between facing this challenge with optimism and confidence or feeling overwhelmed by expectations and responsibilities.

This isn’t always easy. At some point in life almost half of Americans develop an emotional disorder. Young adulthood—the years from the late teens to the midtwenties—is a time when many serious disorders, including bipolar illness (manic depression) and schizophrenia, often develop. The saddest fact is not that so many feel so bad, but that so few realize they can feel better. Only a third of those with a mental disorder receive any treatment at all. Yet 80 to 90 percent of those treated for psychological problems recover, most within a few months.

By learning about psychological disorders covered in this chapter, you may be able to recognize early warning signals in yourself or your loved ones so you can deal with potential difficulties or seek professional help for more serious problems.

Caring for Your Mind

The Brain: The Last Frontier

The brain has intrigued scientists for centuries, but only recently have its explorers made dramatic progress in unraveling its mysteries. Leaders in neuropsychiatry—the field that brings together the study of the brain and the mind—remind us that 95 percent of what is known about brain anatomy, chemistry, and physiology has been learned in the last 25 years. These discoveries have reshaped our understanding of the organ that is central to our identity and...
well-being and have fostered great hope for more effective therapies for the more than 1,000 disorders—psychiatric and neurologic—that affect the brain and nervous system.

Inside the Brain

The human brain, the most complex organ in the body, controls the central nervous system (CNS) and regulates virtually all our activities, including involuntary, or “lower,” actions like heart rate, respiration, and digestion, and conscious, or “higher,” mental activity like thought, reason, and abstraction. More than one hundred billion neurons, or nerve cells, within the brain are capable of electrical and chemical communication with tens of thousands of other nerve cells. (The basic anatomy of the brain is shown in Figure 3.1.)

The neurons are the basic working units of the brain. Like snowflakes, no two are exactly the same. Each consists of a cell body containing the nucleus; a long fiber called the axon, which can range from less than an inch to several feet in length; an axon terminal, or ending; and multiple branching fibers called dendrites (Figure 3.2). The glia serve as the scaffolding for the brain, separate the brain from the bloodstream, assist in the growth of neurons, speed up the transmission of nerve impulses, and engulf and digest damaged neurons.

Until quite recently scientists believed no new neurons or synapses formed in the brain after birth. This theory has been soundly disproved. The brain and spinal cord contain stem cells, which turn into thousands of new neurons a day. The process of creating new brain cells and synapses occurs most rapidly in childhood but continues throughout life, even into old age. Whenever you learn and change, you establish new neural networks.

Anatomically, the brain consists of three parts: the forebrain, midbrain, and hindbrain. The forebrain includes the several lobes of the cerebrum, cerebellum, and brainstem (medulla). The cerebrum is divided into two hemispheres—the left, which regulates the right side of the body, and the right, which regulates the left side of the body. The cerebellum plays the major role in coordinating movement, balance, and posture. The brainstem contains centers that control breathing, blood pressure, heart rate, and other physiological functions.

Figure 3.1 The Brain

The three major parts of the brain are the cerebrum, cerebellum, and brainstem (medulla). The cerebrum is divided into two hemispheres—the left, which regulates the right side of the body, and the right, which regulates the left side of the body. The cerebellum plays the major role in coordinating movement, balance, and posture. The brainstem contains centers that control breathing, blood pressure, heart rate, and other physiological functions.
Chapter 3  Caring for Your Mind

neurotransmitters  Chemicals released by neurons that stimulate or inhibit the action of other neurons.

synapse  A specialized site at which electrical impulses are transmitted from the axon terminal of one neuron to a dendrite of another.

receptors  Molecules on the surface of neurons on which neurotransmitters bind after their release from other neurons.

reuptake  Reabsorption by the originating cell of neurotransmitters that have not connected with receptors and have been left in synapses.

antidepressant  A drug used primarily to treat symptoms of depression.

Communication within the Brain

Neurons “talk” with each other by means of electrical and chemical processes (see Figure 3.2). An electric charge, or impulse, travels along an axon to the terminal, where packets of chemicals called neurotransmitters are stored. When released, these messengers flow out of the axon terminal and cross a synapse, a specialized site at which the axon terminal of one neuron comes extremely close to a dendrite from another neuron.

On the surface of the dendrite are receptors, protein molecules designed to bind with neurotransmitters. It takes only about a ten-thousandth of a second for a neurotransmitter and a receptor to come together. Neurotransmitters that do not connect with receptors may remain in the synapse until they are reabsorbed by the cell that produced them—a process called reuptake—or broken down by enzymes.

A malfunction in the release of a neurotransmitter, in its reuptake or elimination, or in the receptors or secondary messengers may result in abnormalities in thinking, feeling, or behavior. Some of the most promising and exciting research in neuropsychiatry is focusing on correcting such malfunctions.

The neurotransmitter serotonin and its receptors have been shown to affect mood, sleep, behavior, appetite, memory, learning, sexuality, and aggression and to play a role in several mental disorders. The discovery of a possible link between low levels of serotonin and some cases of major depression has led to the development of more precisely targeted antidepressant medications that boost serotonin to normal levels. (See “Psychiatric Drugs” later in the chapter.)
Sex Differences in the Brain

From birth, male and female brains differ in a variety of ways. Overall, a woman's brain, like her body, is 10 to 15 percent smaller than a man's, yet the regions dedicated to higher cognitive functions such as language are more densely packed with neurons—and women use more of them. When a male puts his mind to work, neurons turn on in highly specific areas. When females set their minds on similar tasks, cells light up all over the brain.

Male and female brains perceive light and sound differently. A man's eyes are more sensitive to bright light and retain their ability to see well at long distances longer in life. A woman hears a much broader range of sounds, and her hearing remains sharper longer.

The female brain responds more intensely to emotion. According to neuroimaging studies, the genders respond differently to emotions, especially sadness, which activates, or turns on, neurons in an area eight times larger in women than men.

Neither gender’s brain is “better.” Intelligence per se appears equal in both. The greatest gender differences appear both at the top and bottom of the intelligence scales. Nevertheless, more than half the time, regardless of the type of test, most women and men perform more or less equally—even though they may well take different routes to arrive at the same answers.

Cognitive skills show greater variability both among women and among men than between the genders. The best evaluation may have come from essayist Samuel Johnson. When asked whether women or men are more intelligent, he responded, “Which man? Which woman?”

The number of synapses surges in the “tween” years before adolescence, followed, by a “pruning” of nonessential connections. In a sense, each individual determines which synapses stay and which are deleted. If you started to play the piano as a child and continue as an adolescent, for instance, you retain the synapses involved in this skill. If you don’t practice regularly, your brain will prune the unused synapses, and your piano-playing ability will diminish. Inadequate pruning of synapses may contribute to mental disorders such as schizophrenia, which usually first occur in late adolescence.

Brain areas responsible for tasks such as organizing, controlling impulses, planning, and strategizing do not fully develop until the mid-twenties. Brain chemicals such as dopamine that help distinguish between what is worthy of attention and what is mere distraction also do not reach optimal levels until then.

The brains of teens and young adults function differently than those of older individuals. In dealing with daily life, they rely more on the amygdala, a small almond-shaped region in the medial and temporal lobes that processes emotions and memories. This is one reason why any setback—a poor grade or a friend’s snub—can feel like a major crisis. As individuals age, the frontal cortex, which governs reason and forethought, plays a greater role and helps put challenges into perspective.

A young, “maturing” brain does not necessarily lead to poor judgments and risky behaviors. However, if you are under 25, you should be aware that your brain may not always grasp the long-term consequences of your actions, set realistic priorities, or restrain potentially harmful impulses. You can learn to center yourself, seek the counsel of others, and not fly off the handle. Be cautious of drugs and alcohol, which are especially toxic to the developing brain and increase the risk of acts you may later regret.

Understanding Mental Health

Mentally healthy individuals value themselves, perceive reality as it is, accept their limitations and possibilities, carry out their responsibilities,
establish and maintain close relationships, pursue work that suits their talent and training, and feel a sense of fulfillment that makes the efforts of daily living worthwhile (Figure 3.3).

The state of mental health around the world is far from ideal. Psychiatric illness and substance abuse cause more premature deaths than any other factor, according to a recent report by the World Health Organization (WHO). These conditions also account for about a third of years lost to disability among people older than 14. The most common psychiatric conditions worldwide are depression, alcohol dependence and abuse, bipolar disorder, schizophrenia, Alzheimer’s and other forms of dementia, panic disorder, and drug dependence and abuse.

Across the globe, depression is the leading cause of years of health lost to disease in both men and women. The worldwide rate of depression among women is 50 percent higher than in men, and women and girls have higher rates of anxiety disorders, migraine, and Alzheimer’s disease. Men’s rates of alcohol and substance abuse are nearly seven times higher than women’s.

Preventive steps can help maintain and enhance your psychological health, just as similar actions boost physical health. (See Making Change Happen, p. 84.)

Despite public education campaigns, the level of prejudice and discrimination against people with a serious mental illness has changed little over the last ten years. More people now attribute problems like depression and substance abuse to neurobiological causes—and are more likely to favor providing treatment. Yet even these individuals are no less likely to stigmatize patients with mental illness.²

What Is a Mental Disorder?

