C. *Programs and Processes*

Advocates for Youth: **Programs at a Glance**

- **Effective HIV/STD and Teen Pregnancy Prevention Programs**

U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, (SAMHSA) Center for Mental Health Services

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Programs at a Glance

Effective HIV/STD and Teen Pregnancy Prevention Programs for Young Women of Color

In the U.S., rates of HIV, sexually transmitted disease (STD), and unintended pregnancy are disproportionately high among youth of color, particularly young African American and Latina women, when compared to other youth.

- Approximately half of all new HIV infections in the United States occur among young people under age 25, and most of these infections are transmitted sexually.[1]
- Although African Americans and Latinos together account for less than 30 percent of the U.S. population ages 20 to 24, 63 percent of cumulative AIDS cases occurred among these youth through June 1999.[2,3]
- Seventy-seven percent of women diagnosed with AIDS have been African American and Latina.[2]
- Among U.S. teens, the highest syphilis rates have occurred among African Americans.[4]
- Between 1990 and 1996, the overall teen pregnancy, birth, and abortion rates declined significantly. However, young Latinas experienced a six percent pregnancy rate decline compared to 20 percent among African American and 16 percent among non-Hispanic white teens.[1,5]
- Birth rates for African American and Latina teens remain considerably higher than those for non-Hispanic whites, Asians and Pacific islanders, and Native Americans.[6]
- In a nationally representative survey of high school students, young African American women were significantly more likely than either Latinas or young white women to have had sexual intercourse (65.5, 45.7, and 44.0 percent, respectively) and to have had four or more sexual partners (25.4, 10.2, and 12.1 percent, respectively).[7]

In the United States – where one-third of teens are adolescents of color and where their proportion of the total teen population is expected to increase[8] – program planners must recognize the disproportionate rates of HIV, STDs, and unintended pregnancy among these youth and plan culturally appropriate interventions to meet their needs.

Despite demographic shifts and current health indicators, few HIV/STD and teen pregnancy prevention programs meet the needs of youth of color, especially young women. Historically, HIV/AIDS prevention programs have targeted adult populations at high risk, such as white gay men. HIV/AIDS prevention programs have seldom focused on the risk-taking behaviors and holistic needs of young people at high risk. Youth-focused HIV/AIDS prevention programs often emphasize disease prevention rather than sexual health promotion. When prevention programs mimic those designed for adults or focus on disease, youth of color may not receive needed life skills and resources to support healthy sexual attitudes and behaviors.

Pregnancy prevention programs have successfully made unintended pregnancy a priority issue for many youth of color and contributed to the significant decline in teen pregnancy among African American young women.[1] These programs, however, often focus solely on preventing pregnancy rather than health promotion and promote contraceptive methods that effectively prevent pregnancy but do not protect against HIV and other STDs. Consequently, participants may lack skills and knowledge to prevent STDs, including HIV.

Tailoring Programs

Values, attitudes, beliefs, knowledge, and communication patterns about health, sexuality, relationships, contraception, and childbearing vary significantly across cultural and ethnic groups. To encourage self-protective behaviors among young people, interventions must match the culture of the audience targeted. Research shows that interventions effective in altering attitudes *and* behavior among particular populations of adolescents are nearly always gender specific and culturally appropriate.[9,10,11]

Culturally appropriate programs acknowledge cultural practices and attitudes, address cultural taboos, meet needs arising out of a specific cultural milieu, and have staff who represents and understands the target culture. In addition, such programs encourage participants' pride and self-identification with their racial/ethnic group.

Gender specific strategies explore and address the separate social influences that affect females or males, such as divergent societal expectations and differing messages about body image, sexuality, and sexual responsibility. These strategies may be particularly important in empowering young women to make critical sexual decisions and in helping them strengthen their relationships. Having skills in communication, negotiation, and refusal skills can empower teenage women to protect their sexual health.[9,12,13]

No single strategy works for all youth. However, program planners can benefit from the experience of effective programs. Programs are most likely to be effective when they –

- Incorporate comprehensive sexuality education, including information on *both* contraception and abstinence[14,15]
- Provide access to contraceptive services and methods[16,17,18,19,20]
- Offer opportunities – such as mentoring, community service, and job training – that develop life skills so young people can prepare for their futures.[21]

Furthermore, HIV/STD and teen pregnancy prevention programs targeting youth of color are most likely to be effective when they

- Are in the native language of the target population[21]
- Involve community members and youth in planning and implementation[22]
- Focus on the assets of teenage participants[23]
- Address the needs of the whole young person[24]
- Consider the social and cultural factors that influence behavior[18]
- Provide peer support to change peer norms[23]
- Are culturally appropriate[25]
- Offer gender-specific opportunities and activities[13]
- Aim at building skills[11,26,27]
- Use multiple pathways to reach and empower youth in the community.[12,13]

To assist providers in designing comprehensive, effective teen pregnancy *and* HIV/STD prevention programs for youth of color, this paper highlights evaluated programs that successfully reduce sexual risk-taking among youth of color and promote their sexual health. Each program uses some or all of the strategies listed above.

Educational Programs

Educational programs impart knowledge and explore attitudes about human development, relationships, personal skills, sexual health and behavior, sexuality, and culture. While pregnancy prevention programs usually offer education about HIV and other STDs, some of the following programs focus exclusively on preventing STDs.

