

A long-term view of serious emotional problems:
“Is there such a thing as ‘getting better’ from this or not?”

Critical issues along the journey to an answer

Jacob Z. Hess, Ph.D.

Research Director, Utah Youth Village

Alpine Academy Research Series



*Dedicated to Mary & Brannigan,
For two who deny being anything heroic whatsoever,
. . . to me and others who know you best, this is what you will always be.*

*"The world is fundamentally made not of atoms, but of stories."
--Muriel Rukeyser, poet*

Table of Contents

Introduction	1
Part I. Making sense of the problem: What’s going on?	7
Chapter 1: ‘Why are so many people depressed these days?’	
Considering the role of socio-cultural toxicity in emotional problems	8
Chapter 2: ‘Now, how exactly are these problems biological?’	
Reviewing the changing views on the relationship between emotional problems and the body	22
Part II. Making sense of the answers: What do we do?	35
Chapter 3: ‘Is there a getting better from this, or not?’	
Exploring the meaning and possibility of recovery	37
Chapter 4: ‘But what if it comes back again?!’	
Facing the disheartening prospect of relapse	51
Chapter 5: ‘Okay, it’s time we fixed this problem.’	
Considering three different ways others may intervene	62
Chapter 6: ‘But I’m not a therapist...I’m just a mom!’	
Seven challenges to creating a healing atmosphere	73
Concluding observations	93
Citations	95

Copyright © 2010 by Utah Youth Village

Note: No part of this text may be copied or reproduced without permission from the author. Until it is revised and prepared for a broader audience, the manuscript is intended primarily for internal use of clients and families associated with Utah Youth Village and Alpine Academy. Although supported by UYV in its development, the views and opinions expressed in this book are that of the author alone, and do not necessarily represent those of Alpine Academy or Utah Youth Village.

Feel free to send any feedback or questions to Jacob at jhess@youthvillage.org.

**A long-term view of serious emotional problems:
“Is there such a thing as ‘getting better’ from this or not?”
Critical issues along the journey to an answer**

**Jacob Z. Hess, Ph.D.
Research Director, Utah Youth Village**

“I’ve had . . . beatings to the point of unconsciousness—ripped, broken, arms taken out of the socket and that compares *nothing* . . . doesn’t even *begin* to be the pain that became every day, just right here [*pointing to her chest*—this thing that wouldn’t come off, that made it hard to breathe . . . like, I would rather have had hours and hours of people beating the crap out of me every day than to have been where I was *just inside*. It hurt that bad. . . . There were times I thought it *would* kill me . . . all on its own--that I wouldn’t have to do anything.”
—23 year-old survivor of abuse and depression

Introduction

The pain of severe emotional problems can be uniquely intense. This young woman, interviewed several years ago, compares a recent encounter with depression to an earlier period of cruel child abuse. Similar anguish can be found in accounts of eating disorders, panic attacks, delusional problems and other serious emotional conditions, including addictions to a variety of substances and behaviors. While any one such case is disturbing enough to witness, in recent years the number of individuals facing severe emotional problems¹ has risen sharply. According to recent indicators, for instance, depression has become the “leading cause of disability in the U.S. for ages 15-44” (see National Institute of Mental Health, 2009) and the fourth highest source of the “global disease burden” (World Health Organization, 2004; Hyman & colleagues, 2006). Trends for other emotional problems are also alarming, including heightened levels of anxiety (Twenge, 2000; USA Today, 2010), a veritable eating disorder “epidemic” (Gordon, 1992; Gura, 2008) and ever-rising cases of debilitating attention problems among both youth and adults (Stolzer, 2007). In some areas of the world, even delusional problems have risen in recent decades (Boydell, Van Os, Lambri, et al., 2003).

Of course, statistics can remain general abstractions until someone you love becomes one of those numbers. In 2002, after my brother passed away to cancer, his fiancé fell into severe depression, anxiety and ultimately, a combination of anorexia and bulimia. Over the subsequent years, our family has often felt helpless wondering what more we could do, as she received outpatient counseling and medication, followed by two stays in residential treatment.

At the time of her initial deterioration, I was beginning a doctoral program of clinical-community psychology at the University of Illinois, optimistic at the possibilities of treatment and support available. In spite of all the interventions and support provided in my sister’s case, however, she seemed to find no lasting relief.² Over the next several years, we watched as she faced deepening pain and growing distance from us all.

Why wasn’t treatment bringing her a more enduring reprieve from this emotional pain? How come the most ‘cutting-edge’ help available seemed to be offering only short-term relief? Was there anything that could go beyond symptom control or behavior change?

¹ Although a limited set of conditions has historically been considered ‘serious’ or severe emotional challenges (e.g., schizophrenia/schizoaffective problems, bipolar disorder, OCD), the term is here used more broadly to refer to any emotional or psychological problem that has become debilitating (e.g., depression, severe anxiety, ADHD, eating disorders, alcohol/drug/sexual addiction, etc.).

² As she grew closer to us, this woman literally became a member of our family and is called my ‘sister’ throughout the manuscript.

Over the last forty years, an enormous research effort across psychology and related fields has explored the source of serious emotional problems and how best to alleviate them. In literature reviews being conducted by Utah Youth Village, for instance, we have identified approximately 200,000 studies immediately relevant to further developing our own programmatic interventions for depression, anxiety, eating disorders and ADHD in our treatment youth.

In my case, graduate school provided an ideal opportunity to explore the rich array of insights arising in this research literature, mentored by a series of remarkable professors supervising their own neuroscientific and clinical research programs. During these seven years, I was exposed to exciting, cutting-edge ideas in psychology, including multiple innovations of which I had never been aware myself. After leading an eating disorder research team for a year, I ultimately focused my dissertation study on the long-term outcomes of medical treatment for depression.

During this time, among other things, I began to notice a puzzling discrepancy. When I came home from school and discussed my sister's treatment with family members, I often heard second-hand pronouncements by her therapists or doctors that science had "clearly proven" certain theoretical explanations and treatments. From specific residential treatment philosophies, to particular medical interventions, the message my family was hearing from practitioners was, more often than not, that research had already provided proof of the treatments that worked best.

Yet from my own exposure to the relevant research literature, I knew that basic treatment questions regarding the very problems she faced remained *deeply contested*—at least among scientists. From how to define a particular problem, to where exactly it comes from, to what best to do about it, thoughtful research teams across many universities disagreed sharply on fundamental, basic questions across each of these areas.