While laypeople may speak of “nervous breakdowns” or “insanity,” these are not scientific terms. The U.S. government’s official definition states that a serious mental illness is “a diagnosable mental, behavioral, or emotional disorder that interferes with one or more major activities in life, like dressing, eating, or working.”

The mental health profession’s standard for diagnosing a mental disorder is the pattern of symptoms, or diagnostic criteria, spelled out for the almost 300 disorders in the American Psychiatric Association’s Diagnostic and Statistical Manual, 4th edition (DSM-IV). Psychiatrists define a mental disorder as a clinically significant behavioral or psychological syndrome or pattern that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.³

Who Develops Mental Disorders?

In the course of their lifetime, almost half of all Americans experience a diagnosable psychological problem. The most common mental disorders are substance abuse (discussed in Chapters 11 and 12), mood disorders such as depression and bipolar disorder, and anxiety disorders such as phobias and panic disorder.

Unlike most disabling physical diseases, mental illness starts early in life. Anxiety disorders often begin in late childhood, mood disorders in late adolescence, and substance abuse in the early twenties. Researchers describe such problems as “the chronic diseases of the young,” striking when men and women are in their prime.

mental disorder Behavioral or psychological syndrome associated with distress or disability or with a significantly increased risk of suffering death, pain, disability, or loss of freedom.
Building Your Future

The Exercise Prescription

Imagine a drug so powerful it can alter brain chemistry, so versatile it can help prevent or treat many common mental disorders, so safe that moderate doses cause few, if any, side effects, and so inexpensive that anyone can afford it. This wonder drug, proved in years of research, is exercise.

Chapter 8 provides detailed information on improving your fitness. To make a difference in the way you look and feel, follow these simple guidelines:

- **Work in short bouts.** Three 10-minute intervals of exercise can be just as effective as exercising for 30 minutes straight.

- **Mix it up.** Combine moderate and vigorous intensity exercises to meet the guidelines. For instance, you can walk briskly two days a week and jog at a faster pace on the other days.

- **Set aside exercise times.** Schedule exercise in advance so you can plan your day around it.

- **Find exercise buddies.** Recruit roommates, friends, family, coworkers. You’ll have more fun on your way to getting fit.

The prevalence of mental disorders increases from early adulthood (ages 18 to 29) to the next-oldest age group (ages 30 to 44) and then declines. Women have higher rates of depressive and anxiety disorders; men have higher rates of substance abuse and impulse disorders.

About 6 percent of Americans have a “severe” mental disorder, one that significantly limits their ability to work or carry out daily activities or that has led to a suicide attempt or psychosis (a gross impairment of a person’s perception of reality). On average, they are unable to function for nearly three months of the year.

Disease Risks

Mental disorders, on the other hand, can undermine physical well-being. Anxiety can lead to intensified asthmatic reactions, skin conditions, and digestive disorders. Stress can play a role in hypertension, heart attacks, sudden cardiac death, and immune disorders in the young as well as in older individuals. People who suffer from migraine headaches are at increased risk of depression, anxiety, and neurological disorders.

The brain and the heart—and the health of each—are linked in complex ways. Heart disease increases the likelihood of depression, and depression increases the likelihood of heart disease. For people with heart disease, depression can be fatal. It may contribute to sudden cardiac death and increase all causes of cardiac mortality.

Large-scale, longitudinal studies have found complex links between depression and diabetes. Individuals who are depressed are at much higher risk of developing diabetes, and those with diabetes are much more likely to become depressed. Preventing diabetes, which affects about 10 percent of Americans, may prevent depression—and preventing depression, which affects about 7 percent of adults over age 18, could prevent diabetes.4

Major depression is associated with lower bone density in young men and in adolescent girls. A history of depression increases the risk of cardiovascular and lung disease, stroke, diabetes, colds, and upper respiratory infections. Gratitude, in particular, has proven health benefits. (See “Health in Action: Count Your Blessings,” p. 63.)

In addition to its head-to-toe physical benefits, discussed in Chapter 8, exercise may be, as one therapist puts it, the single most effective way to lift a person’s spirits and to restore feelings of potency about all aspects of life. People who exercise regularly report a more cheerful mood, higher self-esteem, and less stress. Their sleep and appetite also tend to improve. In clinical studies, exercise has proved effective as a treatment for depression and anxiety disorders. But remember: Although exercise can help prevent and ease problems for many people, it’s no substitute for professional treatment of serious psychiatric disorders.

The Mind-Body Connection

According to a growing number of studies, mental attitude may be just as important a risk factor for certain diseases as age, race, gender, education, habits, and health history. Positive states like happiness and optimism have been linked with longer lifespans as well as lower risk
### Mental Health Problems on Campus

Students reporting the following feelings at any time with the last 12 months:

- Exhausted (not from physical activity): 80 percent
- Very sad: 61 percent
- Overwhelmingly anxious: 48 percent
- Hopeless: 46 percent
- So depressed it was difficult to function: 31 percent

Students reporting a diagnosis of a mental disorder by a professional in the last 12 months:

- Anxiety: 10 percent
- Depression: 10 percent
- Both anxiety and depression: 6 percent
- Panic attacks: 5 percent
- Attention disorder: 4 percent
- Insomnia: 4 percent

### Mental Health on Campus

Young people in their late teens and early twenties are at risk of mental health problems simply because of their age. In three of four cases, the first episodes of mental and substance abuse disorders occur before age 24. Nearly half of all young adults have suffered some form of a psychological disorder. The rates of such problems are lower among students than among those not enrolled in higher education, but undergraduates are far from immune.

Among entering freshmen, self-reported emotional health is at the lowest point in the last quarter-century. The percentage of students describing their mental state as above average or in the top 10 percent dropped to 52 percent, with much fewer women (46 percent) than men (59 percent) rating their mental health highly.

In the American College Health Association National College Health Assessment, almost half (46 percent) of the more than 95,000 students reporting a diagnosis of a mental disorder by a professional in the last 12 months.

### Health in Action

**Count Your Blessings**

As discussed in Chapter 2, gratitude has proven as effective in brightening mood and boosting energy as the standard, well-studied techniques used in psychotherapy. Below are some simple steps to cultivating and expressing gratitude. See “The Grateful Thread” in *Labs for IPC* for more suggestions:

- Every day write down ten new things for which you are grateful. You can start with this list and keep adding to it: your bed, your cell phone and every person whose efforts led to its development, every road you take, loyalty, your toothbrush, your toes, the sky, ice cream, etc.
- Record the ways you express gratitude. How do you feel when doing so?
- Create a daily practice of appreciation. This may be as simple as saying a few words of thanks before each meal (if only to yourself) or writing down your feelings of gratitude.
- Make a list of ten people to whom you owe a debt of gratitude. Write a one- to two-page letter to each of them, stating your appreciation of what he or she has contributed to you and your well-being. These people could include schoolteachers, music or dance instructors, coaches, doctors, neighbors, and, of course, family members. It is not important that you send the letters. What is important is that you focus deeply on the contribution of each person and allow feelings of gratitude to come as they may.
Some psychiatric symptoms increase the risk of developing other disorders. College women who reported symptoms of depression, for example, are at higher risk for alcohol problems.

The few studies that have looked into ethnic differences in psychological health have yielded conflicting or inconclusive results: Some found no differences; others suggested higher rates of depression among Indian, Korean, and South Asian students. Various ethnic groups report less of a sense of belonging and a lack of mentoring and peer support. A recent survey of Latino/a college students found that they did not differ from other students in overall mental health, but showed subtle signs of low-level psychological problems, such as a past history of depression and feeling “worried” or “sad.”

The Toll on Students

Psychological and emotional problems can affect every aspect of a student’s life, including physical health, overall satisfaction, and relationships. Students who struggle with symptoms of anxiety or depression, which can interfere with concentration, study habits, classroom participation, and testing, commonly report struggling with academics.

In the ACHA’s national assessment, 18 percent of students reported that anxiety had impaired their ability to learn and earn higher grades; 12 percent said that depression had affected their academic performance. Some estimate that 5 percent of undergraduates may not complete their degrees because of psychological problems.

The impact of mental health problems extends beyond an individual student to roommates, friends, classmates, family, and instructors. Suicides or suicide attempts affect all members of the campus community, who may experience profound sadness and grief. (See the discussion of violence on campus.)

Students at Risk

Many arrive on campus with a history of psychological problems. Medications for common disorders such as depression and attention disorder have made it possible for young people who might otherwise not have been able to function in a college setting to pursue higher education. Some are dealing with ongoing issues such as bulimia, self-cutting, and childhood sexual abuse. Others become depressed in college or begin abusing alcohol or drugs.

Among the strongest factors that put college students at risk for mental problems is a romantic breakup or loss. In the survey, about one in eight individuals reported a breakup in the previous year. Their odds of having a psychiatric disorder are significantly higher than those who hadn’t been through a breakup.
Depression in Children and Teens

An estimated 5 to 10 percent of American teenagers suffer from a serious depressive disorder; girls are twice as susceptible as boys. Prior to puberty, girls and boys are equally likely to develop depression.

The risks of depression in the young are high. Four in ten depressed adolescents think about killing themselves; two in ten actually try to do so. Every year an estimated 11 to 13 in every 100,000 teens take their own lives, twice as many as the number who die from all natural causes combined.