AIDS Prevention and Health Promotion among Women helps young women make responsible, healthy decisions about their sexual behavior. Culturally sensitive strategies include group social support, empowerment, and exercises to build skills. The program educates participants about the association of alcohol and other drug use with the risk of HIV infection. Evaluation shows that young African American and Latina women significantly increased their knowledge of HIV/AIDS prevention and improved their use of safer sex practices, including using condoms.[11]

Be Proud! Be Responsible! An AIDS Risk Reduction Program targets African American students in junior and senior high schools. The program seeks to improve knowledge of HIV/STDs, increase self-esteem, and support safer sexual behaviors among participants. Sessions include oral and written exercises as well as games and role plays to build and practice skills. In evaluation, participants reported less sexual risk-taking behavior, demonstrated increased HIV/STD knowledge, and expressed less favorable attitudes toward sexual risk behaviors compared to the control group. At follow-up, participants reported fewer acts of vaginal sexual intercourse, fewer sexual partners, greater use of condoms, and less heterosexual anal intercourse compared to controls.[27]

Youth AIDS Prevention Project (YAPP) is designed to prevent HIV/STD and substance abuse among junior high school students. Developed initially for use among African Americans, the program provides both classroom educational sessions and opportunities to build skills. Evaluation indicates that participants who initiated sexual intercourse during the study were more likely than the control group to use condoms with foam. Participants demonstrated increased HIV/AIDS knowledge and reported a greater sense of comfort in discussing sexuality and drug use with their parents. Sexually active participants reported a lower frequency of sexual intercourse compared to controls.[26]

The Fenix Project provides educational services and outreach through teams of trained peer educators whose skill and supportive networks promote healthy attitudes and behaviors and reduce risks among their peers. Designed to provide accurate information, this HIV/STD and teen pregnancy prevention initiative also increases teens' awareness of each individual's sexual responsibility and options. Strategies include a telephone help-line, street theater, presentations, and street outreach. The Project reaches disenfranchised youth, including out-of-school and homeless youth. Pre/post test evaluation showed participants to have increased both their safer sex behaviors and their knowledge of HIV/AIDS.[22]

Girl Talk is gender-specific, age adapted, and culturally appropriate for teenage Latina and African American women. The program reflects attitudes, traits, and experiences of teens that actively participated in its planning and review. *Girl Talk* focuses on the strengths of participants and uses peers and adults as group facilitators, mentors, and role models. Diverse educational techniques help to strengthen self-efficacy and peer relationships as well as to enhance self-protective behaviors. The program incorporates community-wide partners including health care agencies, businesses, and schools. Findings indicate that participants increased both their knowledge and self-efficacy.[23]

Girls Incorporated Preventing Adolescent Pregnancy[7] is a multifaceted program in four age-appropriate divisions. It provides information and fosters skills in communication, assertiveness and refusal, contraception and STD prevention, and academic and career planning. Evaluation indicates that participants active in completing the program were 50 percent less likely to become pregnant compared to non-participants or those less involved. Younger teens completing the program were twice as likely as non-participants to postpone sexual intercourse.[13]

Contraceptive Access Programs

Contraceptive counseling and teen-focused services and follow-up care are critical elements of effective contraceptive access programs.

School/Community Program for Sexual Risk Reduction among Teens was a school- and community-based pregnancy prevention program providing access to contraception as well as abstinence-based sexuality education. The program educated and trained teachers, parents, and civic and religious leaders in sexuality education and issues of adolescent decision making, self-esteem, and communication. A community-wide public education media campaign raised awareness about the importance of sexually active teens using contraception.[18] Evaluation showed a significant decrease in the annual teen pregnancy rate among female participants. Pregnancy rates dropped from 77 per 1,000 in 1981 and 1982 to 37 per 1,000 during 1984 to 1986 when the program was in full operation. In 1987, dispensing contraceptives on school grounds was prohibited, and the pregnancy rate increased significantly.[18]

The Self Center in Baltimore, MD, provided education, counseling, and reproductive health services to African American students in grades seven to 12. Working together in this school-linked program, a social worker and a nurse practitioner conducted educational sessions, informal discussions, and individual counseling in the schools. In the nearby clinic, students received reproductive health care services, including contraception as well as referral to other health services. Evaluation showed that the Self Center improved participants' knowledge of health risks and behaviors, significantly delayed the initiation of sexual activity among 14- and 15-year-old participants, and increased contraceptive use at most recent sexual intercourse among sexually active females by 22 percent.[19,20]

Multifaceted Programs

Because these programs offer a wide range of services, they may be especially important for disadvantaged youth at increased risk of early childbearing or of infection with HIV or STDs. These programs are most effective when they provide academic assistance, career counseling, vocational training, and/or service learning opportunities along with sexual health education and services.

Children's Aid Society Teen Pregnancy Prevention Program, currently being replicated and evaluated at 10 sites in New York City and at 48 sites in 20 states around the nation, uses case management to ensure long-term, individualized care and to connect youth to other needed services. The holistic, multidimensional components include primary health care, self-esteem enhancement, financial planning, skills training in individual sports, academic assessment and assistance, family life education, and a job club. Evaluation at replication sites showed program participants were less likely to be sexually active, less likely to be involved in pregnancy, more likely to use condoms at most recent sexual intercourse, and less likely to drop out of school compared to non-participants.[24]

Teen Outreach Program, TOP, is a youth development program combining life skills and sexuality education – using the classroom-based curriculum, *Changing Scenes* – with involvement in community service. The recently released *TOP en Espanol* (*TOP-E*) is a Spanish translation of TOP as well as a culturally specific adaptation of *CAMBIOS*. *TOP-E* enables Spanish-speaking youth to learn about and discuss sexuality and other intimate subjects in their primary language. By encouraging Latino youth to focus on their own assets within the context of their culture and ethnicity, the program assists Latino youth to generate a more positive self-identity. A five-year impact evaluation showed TOP program participants generally to have been involved in fewer pregnancies, experienced fewer course failures, and had fewer school suspensions compared to non-participants.[21]

I Have A Future, a community-based program in Nashville, TN, asked community residents to identify their community's problems and to develop a plan of action to address the problems. Residents identified teen pregnancy, alcohol and drug abuse, crime, and youth unemployment as critical issues. Age-appropriate, individual, and group interventions were developed to meet the community's objectives. The program included social learning activities based on the *Nguzo Saba* Principles (Seven Principles of Blackness). Gender-specific activities, such as CHARM Class for Females (*Choosing How to Adorn and Refine Myself*) and MATURE (Males Adorning, Thinking, and Using Refined Energies) promoted self-esteem and physical and emotional well-being. Evaluation found a statistically significant difference between active and low-level participants or non-participants. Active youth were involved in no pregnancies compared to 59 pregnancies in the other two groups. In addition, active males reported lower levels of involvement in delinquent acts than did the other males.[25]

Conclusion

These programs are effective models of prevention and employ sound, research-based strategies to reach youth of color in need of education, services, and opportunities to build hopeful futures. As the population in the United States continues to become more diverse, these effective and innovative programs can serve as prototypes for health promotion among *all* adolescents.