Why then, was the general public being told so confidently that certain answers had been found? After discussing some of the research debates with a medical doctor colleague recently, I suggested that perhaps we should let clients know more about the areas where conflicted findings exist. His response was telling. "Oh, no," he said with a tone of admonishment. "You don't want to do that. Families and individuals facing these kinds of problems shouldn't have to deal with that kind of confusion." He went on to explain that exploring complex issues was a realm best reserved for doctors and researchers who had the training to know best how to make sense of the contradictions.

Perhaps this kind of attitude explains some of the certainty families hear from helping professionals and other mental health educators. Maybe others were also presuming that families of distressed individuals deserved to hear a unified voice—and be 'spared' having to sort through questions themselves.

But here's the point: What if we *don't* really know? What if there are questions that haven't been settled yet and issues not fully explored? If this were the case, what would it mean to take one available view and promote it as 'established'—perhaps prematurely? What if that view, after it became widespread, turned out to be misleading in fundamental ways?

And what about other less dominant positions? Would they be heard as well or would they be overlooked or even minimized? What if one of these views turned out to be a breakthrough discovery, with wide implications for treatment?

This manuscript comes from my own journey exploring contested issues relevant to severe emotional problems, as well as the larger questions they spawn for the real-life experience of individuals and families living out these same

problems. While writing as a full-time researcher myself, my primary qualification is being a brother to a remarkable woman still facing painful challenges.

Rather than proselyting my own conclusions of ‘how others should think’ about these issues, however, experiences summarized above have prompted a different focus and goal for my research program, inspired by several innovative mentors (Slife & Williams, 1995; Schwandt, 1996).

With all due respect to my doctor friend, I believe that those facing severe emotional problems, their families and others who seek to assist them (friends, neighbors, teachers, counselors, consultants, etc.), all deserve clear and comprehensive information on *any issue* relevant to the problem they are facing. This might include issues concerning the range of potential explanations for the problem or it might take up a similar range of issues pertaining to possible answers for the same problem. Rather than ‘sparing’ families the full scope of ambiguities and nuances associated with the range of these issues, it seems not only fair, but also ethical, for social service practitioners and researchers to help such families and individuals be *more aware* of critical issues, tough questions and thorny debates. In this, the educational role of a doctor or therapist or mental health advocate is more akin to a mentor or advisor who helps others think through issues, than a missionary or school teacher that aims to deliver ‘the truth’ about emotional problems.

The following chapters take up a series of key issues still being debated by social scientists, alongside concrete illustrations of the different positions being taken on a given issue. In light of this format, although my own views of these issues are also evident, the explicit aim is to help individuals and their families (and other helpers) know enough about contrasting positions to be able to *examine the issues themselves*. In this way, people most directly impacted by the problem, can better make their *own decisions* on how best to respond to the problem—be that their own, or that of their loved one (see Schwandt, 1996).

In all this, I echo one of my college mentors, C.T. Warner, who cautions in his own book: “Beware of people who are anxious to tell you how you ought to live. Instead, test everything, including what is said in this book, against your own thoughtfully considered experience. If you are honest about that experience, what is true will ring true—you will not have to rely on my say-so or anybody else’s. No self-proclaimed human authority will serve you better than your own straightforward sense of what is right” (Warner, 2001, p. xiv).

Overview. Part one begins by calling closer attention to how we commonly think and talk about severe emotional problems. Chapter 1 introduces an overlooked, but fascinating debate being waged within the field of psychology: to what degree do emotional problems emerge from external vs. internal forces? After considering the role of society and culture in these problems, Chapter 2 explores another crucial question: In what way exactly are severe emotional problems biological? Alongside a review of paradigm-shifting findings in neuroscience and genetics, this chapter considers associated implications for both treatment decisions and individual agency in the face of these debilitating problems.

At this point, we turn in Part II to the examination of questions regarding interventions and treatments for serious emotional problems. In Chapter 3, we explore the issue of lasting recovery--e.g.: Is it possible? If so, what does it look like? This chapter combines a variety of narrative accounts with a review of the research on a range of possible contributors to recovery across conditions. We follow this discussion by considering, according to many indicators, one of the most groundbreaking innovations to emerge in psychology of late—a refreshing school of thought hailing from ancient distinctions in Eastern philosophy. Chapter 4 attempts to summarize the essence of this theoretical shift involved in ‘mindfulness-based interventions’ in an accessible way, and detail what it might mean for debilitating depression, anxiety and addictions. In Chapter 5, we begin to review more explicitly, patterns from

our own Utah Youth Village research in terms of natural support systems (e.g., families, friends, etc.) and their role in long-term healing. After considering in that chapter three different patterns of involvement in supporting someone with a serious emotional problem, we turn in the final Chapter 6, to seven challenges that may arise as families seek to cultivate a healing atmosphere at home.

The manuscript has been prepared as relevant to both an individual facing severe emotional problems himself or herself, and to other loved ones or caregivers. While the parent-child relationship is the most common illustration cited below, the ideas discussed have equal application to other relationships as well, including one spouse supporting another who is struggling and any other loved ones (friends, neighbors, siblings, therapist) offering the same support.

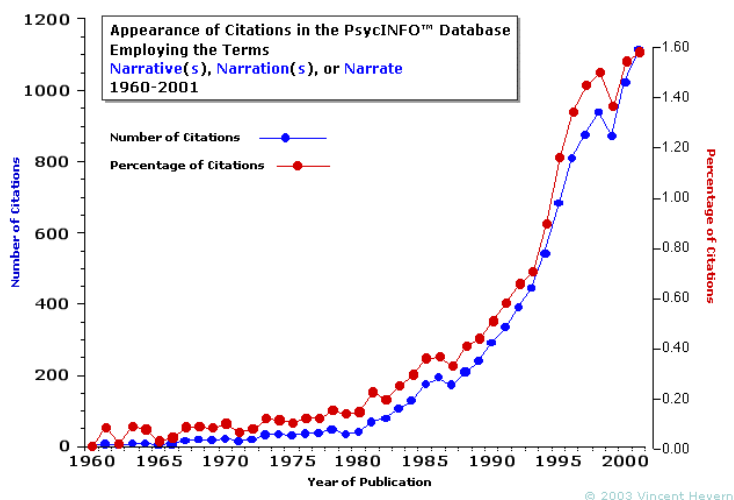
Although specific examples will be shared from a number of emotional problems, illustrations from depression, eating disorders and ADHD will be most common, since they have been primary research interests to date. While some might question the wisdom of examining a range of emotional problems in such a work, it is precisely this kind of broad overview that reveals some interesting patterns and issues across conditions. This general cluster of themes common to multiple emotional problems in youth is what draws our primary attention here. In this way, meaningful differences in both the origin of particular conditions and their best treatments are acknowledged.