No one knows the reason for this steady surge in sadness, but experts point to the breakdown of families, the pressures of the information age, and increased isolation. A family history of depression greatly increases a young person’s vulnerability. A mother’s anxiety and depression during early childhood can increase the risk that adolescents will develop symptoms of anxiety and depression. Racial and ethnic factors also contribute. Among Asian American college students, for instance, perfectionism has been linked to depressive symptoms.

Teens who spend many hours watching television are at higher risk of depression as adults. However, the strongest predictor of depression is cigarette smoking. Depressed teens may smoke because they think smoking will make them feel better, but nicotine alters brain chemistry and actually worsens symptoms of depression.

Treatment with antidepressants and cognitive behavioral therapy helps most adolescents recover from major depression, but the risk of relapse is high, especially in girls. In one recent study, nearly half of adolescents developed a second episode of major depression.14

Depression in Students

An estimated 15 to 40 percent of college-age men and women (18- to 24-year-olds) may develop depression. Among the most vulnerable students are those being treated for mental disorders. (See the Self Survey: “Recognizing Depression,” p. 83.)
around-the-clock television, and the college tradition of pulling all-nighters can conspire to sabotage rest and increase vulnerability to depression.

Gender and Depression

Female Depression Depression is twice as common in women as men. However, this gender gap decreases or disappears in studies of men and women in similar socioeconomic situations, such as college students, civil servants, and the Amish community. Women may not necessarily be more likely to develop depression, this research suggests, but may have an underlying predisposition that puts them at greater risk under various social stressors.15

Brain chemistry and sex hormones may play a role. Women produce less of certain metabolites of serotonin, a messenger chemical that helps regulate mood. Their brains also register sadness much more intensely than men’s, and they are more sensitive to changes in light and temperature. Women are at least four times more likely than men to develop seasonal affective disorder (SAD) and to become depressed in the dark winter months.

Some women also seem more sensitive to their own hormones or to the changes in them that occur at puberty, during the menstrual cycle, after childbirth, or during perimenopause and menopause. Primary ovarian insufficiency, a condition that causes menopause-like symptoms and that can develop as early as the teens or twenties, greatly increases a woman’s risk of depression.16 Pregnancy, contrary to what many people assume, does not “protect” a woman from depression, and women who discontinue treatment when they become pregnant are at risk of a relapse. Women and their psychiatrists must carefully weigh the risks and benefits of psychiatric medications during pregnancy.

Childhood abuse also contributes to female vulnerability. In epidemiological studies, 60 percent of women diagnosed with depression—compared with 39 percent of men—were abused as children. In adulthood, relationships may protect women from depression, while a lack of social support increases vulnerability to depression. Women with at least one “confiding relationship,” as researchers put it, are physically and psychologically more resilient.

Researchers at the University of Michigan have identified three key contributors to depression in college students: stress, substance abuse, and sleep loss.

As they adjust to campus life, undergraduates face the ongoing stress of forging a new identity and finding a place for themselves in various social hierarchies. This triggers the release of the so-called stress hormones (discussed in Chapter 4), which can change brain activity. Drugs and alcohol, widely used on campus, also affect the brain in ways that make stress even harder to manage.

Too little sleep adds another ingredient to this dangerous brew. Computers, the Internet, Many men don’t realize that a sense of hopelessness, worthlessness, helplessness, or feeling dead inside can be a symptom of depression.
Male Depression  More than 6 million men in the United States—1 in every 14—suffer from this insidious disorder, many without recognizing what’s wrong. Experts describe male depression as an “under” disease: under-discussed, under-recognized, under-diagnosed, and undertreated.

Depression “looks” different in men than women. Rather than becoming sad, men may be irritable or tremendously fatigued. They feel a sense of being dead inside, of worthlessness, hopelessness, helplessness, of losing their life force. Physical symptoms, such as headaches, pain, and insomnia, are common, as are attempts to “self-medicate” with alcohol or drugs.

Genes may make some men more vulnerable, but chronic stress of any sort plays a major role in male depression, possibly by raising levels of the stress hormone cortisol and lowering testosterone. Men also are more likely than women to become depressed following divorce, job loss, or a career setback. Whatever its roots, depression alters brain chemistry in potentially deadly ways. Four times as many men as women kill themselves; depressed men are two to four times more likely to take their own lives than depressed women.

Dysthymic Disorder

Dysthymia is a depressive disorder characterized by a chronically depressed mood. Symptoms include feelings of inadequacy, hopelessness, and guilt; low self-esteem; low energy; fatigue; indecisiveness; and an inability to enjoy pleasurable activities.

Minor Depression

Minor depression is a common disorder that is often unrecognized and untreated, affecting about 7.5 percent of Americans during their lifetime. Its symptoms are the same as those of major depression, but less severe and fewer in number. They include either a depressed mood most of the day, nearly every day, or diminished interest or pleasure in daily activities.

Psychotherapy is remarkably effective for mild depression. In more serious cases, antidepressant medication can lead to dramatic improvement in 40 to 80 percent of depressed patients.

Your Strategies for Prevention

How to Help Someone Who Is Depressed

• Express your concern, but don't nag. You might say: “I'm concerned about you. You are struggling right now. We need to find some help.”

• Don't be distracted by behaviors like drinking or gambling, which can disguise depression in men.

• Encourage the individual to remain in treatment until symptoms begin to lift (which takes several weeks).

• Provide emotional support. Listen carefully. Offer hope and reassurance that with time and treatment, things will get better.

• Do not ignore remarks about suicide. Report them to his or her doctor or, in an emergency, call 911.

Exercise also works. Several studies have shown that exercise effectively lifts mild to moderate depression.

Major Depression

The simplest definition of major depression is sadness that does not end. The incidence of major depression has soared over the last two decades, especially among young adults. Major depression can destroy a person’s joy for living. Food, friends, sex, or any form of pleasure no longer appeals. It is impossible to concentrate on work and responsibilities. Unable to escape a sense of utter hopelessness, depressed individuals may fight back tears throughout the day and toss and turn through long, empty nights. Thoughts of death or suicide may push into their minds.

The characteristic symptoms of major depression include:

• Feeling depressed, sad, empty, discouraged, tearful.

• Loss of interest or pleasure in once-enjoyable activities.

• Eating more or less than usual and either gaining or losing weight.

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• Having trouble sleeping or sleeping much more than usual.
• Feeling slowed down or restless and unable to sit still.
• Lack of energy.
• Feeling helpless, hopeless, worthless, inadequate.
• Difficulty concentrating, forgetfulness.
• Difficulty thinking clearly or making decisions.
• Persistent thoughts of death or suicide.
• Withdrawal from others, lack of interest in sex.
• Physical symptoms (headaches, digestive problems, aches and pains).

As many as half of major depressive episodes are not recognized because the symptoms are “masked.” Rather than feeling sad or depressed, individuals may experience low energy, insomnia, difficulty concentrating, and physical symptoms.

### Treating Depression

The most recent guidelines for treating depression, developed by the American Psychiatric Association, call for an individualized approach tailored to each patient’s symptoms. Specific treatments might include medication, healthy behaviors, exercise (proven to reduce depressive symptoms, especially in older adults and those with chronic medical problems), and psychotherapy.17

The rate of depression treatment, particularly with antidepressants, has increased in the last decade. Medication has become the most common approach, while fewer patients receive psy-

### CONSUMER ALERT

#### The Pros and Cons of Antidepressants

Millions of individuals have benefited from the category of antidepressant drugs called selective serotonin reuptake inhibitors (SSRIs). However, like all drugs, they can cause side effects that range from temporary physical symptoms, such as stomach upset and headaches, to more persistent problems, such as sexual dysfunction. The most serious—and controversial—risk is suicide.

#### Facts to Know

- The FDA has issued a “black box” warning about the risk of suicidal thoughts, hostility, and aggression in both children and young adults. The danger is greatest just after pill use begins.
- This risk of suicide while taking an antidepressant is about 1 in 3,000; the risk of a serious attempt is 1 in 1,000.
- Recent reviews of antidepressant use have found that the risk of suicide for both children and adults was higher in the month before starting treatment, dropped sharply in the month after it began, and tapered off in the following months.

#### Steps to Take

- If you are younger than age 20, be aware of the increased suicide risk with the use of SSRIs. Talk these over carefully with a psychiatrist. Discuss alternative treatments, such as psychotherapy.
- For individuals older than age 20, the benefits of antidepressants have proved to outweigh their risks in most cases. Adults treated with SSRIs are 40 percent less likely to commit suicide than depressed individuals who do not receive this therapy.
- In patients initially treated with antidepressants, two approaches based on mindfulness (discussed in Chapter 4)—mindfulness-based cognitive therapy and mindfulness meditation—have proven as effective as continuing drug therapy in preventing a return of depression symptoms.19
- Whatever your age, arrange for careful monitoring and follow-up with a psychiatrist when you start taking an antidepressant. Familiarize yourself with possible side effects, and seek help immediately if you begin to think about taking your own life.

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Section I  Building Your Future
Psychotherapy helps individuals pinpoint the life problems that contribute to their depression, identify negative or distorted thinking patterns, explore behaviors that contribute to depression, and regain a sense of control and pleasure in life. Two specific psychotherapies—cognitive-behavioral therapy and interpersonal therapy (described later in this chapter)—have proved as helpful as antidepressant drugs, although they take longer than medication to achieve results.