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Drug and Alcohol Services Information System

The DASIS Report

March 7, 2003

Facilities Providing Substance Abuse Treatment in Languages Other than English

In Brief

- Facilities providing treatment in languages other than English tended to be larger than English-only facilities
- The States that reported the highest percentages of facilities providing treatment in languages other than English were in the West, Northeast, and South
- Facilities providing treatment in languages other than English also reported providing programs or groups for special populations more frequently than English-only facilities

In 2000, 18 percent of persons 5 years or older in the United States (roughly 47 million) spoke a language other than English at home: 11 percent spoke Spanish and 7 percent spoke another language.[1] This report looks at substance abuse treatment facilities providing treatment in languages other than English, as reported to the National Survey of Substance Abuse Treatment Services (N-SSATS).

N-SSATS is an annual survey of all facilities in the United States, both public and private, that provide substance abuse treatment. Four groups of facilities were compared: 1) facilities providing services only in English (English-only facilities); 2) facilities providing treatment in English and Spanish (Spanish facilities); 3) facilities providing treatment in English, Spanish, and at least one other language (multilingual facilities); and 4) facilities providing treatment in English and at least one language other than Spanish (other language facilities).

Table 1. Facilities Providing Treatment in English and Other Languages, by Services Provided: 2000

	English Only	Spanish	Multi-lingual	Other Language
No. of Facilities*	9,410	3,208	373	414
Services Provided	*Percent*			
Comprehensive Mental Health Assessment	44	40	55	58
Individual Therapy	94	96	96	96
Group Therapy	88	91	92	87
Employment Counseling	33	42	42	35
Services Addressing Domestic Violence	50	67	74	48

Table 2. Facilities Providing Treatment in English and Other Languages, by Programs or Groups for Special Populations: 2000

	English Only	Spanish	Multi-lingual	Other Language
No. of Facilities*	9,410	3,208	373	414
Special Populations	*Percent*			
Adolescents	35	39	49	48
Clients with Co-Occurring Disorders	48	51	66	67
Persons with HIV/AIDS	18	31	22	42
Gays and Lesbians	13	19	16	32
Seniors	16	21	29	30
Pregnant Women	17	28	22	33

*Number of facilities for which language was reported.
Source: 2000 SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS).

Facilities

Of the 13,428 facilities reporting to N-SSATS 2000, 70 percent were English-only facilities, 24 percent were Spanish facilities, 3 percent were multilingual facilities, and 3 percent were other language facilities. Facilities providing treatment in languages other than English tended to be larger than English-only facilities. On a typical day,[2] there were 27 clients in each English-only facility, 48 in each Spanish facility, 37 in each multilingual facility, and 55 in each other language facility.

States

The States that reported the highest percentages of facilities providing treatment in languages other than English were in the West, Northeast, and South (Figure 1). The highest percentages were reported by New Mexico (61 percent), Texas (48 percent), California (48 percent), Utah (46 percent), Arizona (45 percent), Massachusetts (44 percent), Oregon (43 percent), New York (41 percent), Connecticut (40 percent), and Florida (38 percent).

Type of Care

Hospital inpatient facilities comprised the largest proportion of facilities offering treatment in languages other than English (33 percent). Thirty-one percent of outpatient facilities and 16 percent of non-hospital residential facilities offered treatment services in a language other than English. Among facilities offering more than one type of care, approximately 28 percent offered services in a language other than English. In each case, the predominant foreign language was Spanish: approximately 23 percent of the facilities providing each type of care were Spanish facilities. Multilingual and other language facilities were small proportions of the facilities providing each type of care.

Services Provided

For the most part, facilities providing treatment in languages other than English provided such services as mental health assessment, individual therapy, and group therapy as frequently as or more frequently than English-only facilities (Table 1).

Programs and Groups for Special Populations

Facilities providing treatment in languages other than English also reported providing programs or groups for adolescents, clients with co-occurring disorders (i.e., clients with a psychiatric problem in addition to a substance abuse problem), persons with HIV/AIDS, gays and lesbians, seniors, and pregnant or postpartum women more frequently than English-only facilities (Table 2).

Methadone/LAAM Treatment

Of all facilities providing methadone/LAAM treatment, about half (49 percent) provided treatment in other languages: 39 percent were Spanish, 3 percent were multilingual, and 7 percent were other language facilities. Among non-methadone facilities, only 28 percent offered treatment in a language other than English.

Type of Payment Accepted

In most cases, multilingual and other language facilities were slightly more likely to accept each type of payment than English-only or Spanish facilities (Figure 2). Multilingual facilities were slightly less likely than other types of facilities to accept cash or self payment.