Methodological assumptions. Citations from both quantitative and qualitative research are cited below. Until recently, qualitative methodologies (e.g., interviewing, archival analysis, ethnographic work) have been relatively ignored within psychology. David Karp (1997), a sociologist at Boston College, for instance, once noted that “the essential problem with nearly all studies of depression is that we hear the voices of a battalion of mental health experts . . . and never the voices of depressed people themselves.” In his review of the *Journal of Affective Disorders*, he noted that in twelve volumes of this journal, he could not find *one word* spoken by a person who lives with depression (p. 12).

One reason for such neglect is social scientists of an earlier generation typically considered personal stories as mere ‘anecdotes,’ reflecting pure ‘subjectivity,’ and thus of little scientific value. By and large, this attitude has changed in the research world as increasing numbers of in-depth, rigorous investigations of the *qualitative* aspects of human experience has taken place (e.g., Figure 1), including the ‘lived experience’ of severe emotional problems.

By careful attention to variations in the language of individuals sharing a similar experience, insights can emerge on something deeper than even language itself. One of the core appreciations of qualitative research is the importance of our innate human impulse to make sense, interpret or ‘narrate’ one’s life as it unfolds. In

the context of illness, Kleinman (1988) defines narrative as a “story the patient tells, and significant others retell, to give coherence to the distinctive events and long-term course of suffering.” More than a ‘subjective overlay’ or simple ‘perception’ of experience, narratives are understood as directly involved in partially creating the actual unfolding experiences of life itself. As Kleinman continues, “the personal narrative does not merely reflect illness



Increase in narrative studies over the last 40 years (Hevern, 2004).

experience, but rather it contributes to the experience of [both] symptoms and suffering” (p. 49). In other words, rather than just ‘telling stories,’ we can appreciate how stories (and their assumptions, interpretations and definitions), are ‘lived out’ in tangible ways over time (Fay, 1996).

If the moment-by-moment practice of interpretation is as meaningful and consequential as it appears to be, then the careful study of unique interpretations and overarching narratives are a fruitful field of scientific examination (Bruner, 1997; De Rivera & Sarbin, 1998). By attending more carefully, systematically and rigorously to the scope and nature of narrative or interpretive patterns (as manifest in spoken or written language), this research approach thus aims to enhance what we learn from other, more ‘objective’ studies. Indeed, there is a growing awareness of how rigorous qualitative work may complement quantitative (statistical) work in confirming stronger, more compelling conclusions.

This manuscript combines findings from several original research projects, including (1) an in-depth interviewing study of the contrasting treatment experiences of 15 depression survivors completed last year (Hess, 2009) and (2) an in-depth, retrospective study of 120 Alpine Academy families completed in May of this year. This second study draws on 176 interviews, reflecting 50 girls and 126 parents (84 mothers, and 42 fathers). In the first study, participants are identified by a single number (1-15); in the second study, in addition to being identified by a number that indicates order of admission into Alpine Academy (1-189), a letter also confirms which family member is speaking (f = father; m = mother; d = daughter) [a ‘staff’ label also indicates comments from several current and previous Alpine employees who were also interviewed]. In a few instances, excerpts from two other projects are included: a study last year of 15 families whose daughters had especially successful transitions home after residential treatment and an eating disorder narrative project conducted three years ago (Hess, Moore, Brahm, Judd, Petroske, & Klok, 2008). Between the narrative materials generated by the four projects, approximately 350 pages of single-spaced transcription text has been reviewed and content analyzed, with 600 pages of resulting research reports.

Findings from these studies are set against the larger backdrop of scientific findings regarding several emotional problems, especially depression, eating disorders and ADHD. While careful to avoid unnecessary jargon, for reasons outlined earlier, I am equally careful to avoid needlessly ‘dumbing-down’ the contents like many popular texts do. The intended audience, once again, are individuals and families who have already been required to be thoughtful and intent in studying out similar questions for themselves.

Quotations are presented verbatim, with only slight edits to clarify intended thoughts in some cases. Ellipses indicate where text is removed either within (. . .) or between (. . .) sentences, while three dots without space (...) denotes a pause in the interview participant’s commentary. Consistent with our informed consent agreement, where individual identifying information existed, it has been removed to preserve the confidentiality of research participants. Thus, formal names mentioned in quotations below are only pseudonyms.

Acknowledgments. Thank you to those girls and parents who participated in these studies, as well as staff collaborators, Janet Mulitalo, Christian Egan and Nikki Preece. A special thanks to several individuals who offered input on one of the chapters: Shanna Draper [Utah Youth Village/Alpine Academy], Jeffrey Lacasse [Arizona State University], Patrick Berry [research assistant], Mary Louise Bean [high school teacher], and my sweetheart, Monique Tenaya Moore. Thanks also to Nathan Todd for his statistical consultation during data analysis. As an indispensable backdrop, I also want to acknowledge classmates and faculty at the UIUC psychology department, especially my mentors Drs. Nicole Allen, Wendy Heller and Elaine Shpungin, as well as Drs. Tom Schwandt (UIUC) and Brent

Slife (BYU) as mentors in a hermeneutic approach to research. Since graduation, Utah Youth Village (UYV)³ has been a haven of support and remarkable space for research and subsequent writing. Thanks to Eric Bjorklund, Shanna Draper and Wayne Arner for making that happen. And lastly, we return to the beginning, where my own family, especially my father and mother, Paul and Martha Hess. You have all been enduring, unfailing supports to my arriving ‘thus far.’ This book would not be possible without all of your kindness.

³ Some readers may be surprised that this manuscript does not read like a ‘marketing pitch’ for UYV or Alpine Academy. Not only have supervisors given me sufficient freedom to explore and research topics in my own way, they have allowed me full access to their programs and clients. Perhaps the best ‘pitch’ I can give for this organization with the endearing name is how consistently they have supported critical examination of their own programs and practices, while remaining consistently open to hearing results, including those that suggest possible ways to improve.

Part 1. Making sense of the problem: 'What's going on?'

In discussions of severe emotional challenges, the tendency is naturally to focus on ways to solve the problem and resolve the pain: 'so what do we do?!' While such an urgency for answers is understandable, this inclination assumes that the nature of the problem itself is largely settled. As noted in the introduction, in the absence of denying large areas of the research literature, this is simply not the case.