Antidepressants have proven most effective in individuals with severe depression, with minimal or nonexistent benefits for those with mild or moderate symptoms. (See “Consumer Alert: The Pros and Cons of Antidepressants.”)

For individuals who cannot take antidepressant medications because of medical problems, or who do not improve with psychotherapy or drugs, electroconvulsive therapy (ECT)—the administration of a controlled electrical current through electrodes attached to the scalp—remains the safest and most effective treatment. About 70 to 90 percent of depressed individuals improve after ECT. Newer options include transcranial magnetic stimulation, which uses highly focused, pulsed magnetic fields to stimulate brain regions linked with depression, and vagus nerve stimulation, which delivers electrical stimulation to a major nerve linking the brain to internal organs.

Even without treatment, depression generally lifts after six to nine months. However, in more than 80 percent of people, it recurs, with each episode lasting longer and becoming more severe and difficult to treat.

“All the while the depression goes untreated, it is causing ongoing damage that shrivels important regions of the brain,” says John Greden, M.D., director of the University of Michigan Depression Center. “The exciting news is that, as brain scans show, treatment turns the destructive process around and stops depression in its tracks.”20

### Bipolar Disorder

**Bipolar disorder**, known as manic depression in the past, consists of mood swings that may take individuals from manic states of feeling euphoric and energetic to depressive states of utter despair. In episodes of full mania, they may become so impulsive and out of touch with reality that they endanger their careers, relationships, health, or even survival. Psychiatrists view bipolar symptoms on a spectrum that includes depression and states of acute irritability and distress.21

One percent of the population—about 2 million American adults—suffer from this serious but treatable disorder. Men tend to develop bipolar disorder earlier in life (between ages 16 and 25), but women have higher rates overall. About 50 percent of patients with bipolar illness have a family history of the disorder.

The characteristic symptoms of bipolar disorder include:

- **Mood swings** (from happy to miserable, optimistic to despairing, and so on).
- **Changes in thinking** (thoughts speeding through one’s mind, unrealistic self-confidence, difficulty concentrating, delusions, hallucinations).
- **Changes in behavior** (sudden immersion in plans and projects, talking very rapidly and much more than usual, excessive spending, impaired judgment, impulsive sexual involvement).
- **Changes in physical condition** (less need for sleep, increased energy, fewer health complaints than usual).

During manic periods, individuals may make grandiose plans or take dangerous risks. But they often plunge from this high to a horrible, low depressive episode, in which they may feel sad, hopeless, and helpless and develop other symptoms of major depression.

Professional therapy is essential in treating bipolar disorders. An estimated 25 to 50 percent of bipolar patients attempt suicide at least once. About 1 percent take their own lives every year.22 Mood-stabilizing medications are the keystone of treatment, although psychotherapy plays a critical role in helping individuals understand their illness and rebuild their lives. Most individuals continue taking medication indefinitely after remission of their symptoms because the risk of recurrence is high.
Phobias—the most prevalent type of anxiety disorder—are out-of-the-ordinary, irrational, intense, persistent fears of certain objects or situations. About 2 million Americans develop such acute terror that they go to extremes to avoid whatever it is that they fear, even though they realize that these feelings are excessive or unreasonable. The most common phobias involve animals, particularly dogs, snakes, insects, and mice; the sight of blood; closed spaces (claustrophobia); heights (acrophobia); air travel and being in open or public places or situations from which one perceives it would be difficult or embarrassing to escape (agoraphobia).

Although various medications have been tried, none is effective by itself in relieving phobias. The best approach is behavioral therapy, which consists of gradual, systematic exposure to the feared object (a process called systematic desensitization). Numerous studies have proved that...
exposure—especially in vivo exposure, in which individuals are exposed to the actual source of their fear rather than simply imagining it—is highly effective. Medical hypnosis—the use of induction of an altered state of consciousness—also can help.

**Panic Attacks and Panic Disorder**

Individuals who have had panic attacks describe them as the most frightening experiences of their lives. Without reason or warning, their hearts race wildly. They may become light-headed or dizzy. Because they can’t catch their breath, they may start breathing rapidly and hyperventilate. Parts of their bodies, such as their fingers or toes, may tingle or feel numb. Worst of all is the terrible sense that something horrible is about to happen: that they will die, lose their minds, or have a heart attack.

Individuals of different ethnic and racial backgrounds may experience panic symptoms differently. In one cross-cultural study of undergraduates, Asians tended to report symptoms such as dizziness, unsteadiness, choking, and feeling terrified more frequently than did Caucasians. African Americans reported feeling less nervous than Caucasians. However, panic symptoms were equally severe across all racial and ethnic groups. Most attacks reach peak intensity within ten minutes. Afterward, individuals live in dread of another one. In the course of a lifetime, your risk of having a single panic attack is 7 percent.

**Panic disorder** develops when attacks recur or apprehension about them becomes so intense that individuals cannot function normally. Full-blown panic disorder occurs in about 2 percent of all adults in the course of a lifetime and usually develops before age 30. Women are more than twice as likely as men to experience panic attacks, although no one knows why. Parents, siblings, and children of individuals with panic disorders also are more likely to develop them than are others.

The two primary treatments for panic disorder are (1) cognitive-behavioral therapy (CBT), which teaches specific strategies for coping with symptoms like rapid breathing, and (2) medication. Treatment helps as many as 90 percent of those with panic disorder either improve significantly or recover completely, usually within six to eight weeks. Individuals with a greater internal locus of control (discussed in Chapter 1) may respond better to CBT.

**Generalized Anxiety Disorder**

About 10 million adults in the United States suffer from a generalized anxiety disorder (GAD), excessive or unrealistic apprehension that causes physical symptoms and lasts for six months or longer. It usually starts when people are in their twenties. Unlike fear, which helps us recognize and avoid real danger, GAD is an irrational or unwarranted response to harmless objects or situations of exaggerated danger. The most common symptoms are faster heart rate, sweating, increased blood pressure, muscle aches, intestinal pains, irritability, sleep problems, and difficulty concentrating.
Chronically anxious individuals worry—not just some of the time, and not just about the stresses and strains of ordinary life—but constantly, about almost everything: their health, families, finances, marriages, potential dangers. Treatment for GAD may consist of a combination of psychotherapy, behavioral therapy, and antianxiety drugs.

**Obsessive-Compulsive Disorder**

As many as 1 in 40 Americans has a type of anxiety called obsessive-compulsive disorder (OCD). Some of these individuals suffer only from an obsession, a recurring idea, thought, or image that they realize, at least initially, is senseless. The most common obsessions are repetitive thoughts of violence (for example, killing a child), contamination (becoming infected by shaking hands), and doubt (wondering whether one has performed some act, such as having hurt someone in a traffic accident).

Most people with OCD also suffer from a compulsion, a repetitive behavior performed according to certain rules or in a stereotyped fashion. The most common compulsions involve handwashing, cleaning, hoarding useless items, counting, or checking (for example, making sure dozens of times that a door is locked).

Individuals with OCD realize that their thoughts or behaviors are bizarre, but they cannot resist or control them. Eventually, the obsessions or compulsions consume a great deal of time and significantly interfere with normal routines, job functioning, or usual social activities or relationships with others. A young woman who must follow a very rigid dressing routine may always be late for class, for example; a student who must count each letter of the alphabet as he types may not be able to complete a term paper.

Treatment may consist of cognitive therapy to correct irrational assumptions, behavioral techniques such as progressively limiting the amount of time someone obsessed with cleanliness can spend washing and scrubbing, and medication. Using neuroimaging techniques, researchers have found significant changes in activity in certain regions of the brain after four weeks of daily therapy in patients with obsessive-compulsive disorder.

**Attention-deficit/hyperactivity disorder** (ADHD) is the most common mental disorder in childhood. About one in ten school-age children suffer from ADHD and show marked differences in their brain chemistry. Contrary to previous beliefs, most children do not outgrow it. For as many as two-thirds of youngsters, ADHD persists into adolescence and young adulthood. About 4 percent of college students have ADHD and another 11 percent have ADHD symptoms.

ADHD looks and feels different in adults. Hyperactivity is more subtle, an internal fidgety feeling rather than a physical restlessness. As youngsters with ADHD mature, academic difficulties become much more of a problem. Students with ADHD may find it hard to concentrate, read, make decisions, complete complex projects, and meet deadlines. The academic performance and standardized test scores of college students with ADHD are significantly lower than those of their peers.

Relationships with peers also can become more challenging. Young people with ADHD may become frustrated easily, have a short fuse, and erupt into angry outbursts. Some become more argumentative, negative, and defiant than most other teens. Sleep problems, including sleeping much more or less than normal, are common.

The likelihood of developing other emotional problems, including depression and anxiety disorders, is higher. As many as 20 percent of those diagnosed with depression, anxiety, or substance abuse also have ADHD.

The risk of substance use disorders for individuals with ADHD is twice that of the general population. According to several reports, between 15 and 25 percent of adults with substance use disorders have ADHD. In addition, individuals with ADHD start smoking at a younger age and have higher rates of smoking and drinking. (The use of stimulant medication to treat ADHD does not increase the risk of substance abuse.)
ADHD. However, if you have ADHD, check with your student health or counseling center to see if any special services are available.