Figure 1. Percent of Facilities Providing Substance Abuse Treatment in Languages Other than English, by State: 2000

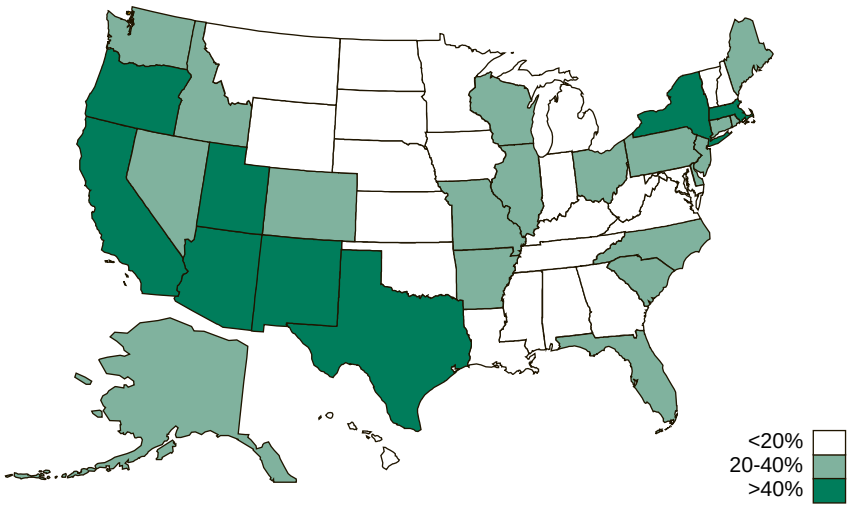
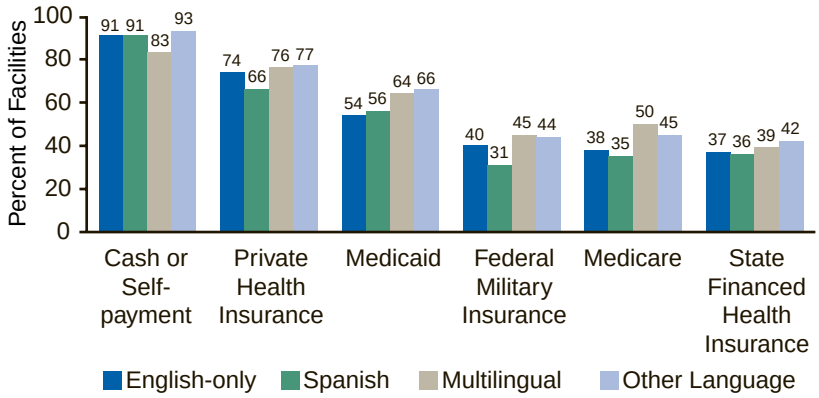


Figure 2. Payment Type Accepted, by Facilities Providing Treatment in English and Other Languages: 2000



End Notes

[1] Department of Commerce, Bureau of the Census. (2000). *Census 2000 Summary File 3 (SF 3) - Sample Data* [Data file]. Available from the U.S. Census Bureau Web site, http://factfinder.census.gov

[2] Based on the survey reference date, October 1, 2000.

The Drug and Alcohol Services Information System (DASIS) is an integrated data system maintained by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA). One component of DASIS is the National Survey of Substance Abuse Treatment Services (N-SSATS), an annual survey of all facilities in the United States, both public and private, that provide substance abuse treatment. N-SSATS was formerly known as the Uniform Facility Data Set (UFDS).

The DASIS Report is prepared by the Office of Applied Studies, SAMHSA; Synectics for Management Decisions, Inc., Arlington, Virginia; and RTI, Research Triangle Park, North Carolina.

Information and data for this report are based on data reported to N-SSATS for the survey reference date October 1, 2000.

Access the latest N-SSATS/UFDS reports at: http://www.samhsa.gov/oas/dasis.htm
Access the latest N-SSATS/UFDS public use files at: http://www.samhsa.gov/oas/SAMHDA.htm
Other substance abuse reports are available at: http://www.DrugAbuseStatistics.samhsa.gov

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How Therapy Helps
GET THE FACTS

Anxiety Disorders: The Role of Psychotherapy in Effective Treatment

Everyone feels anxious and under stress from time to time. Situations such as meeting tight deadlines, important social obligations or driving in heavy traffic, often bring about anxious feelings. Such mild anxiety may help make you alert and focused on facing threatening or challenging circumstances. On the other hand, anxiety disorders cause severe distress over a period of time and disrupt the lives of individuals suffering from them. The frequency and intensity of anxiety involved in these disorders is often debilitating. But fortunately, with proper and effective treatment, people suffering from anxiety disorders can lead normal lives.

What are the major kinds of anxiety disorders?

There are several major types of anxiety disorders, each with its own characteristics.

- People with generalized anxiety disorder have recurring fears or worries, such as about health or finances, and they often have a persistent sense that something bad is just about to happen. The reason for the intense feelings of anxiety may be difficult to identify. But the fears and worries are very real and often keep individuals from concentrating on daily tasks.
- Panic disorder involves sudden, intense and unprovoked feelings of terror and dread. People who suffer from this disorder generally develop strong fears about when and where their next panic attack will occur, and they often restrict their activities as a result.
- A related disorder involves phobias, or intense fears, about certain objects or situations. Specific phobias may involve things such as encountering certain animals or flying in airplanes, whereas social phobias involve fear of social settings or public places.
- Obsessive-compulsive disorder is characterized by persistent, uncontrollable and unwanted feelings or thoughts (obsessions) and routines or rituals in which individuals engage to try to prevent or rid themselves of these thoughts (compulsions). Examples of common compulsions include washing hands or cleaning house excessively for fear of germs, or checking over something repeatedly for errors.
- Someone who suffers severe physical or emotional trauma such as from a natural disaster or serious accident or crime may experience post-traumatic stress disorder. Thoughts, feelings and behavior patterns become seriously affected by reminders of the event, sometimes months or even years after the traumatic experience. Symptoms such as shortness of breath, racing heartbeat, trembling and dizziness often accompany certain anxiety disorders such as panic and generalized anxiety disorders. Although they may begin at any time, anxiety disorders often

surface in adolescence or early adulthood. There is some evidence of a genetic or family predisposition to certain anxiety disorders.