Contrary to public perceptions that the underpinnings of depression, anxiety disorders, eating disorders, ADHD and delusional challenges have been determined beyond doubt, there remain a number of fascinating issues still to resolve, still to explore, still to deliberate. In each case, these issues have tangible implications for what someone *ends up doing* to seek relief—either for themselves or for a family member.

Prior to examining direct interventions for emotional problems in the next chapter, we therefore begin by first considering two key issues relevant to how these problems are being framed--each of which has elicited substantial argument among researchers and professionals over the last several decades. These include:

1. What role does socio-cultural toxicity play in the development of severe emotional problems? (Chapter 1)
2. What is the role of biological conditions in the development of emotional problems, and how do these same conditions interact with actions, lifestyle and larger societal conditions over time? (Chapter 2)



Chapter 1: 'Why are so many people depressed these days?'
Considering the role of socio-cultural toxicity in emotional problems

*"As I looked at the culture that girls enter as they come of age, I was struck by what a girl-poisoning culture it was."
—Dr. Mary Pipher (1994) Reviving Ophelia*

When a problem like clinical depression, severe anxiety or bulimia develops, individuals and families can often pinpoint concrete factors that contributed to increased risk and vulnerability—e.g., past abuse, family conflict, physical injuries, extreme stress, etc. In many other cases, however, as reflected in comments from depression survivors, there seems little or no logical explanation for the intensity and severity of the pain they are facing:

- The thing that made it so frightening (*pause*) and so . . . difficult to handle was that I couldn't find where it came from. It seemed to come out of *nowhere*. . . . I would wake up feeling sad . . . or wake up feeling angry and I *couldn't figure out why*. "How can you be sad when you *wake up*? Nothing *caused* you to be sad!" (10)
- It's always the same thing, you know. There's nothing really to say. There's no explanation; there's no reason that you're depressed really. I mean, like . . . I know that when I lost my little grandson to SID (Sudden Infant Death Syndrome), we were just heart-broken . . . and that was a very depressing thing, but I've been far more depressed over *absolutely nothing*, you know, just in this place. I can't explain what it is (2).
- You have a brain, you have a body, you know what needs to be done around the house . . . to take care of your family and it's just like, there's *no reason on earth* you shouldn't be able to do it. . . . I just kind of felt like someone had put a hundred pounds on my shoulders. I couldn't see any reason why I felt this way (5).

This kind of personal confusion can sometimes prompt individuals to look towards biological processes as a concrete explanation for the perplexing burden of emotional problems. Chapter 2 examines some of the newest findings in neuroscience and genetics that have compelled a dramatic paradigm shift in how researchers now see the role of a 'dynamic biology' in the ebb and flow of vulnerability to such problems over time.

While the biological contributors to these problems are receiving the public and professional attention they deserve, there has been an unfortunate lack of awareness regarding potential contributors in other areas, including broader sociological patterns of lifestyle and environmental factors. As much as the biology, these aspects may also explain some of the emotional oppression people come to feel and may offer an answer, in particular, for the current increase in emotional problems across the nation. Several years ago, a medical doctor, Dr. Nedley (2005), found that nearly half of his patients in his practice were showing symptoms of depression. Even though some individuals experienced temporary relief with medications, this was not always the case. In hopes of better understanding the roots of depression, Nedley conducted his own exhaustive review of the scientific literature, including (a) anything that had been shown to cause depression and (b) anything that had been shown to alleviate it. Across hundreds of studies, Nedley identified 10 different themes, representing multiple areas of risk factors that appear to make individuals more vulnerable to depression. These ranged from genetic and developmental factors and toxicities in the environment, to nutritional and vitamin deficiencies, a lack of sunlight and exercise, and media patterns associated with frontal lobe circuitry. Based on this review, he hypothesized that, generally speaking, no single factor was sufficient to cause depression in a given individual, and that instead, multiple interlocking contributors were likely most often at play. As Marcus (2004) said, "Just as disorders of the body can be caused in dozens of different ways (for example, malnutrition from missing enzymes, disordered organs, etc. . .), disorders of the mind may result from many different underlying aberrations" (p. 136). After mentioning surrounding toxic chemicals, nutritional deficiencies and disrupted circadian rhythms, one interview participant likewise said, "There are hundreds of reasons why an individual, or for that matter generations of individuals from a family, may have

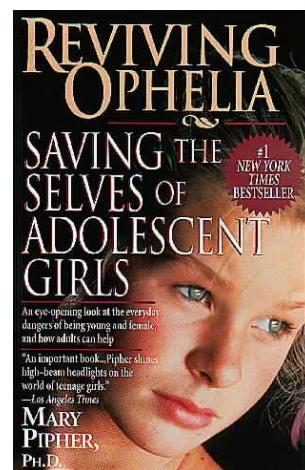
susceptibilities to . . . depression. They might be genetic [reasons], they might be susceptibilities, they might be allergens, or abuse issues. There are so many issues; it's not *one thing*. It's not like diabetes" (12).

Beginning this summer, Utah Youth Village is conducting its own wide-ranging literature reviews across a number of common conditions, including eating disorders (13,606 study abstracts identified), ADHD (18,101 studies), delusional/hallucination problems on the schizophrenia spectrum (45,636 studies) and anxiety/panic attacks/OCD (86,384 studies). So far, we are finding a similar range of results, from new neuroscientific and genetic findings, to many family and sociological investigations. Based on an analysis of patterns across these reviews, the plan is to put together comprehensive classes for youth and families surveying anything that has been shown to contribute to or alleviate the problem. These will be available both in-person and online beginning later on this year (see Chapter 3 for more details).

In what follows, we turn attention to some of the emerging evidence that compels more serious attention to some of the potential sociological, environmental contributors to emotional problems. As we only begin to highlight below, the cumulating evidence is both persuasive and alarming. After reviewing some of the patterns, we turn attention to competing ways of framing emotional problems in light of these societal factors. We conclude by tracing some of the implications of these different ways of thinking for practical realities of treatment and one's individual sense of self.