Many students with ADHD benefit from strategies such as sitting in the front row to avoid distraction, recording lectures if they have difficulty listening and taking notes at the same time, being allowed extended time for tests, and taking oral rather than written exams. Some students have tried to feign ADHD to qualify for such special treatment or to obtain prescriptions for stimulants. However, a thorough examination by an experienced therapist can usually determine whether a student actually suffers from ADHD.

Autism, a complex neurodevelopmental disability that causes social and communication impairments, is a “spectrum” disorder that includes several disorders with similar features. These problems affect all racial, ethnic, and socioeconomic groups but are four times more likely to occur in boys than girls.

The CDC estimates that between about 1 in 80 and 1 in 240, with an average of 1 in 110, children in the United States have an autism spectrum disorder. Autism rates have risen steadily in recent decades, but the reasons why are not clear. There is no scientific evidence that any part of a vaccine or combination of vaccines causes autism, nor is there proof that any material used to produce the vaccine, such as thimerosal, a mercury-containing preservative, plays a role in causing autism. Although past studies linked vaccines to autism, further investigations have refuted these findings.

Symptoms, which include repetitive patterns of thoughts and behavior and inability to communicate verbally, usually start before age three and can create delays or problems in many different skills that develop from infancy to adulthood. The earlier that interventions begin, the more effective they have proved to be.
Individuals with Asperger syndrome, the mildest of the autism spectrum disorders, have autism-like problems in social interaction and communication but normal to above-average intelligence. However, they usually are very rigid and literal and may have trouble understanding nonverbal communications, such as body language. One of their most distinctive symptoms is having such an obsessive interest in a single object or topic that they ignore other objects, topics, or thoughts.

Treatments for managing autism spectrum disorders include behavioral therapy to reinforce wanted behaviors and reduce unwanted behaviors; speech–language therapy to improve ability to communicate and interact with others; physical therapy to build motor control and improve posture and balance; and school-based educational programs. There are no medications specifically for the treatment of autism, but various medicines can help manage associated symptoms.

Schizophrenia

Schizophrenia, one of the most debilitating mental disorders, profoundly impairs an individual’s sense of reality. As the National Institute of Mental Health (NIMH) puts it, schizophrenia, which is characterized by abnormalities in brain structure and chemistry, destroys “the inner unity of the mind” and weakens “the will and drive that constitute our essential character.” It affects every aspect of psychological functioning, including the ways in which people think, feel, view themselves, and relate to others.

The symptoms of schizophrenia include:

- Hallucinations.
- Delusions.
- Inability to think in a logical manner.
- Talking in rambling or incoherent ways.
- Making odd or purposeless movements or not moving at all.
- Repeating others’ words or mimicking their gestures.
- Showing few, if any, feelings; responding with inappropriate emotions.
- Lacking will or motivation to complete a task or accomplish something.
- Functioning at a much lower level than in the past, at work, in interpersonal relations, or in taking care of themselves.

Schizophrenia is one of the leading causes of disability among young adults. The mean age for schizophrenia to develop is 21.4 years for men and 26.8 years for women. Although symptoms do not occur until then, they are almost certainly the result of a failure in brain development that occurs very early in life. The underlying defect is probably present before birth. The risk increases along with the age of a father at the birth of his first child. Schizophrenia has a strong genetic basis and is not the result of upbringing, social conditions, or traumatic experiences.

For the vast majority of individuals with schizophrenia, antipsychotic drugs are the foundation of treatment. Newer agents are more effective in making most people with schizophrenia feel more comfortable and in control of themselves, helping organize chaotic thinking, and reducing or eliminating delusions or hallucinations, allowing fuller participation in normal activities.

Suicide

Suicide is not in itself a psychiatric disorder, but it is often the tragic consequence of emotional and psychological problems. Every year 30,000 Americans—among them many young people who seem to have “everything to live for”—commit suicide, and an estimated 811,000 attempt to take their own lives. There may be 4.5 million suicide “survivors” in the United States.

The suicide rate for African American and Caucasian men peaks between ages 20 and 40. It rises again after age 65 among white men and after age 75 among blacks. In general, whites are at highest risk for suicide, followed by American Indians, African Americans, Hispanic Americans, and Asian Americans. Internationally, suicide rates are highest in Germany, Scandinavia, Eastern Europe, and Japan; average in the United States, Canada, and Great Britain; and low in Italy, Spain, and Ireland.
At all ages, men commit suicide three to four times more frequently than women, but women attempt suicide much more often than men (Table 3.1). Elderly men are ten times more likely to take their own lives than elderly women. (See Chapter 20 for more on depression and suicide in older men and women.

**Suicide in the Young**

Suicide rates among youths between ages 10 and 19 in the United States have risen after a decade-long decline. In a national survey, an estimated 15 percent of high school students seriously considered suicide, and 7 percent attempted suicide at least once. Girls and black and Hispanic students were most likely to attempt suicide. Up to 50 percent of adolescents who attempt suicide try again to take their own lives. An estimated 11 percent of those who attempt suicide eventually die by suicide.

The controversy about the use of antidepressants in children and teens may play a role in the spike in youth suicide. Although several re-analyses and reviews have confirmed that these medications can themselves increase the likelihood of suicide in individuals younger than age 20, this risk is small. In many cases, the benefits may well outweigh the risk, but there is a need for careful monitoring for warning signs of suicide whenever a child or teen begins antidepressant therapy.

Native American communities have especially high rates of suicide among both young men and women. Young African American men, historically at low suicide risk, are narrowing the gap with their white peers, while suicide by Hispanic young men has declined. The lowest rates are for Asian Pacific males and African American females.

Firearms and suffocation (mainly by hanging) are the most common methods of suicide among young people. In recent years, deaths with firearms have decreased, in part because of laws restricting access to guns by youngsters.

Researchers also have identified factors that protect young people from suicide. Number one for both boys and girls was feeling connected to their parents and family. For girls, emotional well-being was also protective; grade-point average was an additional protective factor for boys.

<table>
<thead>
<tr>
<th>Table 3.1 Suicide Risk</th>
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<tr>
<td><strong>Who Attempts Suicide?</strong></td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Female</td>
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<tr>
<td>Male</td>
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Suicide on Campus

More than 1,100 college students take their own lives every year; 1.5 percent attempt to do so. In a recent survey, 12 percent of students reported suicidal thoughts; 25 percent of these had more than one episode.53 The rates of self-harm without intent to die are even higher.56

The reasons that students consider or attempt suicide vary, but the most significant is untreated depression. Two-thirds of individuals who kill themselves experienced depressive symptoms at the time of their deaths. However, rates of suicide attempts and completions are consistently lower than among college-age peers who are not in college.

Suicide rarely stems from a single cause. Researchers have identified several common ones for college students, including the following:

• Depression or depressive symptoms.
• Family history of mental illness.
• Personality traits, such as hopelessness, helplessness, impulsivity, and aggression.
• Alcohol use and binge drinking. Among college students, binge drinkers are significantly more likely to contemplate suicide, to have attempted suicide in the past, and to believe they would make a future suicide attempt than non-binge drinkers.
• Ineffective problem solving and coping skills.
• Recent sexual or physical victimization; being in an emotionally or physically abusive relationship;
• Family problems.
• Exposure to trauma or stress.
• Feelings of loneliness or social isolation.
• Harassment because of sexual orientation.

The stress of acculturation (the psychosocial adjustments that occur when an ethnic minority interacts with the ethnic majority, discussed in Chapter 4) may also play a role. Blacks who take their own lives tend to be younger, less likely to have been depressed, and less likely to have financial problems, chronic illness, or substance abuse problems. While alcohol and cocaine play a role in more than 40 percent of suicides by European American youths, they are involved in less than 18 percent of suicides of African Americans.

Although many schools offer counseling and crisis services, students often don’t know where to turn when they feel hopeless or are thinking about suicide. In a study of undergraduates, as suicidal thoughts increased, students’ help-seeking decreased. Negative feelings or stigma, both about themselves and about getting mental health care, contributed to the inability or unwillingness to reach out for professional help.57

Factors That Lead to Suicide

Researchers have looked for explanations for suicide by studying everything from phases of the moon to seasons (suicides peak in the spring and early summer) to birth order in the family. They have found no conclusive answers. However, the most important risk factors for suicide appear to be impulsivity, high levels of arousal and aggression, and past suicidal behavior.58 (See Table 3.2 on page 78.)

Mental Disorders More than 95 percent of those who commit suicide have a mental disorder. Two in particular—depression and alcoholism—account for two-thirds of all suicides. Suicide also is a risk for those with other disorders, including schizophrenia, posttraumatic stress disorder, personality disorders, and untreated depression. The lifetime suicide rate for people with major depression is 15 percent.

Substance Abuse Many of those who commit suicide drink beforehand, and their use of alcohol may lower their inhibitions. Since alcohol itself is a depressant, it can intensify the despondency suicidal individuals are already feeling. Alcoholics who attempt suicide often have other risk factors, including major depression, poor social support, serious medical illness, and unemployment. Drugs of abuse also can alter thinking and lower inhibitions against suicide.

Hopelessness The sense of utter hopelessness and helplessness may be the most common contributing factor in suicide. When hope dies, individuals view every experience in negative terms and come to expect the worst possible outcomes for their problems. Given this way of thinking, suicide often seems a reasonable response to a life seen as not worth living. Optimism, on the other hand, correlates with fewer thoughts of suicide by college students.
**Combat Stress** According to a congression- nal report, veterans who have been exposed to the violence and trauma of combat or deployment in a war zone may account for as many as 20 percent of suicides. Conditions that may increase a veteran’s risk of suicide include depression, PTSD, traumatic brain injury, and lack of social support. In response to this, the Veterans Administration has set up a Suicide Prevention Hotline number: 1-800-274-TALK.