Why is it important to seek treatment for these disorders?

If left untreated, anxiety disorders can have severe consequences. For example, some people who suffer from recurring panic attacks avoid at all costs putting themselves in a situation that they fear may trigger an attack. Such avoidance behavior may create problems by conflicting with job requirements, family obligations or other basic activities of daily living.
Many people who suffer from an untreated anxiety disorder are prone to other psychological disorders, such as depression, and they have a greater tendency to abuse alcohol and other drugs. Their relationships with family members, friends and coworkers may become very strained. And their job performance may falter.

Are there effective treatments available for anxiety disorders?

Absolutely. Most cases of anxiety disorder can be treated successfully by appropriately trained health and mental health care professionals.

According to the National Institute of Mental Health, research has demonstrated that both 'behavioral therapy' and 'cognitive therapy' can be highly effective in treating anxiety disorders. Behavioral therapy involves using techniques to reduce or stop the undesired behavior associated with these disorders. For example, one approach involves training patients in relaxation and deep breathing techniques to counteract the agitation and hyperventilation (rapid, shallow breathing) that accompany certain anxiety disorders.

Through cognitive therapy, patients learn to understand how their thoughts contribute to the symptoms of anxiety disorders, and how to change those thought patterns to reduce the likelihood of occurrence and the intensity of reaction. The patient's increased cognitive awareness is often combined with behavioral techniques to help the individual gradually confront and tolerate fearful situations in a controlled, safe environment.

Proper and effective medications may have a role in treatment along with psychotherapy. In cases where medications are used, the patient's care may be managed collaboratively by a therapist and physician. It is important for patients to realize that there are side effects to any drugs, which must be monitored closely by the prescribing physician.

How can a qualified therapist help someone suffering from an anxiety disorder?

Licensed psychologists are highly qualified to diagnose and treat anxiety disorders. Individuals suffering from these disorders should seek a provider who is competent in cognitive and behavioral therapies. Experienced mental health professionals have the added benefit of having helped other patients recover from anxiety disorders.

Family psychotherapy and group psychotherapy (typically involving individuals who are not related to one another) offer helpful approaches to treatment for some patients with anxiety disorders. In addition, mental health clinics or other specialized treatment programs dealing with specific disorders such as panic or phobias may also be available nearby.

How long does psychological treatment take?

It is very important to understand that treatments for anxiety disorders do not work instantly. The patient should be comfortable from the outset with the general treatment being proposed and with the therapist with whom he or she is working. The patient's cooperation is crucial, and there must be a strong sense that the patient and therapist are collaborating as a team to remedy the anxiety disorder.

No one plan works well for all patients. Treatment needs to be tailored to the needs of the patient and to the type of disorder, or disorders, from which the individual suffers. A therapist and patient should work together to assess whether a treatment plan seems to be on track. Adjustments to the plan sometimes are necessary, since patients respond differently to treatment.

Many patients will begin to improve noticeably within eight to ten sessions, especially those who carefully follow the outlined treatment plan.

There is no question that the various kinds of anxiety disorders can severely impair a person's functioning in work, family and social environments. But the prospects for long-term recovery for most individuals who seek appropriate professional help are very good. Those who suffer from anxiety disorders can work with a qualified and experienced therapist such as a licensed psychologist to help them regain control of their feelings and thoughts -- and their lives.

October 1998

How Therapy Helps

GET THE FACTS

Depression

According to the National Institute of Mental Health, an estimated 17 million adult Americans suffer from depression during any one-year period. Many do not even recognize that they have a condition that can be treated very effectively. This question-and-answer fact sheet discusses depression with a focus on the ways in which psychotherapy can help a depressed person recover.

How does depression differ from occasional sadness?

Everyone feels sad or 'blue' on occasion. Most people grieve over upsetting life experiences such as a major illness, loss of job, a death in the family or divorce. These feelings of grief tend to become less intense on their own as time goes on.

Depression occurs when feelings of extreme sadness or despair last for at least two weeks or longer and when they interfere with activities of daily living -- such as working, or even eating and sleeping. Depressed individuals tend to feel helpless and hopeless and to blame themselves for having these feelings. Some may have thoughts of death or suicide.

People who are depressed may become overwhelmed and exhausted and stop participating in certain everyday activities altogether. They may withdraw from family and friends.

What causes depression?

Changes in the body's chemistry influence mood and thought processes, and biological factors contribute to some cases of depression. In addition, chronic and serious illness such as heart disease or cancer may be accompanied by depression. With many individuals, however, depression signals first and foremost that certain mental and emotional aspects of a person's life are out of balance.

Significant transitions and major life stressors such as the death of a loved one or the loss of a job can help bring about depression. Other more subtle factors that lead to a loss of identity or self-esteem may also contribute. The causes of depression are not always immediately apparent, so the disorder requires careful evaluation and diagnosis by a trained mental health care professional.

Sometimes the circumstances involved in depression are ones over which an individual has little or no control. At other times, however, depression occurs when people are unable to see that they actually have choices and can bring about change in their lives.

Can depression be treated successfully?

Absolutely. Depression is highly treatable when an individual receives competent care. Psychologists are among the licensed and highly trained mental health providers with years of experience studying depression and helping patients recover from it.

There is still some stigma, or reluctance, associated with seeking help for emotional and mental problems, including depression. Unfortunately, feelings of depression often are viewed as a sign of weakness rather than as a signal that something is out of balance. The fact is that people with depression can not simply 'snap out of it' and feel better spontaneously.

Persons with depression who do not seek help suffer needlessly. Unexpressed feelings and concerns accompanied by a sense of isolation can worsen a depression. The importance of obtaining quality professional health care can not be overemphasized.

How does psychotherapy help people recover from depression?