'Something in the air?' Evidence for socio-cultural toxicity. In her 1994 book *Reviving Ophelia*, Dr. Mary Pipher reviews many accounts of U.S. adolescent girls brought to her as therapy clients. The book begins with her own admissions of bewilderment and confusion at the severity and intensity of problems girls were facing: "Why are so many girls in therapy in the 1990s? Why are there more self-mutilators? What is the meaning of lip, nose and eyebrow piercings? How do I help thirteen-year-olds deal with herpes or genital warts? Why are drugs and alcohol so common in the stories of seventh-graders? Why do so many girls hate their parents?" She continues, "I have struggled to make sense of this. Why are girls having more trouble now than my friends and I had when we were adolescents? Many of us hated our adolescent years, yet for the most part we weren't suicidal and we didn't develop eating disorders, cut ourselves or run away from home. At first blush, it seems things should be better now." She then provides some of her own answers to this series of questions:

Girls [in my day] were living in a whole new world . . . Girls today are much more oppressed. They are coming of age in a more dangerous, sexualized and media-saturated culture. They face incredible pressures to be beautiful and sophisticated, which in junior high means using chemicals and being sexual. As they navigate a more dangerous world, girls are less protected. As I looked at the culture that girls enter as they come of age, I was struck by what a girl-poisoning culture it was. The more I looked around, the more I listened to today's music, watched television and movies and looked at sexist advertising, the more convinced I became that we are on the wrong path with our daughters. . . . Increasingly women have been sexualized and objectified, their bodies marketed to sell tractors and toothpaste. . . . America today limits girls' development, truncates their wholeness and leaves many of them traumatized (pp. 11-12, 27).



If claims of a "girl-toxic culture" were plausible in 1994, how about sixteen years later in 2010? The surrounding culture has continued to change so much in recent years that in 2007 the American Psychological Association convened a special task force headed by Eileen Zurbriggen, professor of psychology at the University of California-Santa Cruz, to conduct an exhaustive review of the scientific research literature regarding the "sexualization" of

young women in the nation. In contrast to healthy sexuality, sexualization was defined by one or more of the following criteria:

- ✓ A person's value comes only from his or her sexual appeal or behavior, to the exclusion of other characteristics.
- ✓ A person is held to a standard that equates physical attractiveness (narrowly defined) with being sexy.
- ✓ A person is sexually objectified—that is, made into a thing for others' sexual use, rather than seen as a person with the capacity for independent action and decision making.
- ✓ (And/or) sexuality is inappropriately imposed upon a person.

Among other things, this team of researchers found an alarming increase in the prevalence of sexualization across U.S. culture:

Virtually every media form studied provides ample evidence of the sexualization of women, including television, music videos, music lyrics, movies, magazines, sports media, video games, the Internet, and advertising (e.g., Gow, 1996; Grauerholz & King, 1997; Krassas, Blauwkamp, & Wesselink, 2001, 2003; Lin, 1997; Plous & Neptune, 1997; Vincent, 1989; Ward, 1995) [see original report for reference list]. In study after study, findings have indicated that women more often than men are portrayed in a sexual manner (e.g., dressed in revealing clothing, with bodily postures or facial expressions that imply sexual readiness) and are objectified (e.g., used as a decorative object or as body parts rather than a whole person). In addition, a narrow (and unrealistic) standard of physical beauty is heavily emphasized. These are the models of femininity presented for young girls to study and emulate (American Psychological Association, 2007, pp. 1-2).

While the influence of surrounding culture is not new, there is evidence that its influence has grown in recent years, particularly in relation to the prevalence of mass media. A study from researchers at the University of Michigan, for instance, identified the “major sources of influence in children’s lives” over the last 50 years. In 1950, home (1), school (2), church (3) and peers (4) were the top four documented influences on a child, followed by TV (5). In 2000, by contrast, media had become the top influence, ahead of all factors (Ako Kambon, personal communication January 22, 2010; see also <http://www.med.umich.edu/yourchild/topics/tv.htm>).

What are the consequences of this kind of an influence and atmosphere? In the executive summary, the APA researchers note, “We have ample evidence to conclude that sexualization has a range of negative consequences for young women . . . [across] a variety of domains, including cognitive functioning, physical and mental health, and healthy sexual development” (pp. 21-22). In particular, researchers point out solid evidence for alarming rates of ‘body dissatisfaction’:

Sexualization and objectification undermine confidence in and comfort with one’s own body, leading to a host of negative emotional consequences, such as shame, anxiety, and even self-disgust. The evidence to support this claim comes from studies of self-objectification . . . and from experimental and correlational studies of exposure to media emphasizing a narrow ideal of women’s sexual attractiveness. Studies . . . have shown that the near-constant monitoring of appearance that accompanies self-objectification leads to increased feelings of shame about one’s body (e.g., Fredrickson et al., 1998; McKinley, 1998, 1999; Tiggemann & Slater, 2001). Shame is an emotion that occurs when one perceives one’s failure to meet cultural standards of conduct (Lewis, 2000). Individuals who feel shame deem the whole self as deficient and typically have the urge to hide or disappear. Given that so few women meet the dominant cultural standard for an attractive, sexy appearance (Wolf, 1991), it is not surprising that a girl’s chronic comparison of her own body to this impossible cultural standard would result in feelings of inadequacy and shame (APA, 2007, p. 23).

While this atmosphere would be challenging for anyone, for developing adolescents it can be especially dangerous, particularly when combined with their natural interest in friends and emotional validation:

- My daughter was sweet and gentle . . . but wanted to be accepted. At that age, kids will sell their soul to have a friend (47m).
- My daughter feels if she doesn't have a boyfriend, she's got *nobody* (67m).
- We couldn't put enough structure on the internet and she just went crazy . . . meeting people online with total naïveté She was desperate to find friends (142m).

Within the current culture, this kind of a normal impulse has been manipulated to the point of debilitating addictions and painful outcomes for some. Two parents shared horrific stories of their daughters getting in touch with older men and subsequently being stuck in predatorial, abusive relationships. In one case, the girl almost died after experiencing severe trauma and torture at the hands of one man.

On a less extreme level, some youth can be especially vulnerable to the pressures of the culture generally. After their girls completed residential treatment, two parents reflected on the struggles they continued to face:

- I think it's really hard for kids to leave such a protective environment and face the peer pressure and the reality of society and an environment where there are all kinds of unhealthy things going on . . . with the #1 teenage goal of 'fitting in' after being gone for years Back into a new school and environment, it was extremely difficult . . . coming back into an environment where kids have cliques. . . . The tug and pull of this situation is huge That wanting to fit in with other people, especially—this was more important to her than hanging on to what she learned at Alpine. . . . Her friends were clueless and not doing any of the Alpine patterns. They had never been trained to do it. They were resistant to following rules and expectations, with an attitude of 'I am 18 and can do what I want to do'. . . . Some of her unhealthy choices came from being with and trusting these people (142m).
- It was kind of hard to assimilate back with her friends; her whole life has changed. She didn't have a lot of friends before she left and then to come back this age and to go to a high school where . . . all the kids were doing drugs and having sex and not wanting to go to college—the peer group was horrible, *horrible* . . . it was a horrible peer group. They hugely impacted her; that's all she would come home and talk about—'so and so is doing ecstasy' She wanted to go to a 'rave.' I didn't want her to be around that all day, every day . . . when kids are surrounded with that and when that's the majority group, that's hard (154m).