**Family History** One of every four people who attempt suicide has a family member who also tried to commit suicide. While a family history of suicide is not in itself considered a predictor of suicide, two mental disorders that can lead to suicide—depression and bipolar disorder (manic depression)—do run in families.

**Physical Illness** People who commit suicide are likely to be ill or to believe that they are. About 5 percent actually have a serious physical disorder, such as AIDS or cancer. While suicide may seem to be a decision rationally arrived at in persons with serious or fatal illness, this may not be the case. Depression, not uncommon in such instances, can warp judgment. When the depression is treated, the person may no longer have suicidal intentions.

**Brain Chemistry** Investigators have found abnormalities in the brain chemistry of individuals who complete suicide, especially low levels of a metabolite of the neurotransmitter serotonin. There are indications that individuals with a deficiency in this substance may have as much as a ten times greater risk of committing suicide than those with higher levels.

**Access to Guns** For individuals already facing a combination of predisposing factors, access to a means of committing suicide, particularly to guns, can add to the risk. Unlike other methods of suicide, guns almost always work. Suicide rates among children, women, and men of all ages are higher in states where more households have guns. Although only 5 percent of suicide attempts involve firearms, more than 90 percent of these attempts are fatal. States with stricter gun-control laws have much lower rates of suicide than states with more lenient laws.

**Other Factors** Individuals who kill themselves have often gone through more major life crises—job changes, births, financial reversals, divorce, retirement—in the previous six months, lack of social support. In response to this, the Veterans Administration has set up a Suicide Prevention Hotline number: 1-800-274-TALK.

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**Your Strategies for Prevention**

**Steps to Prevent Suicide**

If you worry that someone you know may be contemplating suicide, express your concern. Here are some specific guidelines:

- **Ask concerned questions.** Listen attentively. Show that you take the person’s feelings seriously and truly care.
- **Don’t offer trite reassurances.** Don’t list reasons to go on living, try to analyze the person’s motives, or try to shock or challenge him or her.
- **Suggest solutions or alternatives to problems.** Make plans. Encourage positive action, such as getting away for a while to gain a better perspective on a problem.
- **Don’t be afraid to ask whether your friend has considered suicide.** The opportunity to talk about thoughts of suicide may be an enormous relief and—contrary to a long-standing myth—will not fix the idea of suicide more firmly in a person’s mind.
- **Don’t think that people who talk about killing themselves never carry out their threat.** Most individuals who commit suicide give definite indications of their intent to die.
- **Watch out for behavioral clues.** If your friend begins to behave unpredictably or suddenly emerges from a severe depression into a calm, settled state of mind, these could signal increased danger of suicide. Don’t leave your friend alone. Call a suicide hotline, or get in touch with a mental health professional.

**If you are thinking about suicide . . .**

- **Talk to a mental health professional.** If you have a therapist, call immediately. If not, call a suicide hotline.
- **Find someone you can trust and talk honestly about what you’re feeling.** If you suffer from depression or another mental disorder, educate trusted friends or relatives about your condition so they are prepared if called upon to help.
- **Write down your more uplifting thoughts.** Even if you are despondent, you can help yourself by taking the time to retrieve some more positive thoughts or memories. A simple record of your hopes for the future and the people you value in your life can remind you of why your own life is worth continuing.
- **Avoid drugs and alcohol.** Most suicides are the results of sudden, uncontrolled impulses, and drugs and alcohol can make it harder to resist these destructive urges.
- **Go to the hospital.** Hospitalization can sometimes be the best way to protect your health and safety.
Building Your Future

College students are especially likely to delay getting help for a psychological problem. The median delay for all disorders is nearly ten years. Those with social phobia and separation anxiety disorders may not get help for more than 20 years. The earlier in life that a disorder begins, the longer that individuals tend to delay treatment.

Without treatment, mental disorders take a toll on every aspect of life, including academics, relationships, careers, and risk-taking. Symptoms or episodes of a disorder typically become more frequent or severe. Individuals with one mental disorder are at high risk of having a second one (this is called comorbidity).

Getting Help for a Psychological Problem

Sometimes we all need outside help from a trained, licensed professional to work through personal problems. Here is what you need to know if you are experiencing psychological difficulties.

Consider therapy if you

• Feel an overwhelming and prolonged sense of helplessness and sadness, which does not lift despite your efforts and help from family and friends.
• Find it difficult to carry out everyday activities such as homework, and your academic performance is suffering.
• Worry excessively, expect the worst, or are constantly on edge.
• Are finding it hard to resist or are engaging in behaviors that are harmful to you or others, such as drinking too much alcohol, abusing drugs, or becoming aggressive or violent.
• Have persistent thoughts or fantasies of harming yourself or others.

Most people who have at least several sessions of psychotherapy are far better off than individuals with emotional difficulties who do not get treatment. According to the American Psychological Association, 50 percent of patients noticeably improve after eight sessions, while 75 percent of individuals in therapy improved by the end of six months.

Overcoming Problems of the Mind

About 80 percent of those with mental disorders eventually seek treatment, but many suffer for years, even decades. As discussed earlier in this chapter, college students are especially likely to delay getting help for a psychological problem.

Table 3.2 Risk Factors for Suicide

<table>
<thead>
<tr>
<th>Biopsychosocial Risk Factors</th>
<th>Environmental Risk Factors</th>
<th>Sociocultural Risk Factors</th>
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</thead>
<tbody>
<tr>
<td>Mental disorders, particularly depressive disorders, schizophrenia, and anxiety disorders</td>
<td>Job or financial loss</td>
<td>Lack of social support and sense of isolation</td>
</tr>
<tr>
<td>Alcohol and other substance use disorders</td>
<td>Relational or social loss</td>
<td>Stigma associated with help-seeking behavior</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>Easy access to lethal means</td>
<td>Barriers to accessing health care, especially mental health and substance abuse treatment</td>
</tr>
<tr>
<td>Impulsive and/or aggressive tendencies</td>
<td>Local clusters of suicide that have a contagious influence</td>
<td>Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)</td>
</tr>
<tr>
<td>History of trauma or abuse</td>
<td></td>
<td>Exposure to suicide, including through the media, and the influence of others who have died by suicide</td>
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<tr>
<td>Some major physical illness</td>
<td></td>
<td>Source: Suicide Prevention Resource Center: <a href="http://www.sprc.org/">http://www.sprc.org/</a></td>
</tr>
<tr>
<td>Previous suicide attempt</td>
<td></td>
<td></td>
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<tr>
<td>Family history of suicide</td>
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compared with others. Long-standing, intense conflict with family members or other important people may add to the danger. In some cases, suicide may be an act of revenge that offers the person a sense of control—however temporary or illusory. For example, some may feel that, by rejecting life, they are rejecting a partner or parent who abandoned or betrayed them.
Where to Turn for Help

As a student, your best contact for identifying local services may be your health education instructor or department. The health instructors can tell you about general and mental health counseling available on campus, school-based support groups, community-based programs, and special emergency services. On campus, you can also turn to the student health services or the office of the dean of student services or student affairs. (See “Help Yourself” in Labs for IPC.)

Within the community, you may be able to get help through the city or county health department and neighborhood health centers. Local hospitals often have special clinics and services; and there are usually local branches of national service organizations, such as United Way or Alcoholics Anonymous, other 12-step programs, and various support groups. You can call the psychiatric or psychological association in your city or state for the names of licensed professionals. (Check the telephone directory for listings.) Your primary physician may also be able to help.

Search the Internet for special programs, found either by the nature of the service, by the name of the neighborhood or city, or by the name of the sponsoring group. In addition to suicide-prevention programs, look for crisis intervention, violence prevention, and child-abuse prevention programs; drug-treatment information; shelters for battered women; senior citizen centers; and self-help and counseling services. Many services have special hotlines for coping with emergencies. Others provide information as well as counseling over the phone.

**Types of Therapists**

Only professionally trained individuals who have met state licensing requirements are certified as psychiatrists, psychologists, or social workers. Before selecting any of these mental health professionals, be sure to check the person’s background and credentials.

**Psychiatrists** are licensed medical doctors (M.D.) who complete medical school; a year-long internship; and a three-year residency that provides training in various forms of psychotherapy, psychopharmacology, and both outpatient and inpatient treatment of mental disorders. They can prescribe medications and make medical decisions. *Board-certified* psychiatrists have passed oral and written examinations following completion of residency training.

**Psychologists** complete a graduate program (including clinical training and internships) in human psychology but do not study medicine and cannot prescribe medication. They must be licensed in most states in order to practice independently.

**Certified social workers or licensed clinical social workers (LCSWs)** usually complete a two-year graduate program and have specialized training in helping people with mental problems in addition to conventional social work.

**Psychiatric nurses** have nursing degrees and have passed a state examination. They usually have special training and experience in mental health care, although no specialty licensing or certification is required.