There are several approaches to psychotherapy -- including cognitive-behavioral, interpersonal, psychodynamic and other kinds of 'talk therapy' -- that help depressed individuals recover. Psychotherapy offers people the opportunity to identify the factors that contribute to their depression and to deal effectively with the psychological, behavioral, interpersonal and situational causes. Skilled therapists such as licensed psychologists can work with depressed individuals to:

- pinpoint the life problems that contribute to their depression, and help them understand which aspects of those problems they may be able to solve or improve. A trained therapist can help depressed patients identify options for the future and set realistic goals that enable these individuals to enhance their mental and emotional well-being. Therapists also help individuals identify how they have successfully dealt with similar feelings, if they have been depressed in the past.
- identify negative or distorted thinking patterns that contribute to feelings of hopelessness and helplessness that accompany depression. For example, depressed individuals may tend to overgeneralize, that is, to think of circumstances in terms of 'always' or 'never.' They may also take events personally. A trained and competent therapist can help nurture a more positive outlook on life.
- explore other learned thoughts and behaviors that create problems and contribute to depression. For example, therapists can help depressed individuals understand and improve patterns of interacting with other people that contribute to their depression.
- help people regain a sense of control and pleasure in life. Psychotherapy helps people see choices as well as gradually incorporate enjoyable, fulfilling activities back into their lives.

Having one episode of depression greatly increases the risk of having another episode. There is some evidence that ongoing psychotherapy may lessen the chance of future episodes or reduce their intensity. Through therapy, people can learn skills to avoid unnecessary suffering from later bouts of depression.

In what other ways do therapists help depressed individuals and their loved ones?

The support and involvement of family and friends can play a crucial role in helping someone who is depressed. Individuals in the 'support system' can help by encouraging a depressed loved one to stick with treatment and to practice the coping techniques and problem-solving skills he or she is learning through psychotherapy.

Living with a depressed person can be very difficult and stressful on family members and friends. The pain of watching a loved one suffer from depression can bring about feelings of helplessness and loss. Family or marital therapy may be beneficial in bringing together all the individuals affected by depression and helping them learn effective ways to cope together. This type of psychotherapy can also provide a good opportunity for individuals who have never experienced depression themselves to learn more about it and to identify constructive ways of supporting a loved one who is suffering from depression.

Are medications useful for treating depression?

Medications can be very helpful for reducing the symptoms of depression in some people, particularly for cases of moderate to severe depression. Some health care providers treating depression may favor using a combination of psychotherapy and medications. Given the side effects, any use of medication requires close monitoring by the physician who prescribes the drugs.

Some depressed individuals may prefer psychotherapy to the use of medications, especially if their depression is not severe. By conducting a thorough assessment, a licensed and trained mental health professional can help make recommendations about an effective course of treatment for an individual's depression.

Depression can seriously impair a person's ability to function in everyday situations. But the prospects for recovery for depressed individuals who seek appropriate professional care are very good. By working with a qualified and experienced therapist, those suffering from depression can help regain control of their lives.

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October 1998

How Therapy Helps
GET THE FACTS

How to Find Help Through Psychotherapy

Millions of Americans have found relief from depression and other emotional difficulties through psychotherapy. Even so, some people find it hard to get started or stay in psychotherapy. This brief question-and-answer guide provides some basic information to help individuals take advantage of outpatient (non-hospital) psychotherapy.

Why do people consider using psychotherapy?

Psychotherapy is a partnership between an individual and a professional such as a psychologist who is licensed and trained to help people understand their feelings and assist them with changing their behavior. According to the National Institute of Mental Health, one-third of adults in the United States experience an emotional or substance abuse problem. Nearly 25 percent of the adult population suffers at some point from depression or anxiety.

People often consider psychotherapy, also known as therapy, under the following circumstances:

- They feel an overwhelming and prolonged sense of sadness and helplessness, and they lack hope in their lives.
- Their emotional difficulties make it hard for them to function from day to day. For example, they are unable to concentrate on assignments and their job performance suffers as a result.
- Their actions are harmful to themselves or to others. For instance, they drink too much alcohol and become overly aggressive.
- They are troubled by emotional difficulties facing family members or close friends.

What does research show about the effectiveness of psychotherapy?

Research suggests that therapy effectively decreases patients' depression and anxiety and related symptoms -- such as pain, fatigue and nausea. Psychotherapy has also been found to increase survival time for heart surgery and cancer patients, and it can have a positive effect on the body's immune system. Research increasingly supports the idea that emotional and physical health are very closely linked and that therapy can improve a person's overall health status.

There is convincing evidence that most people who have at least several sessions of psychotherapy are far

better off than untreated individuals with emotional difficulties. One major study showed that 50 percent of patients noticeably improved after eight sessions while 75 percent of individuals in psychotherapy improved by the end of six months. Psychotherapy with children is similar in effectiveness to psychotherapy with adults.

How do I find a qualified therapist?

Selecting a therapist is a highly personal matter.

A professional who works very well with one individual may not be a good choice for another person. There are several ways to get referrals to qualified therapists such as licensed psychologists, including the following:

- Talk to close family members and friends for their recommendations, especially if they have had a good experience with psychotherapy.
- Many state psychological associations operate referral services which put individuals in touch with licensed and competent mental health providers. (Call the American Psychological Association's Practice Directorate at 202-336-5800 for the name and phone number of the appropriate state organization.)
- Ask your primary care physician (or other health professional) for a referral. Tell the doctor what's important to you in choosing a therapist so he or she can make appropriate suggestions.
- Inquire at your church or synagogue.
- Look in the phone book for the listing of a local mental health association or community mental health center and check these sources for possible referrals.

Ideally, you will end up with more than one lead. Call and request the opportunity, either by phone or in person, to ask the therapist some questions. You might want to inquire about his or her licensure and level of training, approach to psychotherapy, participation in insurance plans and fees. Such a discussion should help you sort through your options and choose someone with whom you believe you might interact well.

If I begin psychotherapy, how should I try to gain the most from it?