Part of this atmosphere is men who will 'say anything' to get what they want. Speaking of these guys, one of the mothers above continued, "They promise everything; they told her they loved her" (142m). A girl said, "Guys say a lot of things to manipulate females, to get what they want sexually It's important to learn that if a guy treats you like a princess, it doesn't necessarily mean he has good intentions" (95d).

Against this backdrop, youth can make rash decisions, including getting into "relationships too fast" (104staff) and "rushing into a relationship and moving in with her boyfriend" (130staff). Reflecting on her daughter's current struggles, one mother said, "I don't know what changed She started out good, but I think she got overwhelmed with school, crazy kids . . . and she is in love. . . . It worked at first, until she discovered boys; she became less teachable in that situation I don't know how you keep that enthusiasm?" (113mf).

In addition to sexual pressures, the larger atmosphere can also be extremely oriented towards drugs and alcohol:

- My daughter has been exposed to a lot of the [metropolitan] teen life these past couple years, as all her friends have, and she does smoke pot. . . . It's extremely difficult in [a big city] to avoid (74m).
- In college, she so badly wanted to fit in that she drank too much (95m).
- Where I live, drinking is all people know what to do I was never, ever satisfied with that lifestyle, but I did it because all my friends did and nobody is sober in college (96d).

- Her boyfriend has been trying to get her into alcohol . . . they kept trying to press alcohol on her (136m).
- Social stuff was hard. There are drugs in every single school you go to—it’s really hard to not get into that kind of stuff (147d).

In a later book, Dr. Pipher (1996) recounts “a mother who called to say that her daughter at a small private college in Iowa was lonely on weekends”:



All the students got stoned on alcohol and drugs. The daughter, who didn’t use chemicals, had no place to go and nothing to do. Saturday night at her school, the students had “purity parties,” where they got drunk and quizzed each other about sexual experiences. If a student hadn’t done something on the quiz, he/she did it right then. The daughter was sickened by all the sexual assaults, fights and out-of-control students. The mother asked, “What’s the right thing to do? Should I encourage her to stay or to come home, where it’s more civilized?” (p. 30).

While the surrounding pressures are challenging enough, it becomes even more difficult when home atmospheres reflect this same culture. This was evident in several family interviews. After mentioning that “my parents were both drug abusers,” one girl went on to reflect on her recent depression diagnosis: “I have my mood swings, but not that different from anyone else.” She added, “but *any* 15 year old girl living with drug abusers is going to have some issues” (54d). When families yield to and embrace the larger culture, subtle implications for both emotional health and home life can emerge [see Appendices for explorations of the relationship between mass media and brain development (#1) and family life (#3)]. When families create a protective and nurturing atmosphere in their own home, this can be an important leverage point for youth resisting the larger culture (see Chapter 5).

The focus above has been on the indirect impact of a sexualized and substance-oriented culture, which can generate addictions that in themselves reflect debilitating emotional problems. Others have made similar examinations of cultural dimensions more directly related to more typical ‘psychological’ problems such as depression and anxiety. Drs. Addis and Martell (2004) from Clark University and the University of Washington, for instance, recently suggested that the multiple risk factors in our current society have created an atmosphere that is partially ‘giving birth’ to depression: “The growing number of depressed people can be attributed to a ‘depressogenic society,’ a society that places many of its members at risk for developing depression. . . . You may be living in a society that makes you more prone to depression on a number of levels.” Others have made similar claims about eating disorders and ADHD (see below).

The provocative hypothesis here is that cultures can literally ‘incubate’ certain problems in its otherwise normal citizenry [see dictionary definition to the right]. Like a Petri dish that incubates bacteria, when the cultural conditions are right, we might expect certain problems to emerge naturally.

“Incubate”: (verb)

- 1) To maintain eggs, organisms, or living tissues at optimal environmental conditions for growth and development.
- 2) To maintain a chemical or biochemical system under specific conditions in order to promote a particular reaction.

‘Poor little messed-up kid’: One dominant way of talking about emotional problems. If it is true that surrounding socio-cultural atmospheres are seriously contributing to some of the emotional problems facing youth and adults, it seems worth asking the philosophical (and practical) question of why so many psychological treatments remain focused on adjusting and correcting *individuals within*

these cultures? The woman quoted in the introduction as comparing her previous abuse with depression, later related the following aftermath of her abuse:

When I was six, my step-mother locked me in the closet . . . I was scared of the dark when I was little. And I remember screaming at first . . . After a few hours, I was like *so* embarrassed because I had to go to the bathroom. My Dad was there, but he never opened the door. When the screaming went on longer than she would have liked, she . . . she taped my mouth and taped my hands behind my back and she hog-tied me . . . And after three days, she let me out.

This woman, who we will call ‘Sarah,’ went on to recount how she worried for years about telling anyone about the ongoing abuse, instead wishing that someone would recognize the signs: “Later on, when we visited the medical office as a family, I just kept hoping that maybe my doctor would see through my lies of me going, ‘I’m fine.’ He put me on Prozac” (6).



To be sure, any good doctor would be horrified at this kind of treatment, especially in the absence of confronting the abuse itself. It is shared here as an extreme example of a pattern in the treatment system where the focus is placed on presumed internal issues and deficits in the face of blatantly oppressive external societal conditions.

Perhaps the two most vivid examples of this discrepancy are eating disorders and ADHD. In spite of indicators that media messages are playing a large role in mass-infecting women with body-image/eating-disorder issues, with few exceptions (e.g., Maisel, Epston & Borden, 2004), the treatment discourse continues to frame eating disorders as largely *individual* problems—i.e., ‘how do we help the poor anorexic girl?’ When addressed at all, the disordered culture is typically framed as one of many factors that triggers the underlying internal weakness within an unfortunate individual (Zuckerman, 1999).

In the context of ADHD, Richard DeGrandpre (1999) highlights a media atmosphere that has become so “rapid-fire” in its super-stimulation that even neuroscientists are acknowledging the likelihood of it re-wiring neural-networks to match this level of stimulation (Armstrong, 2006; Lloyd, Stead, & Cohen, 2006). After developing a kind of ‘sensory addiction’ to rapid fire stimulation, these same children are then asked to go to school and sit in a classroom for 6 hours. When these children struggle to pay attention, they are then diagnosed as reflecting an inherent deficiency of attention presumably caused by internal problems—e.g., ‘oh, yes, we found out our son is ADHD.’