**Marriage and family therapists**, licensed in some but not all states, usually have a graduate degree, often in psychology, and at least two years of supervised clinical training in dealing with relationship problems.
Other therapists include pastoral counselors, members of the clergy who offer psychological counseling; hypnotherapists, who use hypnosis for problems such as smoking and obesity; stress-management counselors, who teach relaxation methods; and alcohol and drug counselors, who help individuals with substance abuse problems. Anyone can use these terms to describe themselves professionally, and there are no licensing requirements.

Choosing a Therapist  Ask your physician or another health professional. Call your local or state psychological association. Consult your university or college department of psychology or health center. Contact your area community mental health center. Inquire at your church or synagogue.

- A good rapport with your psychotherapist is critical. Choose someone with whom you feel comfortable and at ease.
- Ask the following questions:
  - Are you licensed?
  - How long have you been practicing?
  - I have been feeling (anxious, tense, depressed, etc.), and I’m having problems (with school, relationships, eating, sleeping, etc.). What experience do you have helping people with these types of problems?
  - What are your areas of expertise—phobias? ADHD? depression?
  - What kinds of treatments do you use? Have they proved effective for dealing with my kind of problem or issue?
  - What are your fees? (Fees are usually based on a 45-minute to 50-minute session.) Do you have a sliding-scale fee policy?
  - How much therapy would you recommend?
  - What types of insurance do you accept?

As you begin therapy, establish clear goals with your therapist. Some goals require more time to reach than others. You and your therapist should decide at what point you might expect to begin to see progress.

As they begin therapy, some people may have difficulty discussing painful and troubling experiences. Feelings of relief or hope are positive signs indicating that you are starting to explore your thoughts and behaviors.

Types of Therapy

The term psychotherapy refers to any type of counseling based on the exchange of words in the context of the unique relationship that develops between a mental health professional and a person seeking help. The process of talking and listening can lead to new insight, relief from distressing psychological symptoms, changes in unhealthy or maladaptive behaviors, and more effective ways of dealing with the world. “Spirituality oriented” psychotherapy pays particular attention to the roles that religion and spiritual and religious beliefs play in an individual’s psychological life.

Landmark research has shown that psychotherapy does not just benefit the mind but actually changes the brain. In studies comparing psychotherapy and psychiatric medications as treatments for depression, both proved about equally effective. But a particular group of patients—those who had lost a parent at an early age or had experienced childhood trauma, including physical or sexual abuse—gained greater benefits with talk therapy.

The most common goal of psychotherapy is to improve quality of life. Most mental health professionals today are trained in a variety of psychotherapeutic techniques and tailor their approach to the problem, personality, and needs of each person seeking their help. Because skilled therapists may combine different techniques in the course of therapy, the lines between the various approaches often blur.

Brief or short-term psychotherapy typically focuses on a central theme, problem, or topic and may continue for several weeks to several months. The individuals most likely to benefit are those who are interested in solving immediate problems rather than changing their characters, who can think in psychological terms, and who are motivated to change.

Psychodynamic Psychotherapy  For the most part, today’s mental health professionals base their assessment of individuals on a psychodynamic understanding that takes into account the role of early experiences and unconscious influences in actively shaping behavior. (This is the dynamic in psychodynamic.) Psychodynamic treatments work toward the goal
of providing greater insight into problems and bringing about behavioral change. Therapy may be brief, consisting of 12 to 25 sessions, or may continue for several years.

**Cognitive-Behavioral Therapy (CBT)**

Cognitive-behavioral therapy (CBT) focuses on inappropriate or inaccurate thoughts or beliefs to help individuals break out of a distorted way of thinking. The techniques of cognitive therapy include identification of an individual's beliefs and attitudes, recognition of negative thought patterns, and education in alternative ways of thinking. Individuals with major depression or anxiety disorders are most likely to benefit, usually in 15 to 25 sessions. However, many of the positive messages used in cognitive therapy can help anyone improve a bad mood or negative outlook.

**Behavioral therapy** strives to substitute healthier ways of behaving for maladaptive patterns used in the past. Its premise is that distressing psychological symptoms, like all behaviors, are learned responses that can be modified or unlearned. Some therapists believe that changing behavior also changes how people think and feel. As they put it, “Change the behavior, and the feelings will follow.” Behavioral therapies work best for disorders characterized by specific, abnormal patterns of acting—such as alcohol and drug abuse, anxiety disorders, and phobias—and for individuals who want to change bad habits.

**Interpersonal Therapy (IPT)**

Interpersonal therapy (IPT), originally developed for research into the treatment of major depression, focuses on relationships in order to help individuals deal with unrecognized feelings and needs and improve their communication skills. IPT does not deal with the psychological origins of symptoms but rather concentrates on current problems of getting along with others. The supportive, empathic relationship that is used in the past. Its premise is that distressing psychological symptoms, like all behaviors, are learned responses that can be modified or unlearned. Some therapists believe that changing behavior also changes how people think and feel. As they put it, “Change the behavior, and the feelings will follow.” Behavioral therapies work best for disorders characterized by specific, abnormal patterns of acting—such as alcohol and drug abuse, anxiety disorders, and phobias—and for individuals who want to change bad habits.

**Alternative Mind-Mood Products**

According to various studies, 5 to 7 percent of college students take antidepressant medications. Direct-to-consumer advertisements for antidepressant drugs can influence students’ perceptions of what is wrong with them. In one study, college women were more likely to rate themselves as having mild-to-moderate depression as a result of reading pharmaceutical company information for popular antidepressants.

**Psychiatric Drugs**

Medications that alter brain chemistry and relieve psychiatric symptoms have brought great hope and help to millions of people. Thanks to the recent development of a new generation of more precise and effective psychiatric drugs, success rates for treating many common and disabling disorders—depression, panic disorder, schizophrenia, and others—have soared. Often used in conjunction with psychotherapy, sometimes used as the primary treatment, these medications have revolutionized mental health care.

At some point in their lives, about half of all Americans will take a psychiatric drug. The reason may be depression, anxiety, a sleep difficulty, an eating disorder, alcohol or drug dependence, impaired memory, or another disorder that disrupts the intricate chemistry of the brain.

Psychiatric drugs are now among the most widely prescribed drugs in the United States. Serotonin-boosting medications (SSRIs) have become the drugs of choice in treating depression. They also are effective in treating obsessive-compulsive disorder, panic disorder, social phobia, posttraumatic stress disorder, premenstrual dysphoric disorder, and generalized anxiety disorder. In patients who don’t respond, psychiatrists may add another drug to boost the efficacy of the treatment.

According to various studies, 5 to 7 percent of college students take antidepressant medications. Direct-to-consumer advertisements for antidepressant drugs can influence students’ perceptions of what is wrong with them. In one study, college women were more likely to rate themselves as having mild-to-moderate depression as a result of reading pharmaceutical company information for popular antidepressants.
Your Strategies for Prevention

Before Taking a Psychiatric Drug

Before taking any psychoactive drug (one that affects the brain), talk to a qualified health professional. Here are some points to raise:

- **What can this medication do for me?** What specific symptoms will it relieve? Are there other possible benefits?
- **When will I notice a difference?** How long does it take for the medicine to have an effect?
- **Are there any risks?** What about side effects? Do I have to take it before or after eating? Will it affect my ability to study, work, drive, or operate machinery?
- **Is there a risk of suicide or increased aggression?** What should I do if I start thinking about taking my own life or of harming others?

Taking Care of Your Mental Health

Like physical health, psychological well-being is not a fixed state of being, but a process. The way you live every day affects how you feel about yourself and your world. Here are some basic guidelines that you can rely on to make the most of the process of living. Check those that you commit to making part of your mental and psychological self-care:

- **Accept yourself.** As a human being, you are, by definition, imperfect. Come to terms with the fact that you are a worthwhile person despite your mistakes.
- **Respect yourself.** Recognize your abilities and talents. Acknowledge your competence and achievements, and take pride in them.
- **Trust yourself.** Learn to listen to the voice within you, and let your intuition be your guide.
- **Love yourself.** Be happy to spend time by yourself. Learn to appreciate your own company and to be glad you’re you.
- **Stretch yourself.** Be willing to change and grow, to try something new and dare to be vulnerable.

Products, such as herbs and enzymes, claim to have psychological effects. However, they have not undergone rigorous scientific testing.

St. John’s wort has been used to treat anxiety and depression in Europe for many years. Data from clinical studies in the United States do not support the efficacy of St. John’s wort for moderate to severe depression. In ten carefully controlled studies, the herb did not prove more effective than a placebo. However, more than two dozen studies have found that St. John’s wort was similar in efficacy to standard antidepressants. Side effects include dizziness, abdominal pain and bloating, constipation, nausea, fatigue, and dry mouth. St. John’s wort should not be taken in combination with other prescription antidepressants. St. John’s wort can lower the efficacy of oral contraceptives and increase the risk of an unwanted pregnancy.

**Look at challenges as opportunities for personal growth.** “Every problem brings the possibility of a widening of consciousness,” psychologist Carl Jung once noted. Put his words to the test.

**When your internal critic—the negative inner voice we all have—starts putting you down, force yourself to think of a situation that you handled well.**

**Set a limit on self-pity.** Tell yourself, “I’m going to feel sorry for myself this morning, but this afternoon, I’ve got to get on with my life.”

**Think of not only where but also who you want to be a decade from now.** The goals you set, the decisions you make, the values you adopt now will determine how you feel about yourself and your life in the future.
Recognizing Depression

Depression comes in different forms, just like other illnesses such as heart disease. Not everyone with a depressive disorder experiences every symptom. The number and severity of symptoms may vary among individuals and also over time.