There are many approaches to outpatient psychotherapy and various formats in which it may occur -- including individual, group and family psychotherapy. Despite the variations, all psychotherapy is a two-way process that works especially well when patients and their therapists communicate openly. Research has shown that the outcome of psychotherapy is improved when the therapist and patient agree early about what the major problems are and how psychotherapy can help.

You and your therapist both have responsibilities in establishing and maintaining a good working relationship. Be clear with your therapist about your expectations and share any concerns that may arise. Psychotherapy works best when you attend all scheduled sessions and give some forethought to what you want to discuss during each one.

How can I evaluate whether therapy is working well?

As you begin psychotherapy, you should establish clear goals with your therapist. Perhaps you want to overcome feelings of hopelessness associated with depression. Or maybe you would like to control a fear that disrupts your daily life. Keep in mind that certain tasks require more time to accomplish than others. You may need to adjust your goals depending on how long you plan to be in psychotherapy.

After a few sessions, it's a good sign if you feel the experience truly is a joint effort and that you and the

therapist enjoy a good rapport. On the other hand, you should be open with your therapist if you find yourself feeling 'stuck' or lacking direction once you've been in psychotherapy awhile.

There may be times when a therapist appears cold and disinterested or doesn't seem to regard you positively. Tell your therapist if this is the situation, or if you question other aspects of his or her approach. If you find yourself thinking about discontinuing psychotherapy, talk with your therapist. It might be helpful to consult another professional, provided you let your therapist know you are seeking a second opinion.

Patients often feel a wide range of emotions during psychotherapy. Some qualms about psychotherapy that people may have result from the difficulty of discussing painful and troubling experiences. When this happens, it can actually be a positive sign indicating that you are starting to explore your thoughts and behaviors.

You should spend time with your therapist periodically reviewing your progress (or your concern that you are not making sufficient headway). Although there are other considerations affecting the duration of psychotherapy, success in reaching your primary goals should be a major factor in deciding when your psychotherapy should end.

Psychotherapy isn't easy. But patients who are willing to work in close partnership with their therapist often find relief from their emotional distress and begin to lead more productive and fulfilling lives.

October 1998

Managing Traumatic Stress: Tips for Recovering From Disasters and Other Traumatic Events

The September 11th terrorist attacks were the type of events we thought could never happen. Like other types of disasters they were unexpected, sudden and overwhelming. In some cases, there are no outwardly visible signs of physical injury, but there is nonetheless a serious emotional toll. It is common for people who have experienced traumatic situations to have very strong emotional reactions. Understanding normal responses to these abnormal events can aid you in coping effectively with your feelings, thoughts, and behaviors, and help you along the path to recovery.

What happens to people after a disaster or other traumatic event?

Shock and denial are typical responses to terrorism, disasters and other kinds of trauma, especially shortly after the event. Both shock and denial are normal protective reactions.

Shock is a sudden and often intense disturbance of your emotional state that may leave you feeling stunned or dazed. Denial involves your not acknowledging that something very stressful has happened, or not experiencing fully the intensity of the event. You may temporarily feel numb or disconnected from life.

As the initial shock subsides, reactions vary from one person to another. The following, however, are normal responses to a traumatic event:

- Feelings become intense and sometimes are unpredictable. You may become more irritable than usual, and your mood may change back and forth dramatically. You might be especially anxious or nervous, or even become depressed.
- Thoughts and behavior patterns are affected by the trauma. You might have repeated and vivid memories of the event. These flashbacks may occur for no apparent reason and may lead to physical reactions such as rapid heart beat or sweating. You may find it difficult to concentrate or make decisions, or become more easily confused. Sleep and eating patterns also may be disrupted.
- Recurring emotional reactions are common. Anniversaries of the event, such as at one month or one year, as well as reminders such as aftershocks from earthquakes or the sounds of sirens, can trigger upsetting memories of the traumatic experience. These 'triggers' may be accompanied by fears that the stressful event will be repeated.

- Interpersonal relationships often become strained. Greater conflict, such as more frequent arguments with family members and coworkers, is common. On the other hand, you might become withdrawn and isolated and avoid your usual activities.
- Physical symptoms may accompany the extreme stress. For example, headaches, nausea and chest pain may result and may require medical attention. Pre-existing medical conditions may worsen due to the stress.

How do people respond differently over time?

It is important for you to realize that there is not one 'standard' pattern of reaction to the extreme stress of traumatic experiences. Some people respond immediately, while others have delayed reactions - sometimes months or even years later. Some have adverse effects for a long period of time, while others recover rather quickly.

And reactions can change over time. Some who have suffered from trauma are energized initially by the event to help them with the challenge of coping, only to later become discouraged or depressed.

A number of factors tend to affect the length of time required for recovery, including:

- The degree of intensity and loss. Events that last longer and pose a greater threat, and where loss of life or substantial loss of property is involved, often take longer to resolve.
- A person's general ability to cope with emotionally challenging situations. Individuals who have handled other difficult, stressful circumstances well may find it easier to cope with the trauma.
- Other stressful events preceding the traumatic experience. Individuals faced with other emotionally challenging situations, such as serious health problems or family-related difficulties, may have more intense reactions to the new stressful event and need more time to recover.

How should I help myself and my family?

There are a number of steps you can take to help restore emotional well being and a sense of control following a terrorist act, a disaster or other traumatic experience, including the following:

- Give yourself time to heal. Anticipate that this will be a difficult time in your life. Allow yourself to mourn the losses you have experienced. Try to be patient with changes in your emotional state.
- Ask for support from people who care about you and who will listen and empathize with your situation. But keep in mind that your typical support system may be weakened if those who are close to you also have experienced or witnessed the trauma.
- Communicate your experience in whatever ways feel comfortable to you - such as by talking with family or close friends, or keeping a diary.
- Find out about local support groups that often are available such as for those who have suffered from natural disasters, or for women who are victims of rape. These can be especially helpful for people with limited personal support systems.
- Try to find groups led by appropriately trained and experienced professionals. Group discussion can help people realize that other individuals in the same circumstances often have similar reactions and emotions.
- Engage in healthy behaviors to enhance your ability to cope with excessive stress. Eat well-balanced meals and get plenty of rest. If you experience ongoing difficulties with sleep, you may be able to find some relief through relaxation techniques. Avoid alcohol and drugs.