Why does this internal emphasis exist in the first place? Much has been said by sociological researchers about the role of corporate profits and funding streams shaping both research and treatment approaches (e.g., Cohen 1990/1994). While these kinds of explorations are clearly important, a second line of thinking arguably gets closer to the source of the discrepancy.

According to philosophical hermeneutics, one tradition of continental thought (Martin & Sugarman, 2001; Taylor, 2002), diverging interpretations and ways of thinking are at the heart of observable differences in practices or institutions. By paying attention to the assumptions and ways of thinking at play in a given system or approach, we begin to understand both the power of particular mindsets and ways they might be ‘upgraded’ by viable alternative assumptions or mindsets. All this becomes justification for paying closer attention to the way individuals, families and professionals talk about and frame their experiences facing emotional problems.

This, then, reflects the reason why we paid close attention to *different ways of thinking* about ADHD and eating disorders above—because in doing so, we also understand the mindsets underlying *different ways of responding* to

these conditions in practice. Extending this illustration, we may see that the issue goes beyond simply whether or not a condition is understood as primarily internal or not, to *how precisely* one's relationship to this condition is framed.

In the realm of physical disease, it is common to speak of individuals 'having' or 'facing/fighting': 'my wife is fighting the flu right now'; 'My friend has cancer.' While similar language is sometimes used for emotional problems, in a surprising number of cases interview comments go beyond this language and reflect a much stronger wording involving the "to be" verb: 'my son is ADHD' / 'I am bipolar' / 'My wife is anorexic.' This verb, as variously defined in the dictionary, functions to "describe, identify, or amplify the subject" or "To equal in meaning; to have the same connotation as; to have identity with; to belong to the class of (the fish is a trout; John is Catholic, Sharon is a woman)" (www.merriam-webster.com, www.dictionary.com). When used in the context of severe emotional problems, this verb thus conveys a message about someone's *identity*.⁴

Depending on the particular way of thinking, framing and talking about a problem chosen by individuals and their caregivers, there are obvious implications for how the problem comes to be experienced and treated. This particular 'I-am-bipolar' way of talking or framing a problem, for instance, by placing the primary source of a severe emotional problem inside a deficient individual, has a series of predictable consequences for practice.

Implications for treatment and identity: Portrayal #1. For one who takes up this view of an emotional problem like depression or anorexia, logical implications follow for how this person comes to see himself/herself. Continuing the story of Sarah, the abused girl who was given Prozac as a child, she reflected in her interview on some of her feelings when she was diagnosed as "being bipolar and OCD, with auditory hallucinations":

I was like... 'this is something that's going to be with me for good. . . it's not a cold that's just going to go away--this is me,' you know—and that's sad. You feel like you lose yourself, almost. Like a part of you dies when you're diagnosed. . . . It's almost like a grieving period realizing that the person that was faking it for so long--she wasn't real. And she kind of did die and it was almost like we were constructing a new being, you know? We had to reinvent and restructure this new being, almost: giving her the tools and the revenues, making sure she had insurance all the time, you know? I mean, it's hard . . . you *do* feel a detachment from everything you thought you were when this happens, because this is *not* who I was supposed to be. (6)

The sense of permanence reflected in her comments is tied, in part, to her emphasis on having learned something about her actual *identity* through the diagnosis. As evidenced by her poignant feelings, the implications of this kind of 'existential' revelation can be profound. In my own family, I noticed a change in my sister during the treatment process, as she came to increasingly view herself as ill at both an emotional and biological level. As this occurred, the sensitivity and beauty that she had always seen in herself seemed to become less certain and subject to question in her own mind.

Language (whether self-talk, family-talk, or professional-talk) is thus proposed as playing a crucial role in how anyone comes to relate to a condition like depression, eating disorders or ADHD. Furthermore, once individuals adopt this kind of a problem frame or definition, tangible treatment implications may also follow. This woman who felt like she had to inevitably "reinvent and restructure" her very being with diagnosis, went on to describe her crucial reliance on medical care to maintain her basic sanity. In this case, an emphasis on internal deficiencies understandably corresponds to an attempt to fix or correct these same issues.

⁴ Once again, in comparison with other conditions like cancer or heart-disease, we don't really see the same kind of language—'Hello, I am heart disease . . . and my wife is breast cancer.'

It is perhaps this way of thinking that underlies an insistence among some families that their daughter's need for medications goes beyond temporary support to a life-long necessity. For instance, one mother said "I'd hate to see my daughter if she went off meds; she would be a manic disaster" (19m). Two other individuals similarly reflected:

- I'm grateful that I was born in this day and age where I could get the medication that I need so that I wouldn't be locked in the attic somewhere, or indisposed all the time (7).
- I'd really like to be off the meds, but the person off the meds is *scary*...my grandchildren (*shaky, crying*) I don't want my grandchildren to see me as this bitter, angry (*laughs*) . . . you know, because all it takes is the screaming . . . and that's how they'll remember you for the rest of their life--so it's just not worth risking the relationships . . . You know, it's not at all fun and games to take the stuff but it's, the alternative is really unpleasant . . . It's the difference between me and a normal person (or fairly normal person) and being the weird lady (2).

Across each comment, it is important to note that the only other alternative seen to prophylactic, long-term treatment is a devastating return of depression and mania.

Once again, we see that particular ways of *intervening* in a problem like depression ensue from particular ways of *explaining* the same problem. Of course, if the internal processes of heart and mind for these individuals are, indeed, inherently defective and deficient and were there little else going on, then it might make sense that we would frame her condition in this way. Laying aside the implications of new biological discoveries for this question (see Chapter 2), we are now living in a society that, according to many indicators, has become literally toxic—so much so, that some are beginning to suggest that the culture itself is breeding or 'incubating' problems (see above).

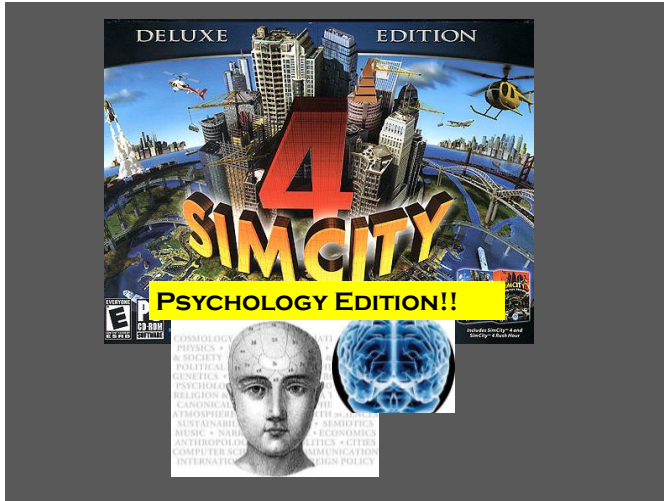
If this is the case, what does it mean for how we decide to think about these severe emotional problems? Rather than only emphasizing deficiencies within individuals, what if equally serious attention were given to addressing some of the problematic societal patterns relevant to these problems?