Read through the following list, and check all the descriptions that apply.

☐ I am often restless and irritable.
☐ I am having irregular sleep patterns—either too much or not enough.
☐ I don’t enjoy hobbies, my friends, family, or leisure activities any more.
☐ I am having trouble managing my diabetes, hypertension, or other chronic illness.
☐ I have nagging aches and pains that do not get better no matter what I do.
☐ Specifically, I often experience:
  ☐ Digestive problems
  ☐ Headache or backache
  ☐ Vague aches and pains like joint or muscle pains
  ☐ Chest pains
  ☐ Dizziness
☐ I have trouble concentrating or making simple decisions.
☐ Others have commented on my mood or attitude lately.
☐ My weight has changed a considerable amount.
☐ I have had several of the symptoms I checked above for more than two weeks.

☐ I feel that my functioning in my everyday life (work, family, friends) is suffering because of these problems.
☐ I have a family history of depression.
☐ I have thought about suicide.*

Checking several items on this list does not mean that you have a depressive disorder because many conditions can cause similar symptoms. However, you should take this list with you to discuss with your health-care provider or mental health therapist. Even though it can be difficult to talk about certain things, your health-care provider is knowledgeable, trained, and committed to helping you.

If you can’t think of what to say, try these conversation starters:

  “I just don’t feel like myself lately.”
  “My friend (parent, roommate, spouse) thinks I might be depressed.”
  “I haven’t been sleeping well lately.”
  “Everything seems harder than before.”
  “Nothing’s fun anymore.”

If you are diagnosed with depression, remember that it is a common and highly treatable illness with medical causes. Your habits or personality did not cause your depression, and you do not have to face it alone.

*University of Michigan Depression Center, 800-475-MICH, www.med.umich.edu/depression
Your physical well-being and psychological health are so intimately related that to a significant degree they are expressions of each other. Yes, grave diseases can occur despite a healthy mental outlook, and physically healthy people can experience psychological difficulties. But overwhelming evidence demonstrates that physical health affects mood and thoughts, and mood and thoughts affect physical health.

“Your Psychological Self-Care Pyramid” from Labs for IPC deals with optimizing your psychological health to benefit body, mind, and spirit. It will teach you how to infuse your life with mentally rewarding and stimulating activities that not only provide balance, prevent the blahs, and add zest but also, if continued, form a lifelong foundation for optimal mental health. Here’s a preview.

Get Real
In this stage you rate yourself from 0 to 10, with 0 being the low end and 10 the high end, on the degree to which you now include or exhibit in your weekly life the 13 elements of Your Psychological Self-Care Pyramid shown in Labs for IPC. Here are three examples:

- **Self-knowledge and self-control.**
  You make your inner world of feelings and thoughts and your relationship to the outer world a source of ongoing contemplation. You seek self-understanding and systematically develop your ability to consider and weigh actions before taking them.

- **Community.**
  You have a circle of trusted friends and participate in a larger social milieu. You look out for and assist the interests of the community as a whole, not merely those of your circle of immediate friends.

- **Generosity.**
  You are giving of your time and your self both toward others and toward yourself. You give materially when this is advisable but more than that when asked you give that which is most precious—that is, who you are.

You will then examine your self-ratings. Are some unacceptably lower than you would like them to be? Completing this lab will address this concern for the short run and, if you continue the activities, for the future.

Get Ready
In this stage you examine your schedule and create pockets of time for the activities that serve as building blocks of Your Psychological Self-Care Pyramid and for journaling about your experiences doing so.

Get Going
In this stage you begin the exercises related to each of the areas you want to bolster by engaging in related activities for at least five minutes four times per week. Immediately after completing the exercise or at some other point the same day, you will make an entry of at least five lines in your IPC Journal and reflect on your experiences . . .

Lock It In
Just as you can use the USDA Food Pyramid to guide your eating choices every day, pay attention to Your Psychological Self-Care Pyramid. Here is one of the steps that can ensure that you are providing adequate daily nourishment for your mind and spirit.

- **Rate yourself.** Every four weeks rate yourself between 0 and 10, with 0 being the low end and 10 the high end, on each element of Your Psychological Self-Care Pyramid. Record your scores.
Review Questions

1. Depression
   a. is not likely to occur in young adults.
   b. is twice as common in men as women.
   c. has the same symptoms in men and women.
   d. is more likely to occur again in those who suffer a first episode.

2. Which statement about depression treatment is true?
   a. Psychotherapy and drug therapy are effective in treating depression, but only about 50 percent of people seek treatment.
   b. Antidepressants help about 90 percent of individuals feel better within four weeks.
   c. Jogging has only a small benefit for most depressed individuals.
   d. With the right therapy, depression will not reoccur.

3. Neurons
   a. transmit information within the brain and throughout the body by means of electrical impulses and chemical messengers.
   b. are specialized support cells that travel through the spinal cord, carrying signals related to movement.
   c. are protein molecules designed to bind with neurotransmitters.
   d. cross a synapse before reuptake.

4. Students with attention-deficit/hyperactivity disorder
   a. perform as well on standardized tests as students without ADHD.
   b. have an increased risk of substance use disorders.
   c. have a decreased risk of developing depression or anxiety disorders.
   d. constitute 10 percent of the student population.

5. Some characteristic symptoms of major depression are
   a. difficulty concentrating, lack of energy, and eating more than usual.
   b. exaggerated sense of euphoria and energy.
   c. palpitations, sweating, numbness, and tingling sensations.
   d. talking in rambling ways, inability to think in a logical manner, and delusions.

6. Which of the following statements is true?
   a. Individuals with phobias are most likely to benefit from psychiatric medications.
   b. Antidepressant medications now require a warning label about the increased risk of suicidal thoughts.
   c. Only children have attention disorders.
   d. Interpersonal therapy focuses on the role of early experiences and unconscious influences in shaping patterns of behavior, such as repeated failed relationships.

7. Which of the following statements about anxiety disorders is true?
   a. Anxiety disorders are the least prevalent type of mental illness.
   b. An individual suffering from a panic attack may mistake her symptoms for a heart attack.
   c. The primary symptom of obsessive-compulsive disorder is irrational, intense, and persistent fear of a specific object or situation.
   d. Generalized anxiety disorders respond to systematic desensitization behavior therapy.

8. A mental disorder can be described as
   a. a condition associated with migraine headaches and narcolepsy.
   b. a condition that is usually caused by severe trauma to the brain.
   c. a behavioral or psychological disorder that impairs an individual’s ability to conduct one or more important activities of daily life.
   d. a psychological disorder that is easily controlled with medication and a change in diet.

9. A person may be at higher risk of committing suicide if
   a. he is taking blood pressure medication.
   b. he lives in a rural environment and is married.
   c. he has been diagnosed with hyperactivity disorder.
   d. he has lost his job because of alcoholism.

10. Which of these therapies focuses on recognizing negative thought patterns and changing those patterns?
    a. psychodynamic psychotherapy
    b. behavioral activation
    c. interpersonal therapy
    d. cognitive therapy

Answers to these questions can be found on page 672.
Critical Thinking

1. Jake, who took antidepressants to recover from depression in high school, began feeling the same troubling symptoms. A physician at the student health center prescribed the same medication that had helped him in the past, but this time Jake noticed the warning about an increased risk of suicide. He has had thoughts of killing himself, and he worries whether or not to start the medication. When he did some online research, he learned that the risk of suicide is greater if depression is untreated than it is with medication. How would you counsel Jake? How would you weigh the risks and benefits of taking an antidepressant? Do you know someone who might benefit from taking antidepressants but is afraid to take them because of the possible risk of suicide? What might you say to this person based on what you have read in this chapter?

2. Research has indicated that many homeless men and women are in need of outpatient psychiatric care, often because they suffer from chronic mental illnesses or alcoholism. Yet government funding for the mentally ill is inadequate, and homelessness itself can make it difficult, if not impossible, for people to gain access to the care they need. How do you feel when you pass homeless individuals who seem disoriented or out of touch with reality? Who should take responsibility for their welfare? Should they be forced to undergo treatment at psychiatric institutions?

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- Allow you to prepare for exams with interactive quizzing.
- Use the CengageNOW product to develop a Personalized Learning Plan targeting resources that address areas you should study.

Internet Connections

**www.save.org**
This site (formerly American Foundation for Suicide Prevention) offers research, facts, survivor support, and more.

**www.nimh.nih.gov**
The National Institute of Mental Health is a federally sponsored organization that provides useful information on a variety of mental health topics including current mental health research.

**www.apa.org**
The APA is the scientific and professional organization for psychology in the United States. Its website provides up-to-date information on psychological issues and disorders.

**www.nmha.org**
This site features fact sheets on a variety of mental health topics, including depression screening, college initiative, substance abuse prevention, and information for families. Also available are current mental health articles, an e-mail newsletter, and a bookstore.

**www.afsp.org**
This site provides facts and statistics about suicide and depression, as well as information about current research and educational projects. It also provides support information for survivors.

**www.activeminds.org**
This site provides fact sheets on mental illness and information about starting an Active Minds chapter and planning events at your campus to create awareness about mental health.
Key Terms

The terms listed are used on the page indicated. Definitions of the terms are in the Glossary at the end of the book.

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