- Establish or reestablish routines such as eating meals at regular times and following an exercise program. Take some time off from the demands of daily life by pursuing hobbies or other enjoyable activities.
- Avoid major life decisions such as switching careers or jobs if possible because these activities tend to be highly stressful.
- Become knowledgeable about what to expect as a result of trauma. Some of the 'Additional Resources' listed at the end of this fact sheet may help you with this learning process.

How do I take care of children's special needs?

The intense anxiety and fear that often follow a disaster or other traumatic event can be especially troubling for children. Some may regress and demonstrate younger behaviors such as thumb sucking or bed wetting. Children may be more prone to nightmares and fear of sleeping alone. Performance in school may suffer. Other changes in behavior patterns may include throwing tantrums more frequently, or withdrawing and becoming more solitary.

There are several things parents and others who care for children can do to help alleviate the emotional consequences of trauma, including the following:

- Spend more time with children and let them be more dependent on you during the months following the trauma - for example, allowing your child to cling to you more often than usual. Physical affection is very comforting to children who have experienced trauma.
- Provide play experiences to help relieve tension. Younger children in particular may find it easier to share their ideas and feelings about the event through non-verbal activities such as drawing.
- Encourage older children to speak with you, and with one another, about their thoughts and feelings. This helps reduce their confusion and anxiety related to the trauma. Respond to questions in terms they can comprehend. Reassure them repeatedly that you care about them and that you understand their fears and concerns.
- Keep regular schedules for activities such as eating, playing and going to bed to help restore a sense of security and normalcy.

When should I seek professional help?

Some people are able to cope effectively with the emotional and physical demands brought about by a natural disaster or other traumatic experience by using their own support systems. It is not unusual, however, to find that serious problems persist and continue to interfere with daily living. For example, some may feel overwhelming nervousness or lingering sadness that adversely affects job performance and interpersonal relationships.

Individuals with prolonged reactions that disrupt their daily functioning should consult with a trained and experienced mental health professional. Psychologists and other appropriate mental health providers help educate people about normal responses to extreme stress. These professionals work with individuals affected by trauma to help them find constructive ways of dealing with the emotional impact.

With children, continual and aggressive emotional outbursts, serious problems at school, preoccupation with the traumatic event, continued and extreme withdrawal, and other signs of

intense anxiety or emotional difficulties all point to the need for professional assistance. A qualified mental health professional can help such children and their parents understand and deal with thoughts, feelings and behaviors that result from trauma.

How may I use APA as a resource?

'Talk to Someone Who Can Help,' brochure about psychotherapy and choosing a psychologist from the American Psychological Association can be ordered free of charge. Call 1-800-964-2000

Get the facts: How to find help through psychotherapy ,a brief question-and-answer guide that provides basic information about psychotherapy and how it can help.
www.helping.apa.org/therapy/psychotherapy.html

Find a Psychologist, information on how to be connected with the state psychological association referral network in your area. This information is also available by calling: 1-800-964-2000.
www.helping.apa.org/find.html

Coping with Terrorism, a document that offers tips on managing this type of stress.
www.helping.apa.org/daily/terrorism.html

Additional Resources

'A Terrible Thing Happened', a story for children who have witnessed a violent or traumatic event.

The American Red Cross has several brochures available on-line, including: Helping Young Children Cope with Trauma, When Bad Things Happen, Disaster Preparedness for People with Disabilities, and How Do I Deal With My Feelings. These can be retrieved and printed from:
www.redcross.org/pubs/dspubs/terrormat.html

Local chapters of the American Red Cross may be able to direct you to additional resources. You can log on at www.redcross.org and enter your zip code where it says "Find Your Local Red Cross". The contact information for your local chapter will also be available in your telephone book.

National Organization for Victims Assistance, 1730 Park Road, NW, Washington, D.C. 20010; toll-free 1-800-TRY-NOVA ; in D.C. metropolitan area, (202) 232-6682. www.try-nova.org

Other materials available via Internet offer additional information about coping with traumatic events:

'Emotional Reactions to Disasters' University of Illinois Cooperative Extension Service

March 2002

To maintain a broad perspective of the reforms needed to address barriers to learning, we organize our thinking and materials around the following three categories:

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
    - Collaborative Teams
    - School-community service linkages
    - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
    - Systemic change strategies
    - Involving stakeholders in decisions
    - Staffing patterns
    - Financing
    - Evaluation, Quality Assurance
    - Legal Issues
- Professional standards

Programs and Process Concerns

- Clustering activities into a cohesive, programmatic approach
    - Support for transitions
    - Mental health education to enhance healthy development & prevent problems
    - Parent/home involvement
    - Enhancing classrooms to reduce referrals (including prereferral interventions)
    - Use of volunteers/trainees
    - Outreach to community
    - Crisis response
    - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
    - Cultural competence
    - Minimizing burnout
- Interventions for student and family assistance
    - Screening/Assessment
    - Enhancing triage & ref. processes
    - Least Intervention Needed
    - Short-term student counseling
    - Family counseling and support
    - Case monitoring/management
    - Confidentiality
    - Record keeping and reporting
    - School-based Clinics

Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Learning problems
- School adjustment (including newcomer acculturation)
- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gangs
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Gender and sexuality
- Reactions to chronic illness

Center for Mental Health in Schools, UCLA
Howard Adelman & Linda Taylor, Co-Directors