'Living in a diseased world': A second way of talking about emotional problems. The following section is taken from a 2009 invited presentation at a social work conference, entitled, "Cultural patterns as incubators of severe emotional problems." After reviewing the same points above illustrating a discrepancy between the numerous societal risk-factors, and how distressed individuals are often framed, approached and treated, I illustrated an alternative way of thinking about these problems by way of the following activity.

"How many in the audience have ever played Sim City? As many of you know, this is a popular video game where players function all-powerful leaders of new societies, given the charge and responsibility of building and cultivating conditions in their culture that will allow citizens to live, work and be happy. For instance, in a normal game, players might create roads, trade routes and water sources to ensure its population has access to healthy food and water supplies. They might also provide entertainment and leisure time, and ensure equitable wages.

Well, as part of this presentation today, I'm excited to introduce a new version of this game: Sim City 'Psychology edition,' and invite you to play one round with me today:





Rather than creating societal conditions that cultivate prosperity and well-being in your citizenry, the focus of this game is to plan and create a new culture and atmosphere that will effectively incubate painful social/emotional problems at a widespread level.

For stage one, 'Incubating Depression,' here are your specific instructions: 'Brainstorm with a partner societal patterns or conditions that you would create to cultivate the widespread propagation of depression in your culture:

- ✓ What would you manufacture for this population to eat and drink?
- ✓ What messages would you convey to them?

- ✓ What kind of entertainment would you provide for them?
- ✓ What would their pace of life be?
- ✓ What kind of relationships and sense of community would you orchestrate?

Audience members raised a number of suggestions: "I would make sure that people don't exercise, and don't even get outside very often"; "I would feed my population lots of processed food and sugar, and convince them that fruits and vegetables are boring." After gathering many insights from the audience, I posed 5 conditions I came up with as my 'ideal plan' for cultivating depression on a societal level. These 'incubation ingredients' included:



#1: Promote an insane pace of life. Ensure widespread, pathological levels of busyness.

#2: Ensure widespread family/community fragmentation. Dilute, degrade or distract close connections between people on a widespread, societal-level.



#3: Work towards a pervasive, relentless media presence. Consume as many Americans as possible with a constant preoccupation with electronic media--especially in their own homes.

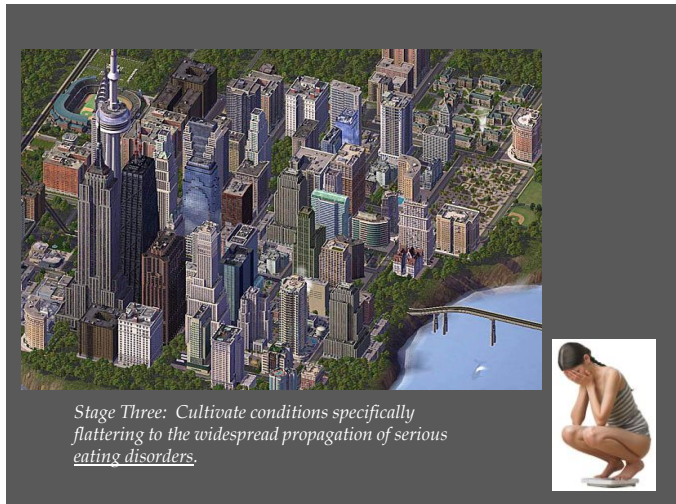
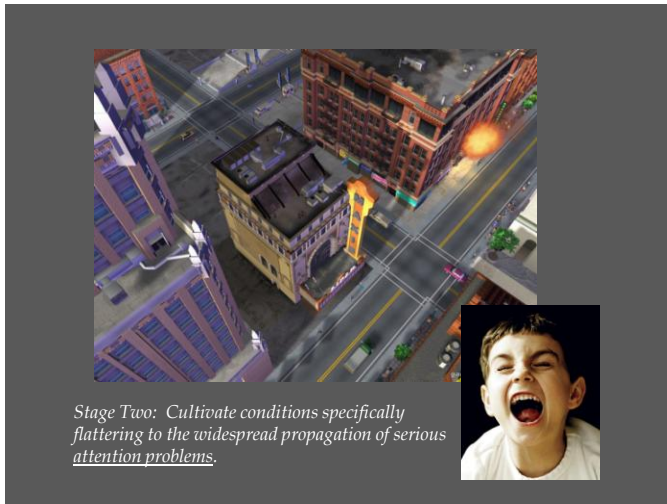
#4: Aggressively promote misinformation about the body. Teach people that their body/brain does not and cannot fundamentally change.

#5: Ignore alternative (eastern) notions of thought and emotion. Allow people to believe that all thoughts/feelings reflect something about themselves or reality itself.

Taken together, these conditions reflect my own version of a morbid 'master plan' for a culture that effectively predisposes a large number of inhabitants towards depression. [The full illustrations and statistics from this original slide presentation are available on the Utah Youth Village website, listed under *Parenting Resources* and *Societal contributors to depression* <http://www.utahparenting.org/resources.php>.⁵

⁵ Of course, we can reverse the exercise and ask, "How can we help individuals and families create combat depressogenic patterns and cultivate protective habits, lifestyles and atmospheres in a culture or home?" Beginning in Part II, a number of these conditions are explored in relation to their potential for helping people recover from serious emotional problems.

After this activity was done, I gave homework assignments for session participants play the next two rounds of the game, brainstorming conditions flattering to the widespread propagation of serious attention problems and eating disorders respectively:



It goes without saying, of course, that this exercise is far more than a hypothetical game about an imaginary world. The research evidence for societal-level contributors to emotional and behavioral problems has mushroomed in recent years (Morrissey, 2000; Bowers, 2000; Horwitz, 2003; Cockerham, 2005), after being emphasized within a few professional circles for many years. For instance, the original Teaching Family Handbook used by youth programs across the nation is emphatic about the primary role of the surrounding environment in the development of social and emotional problems that increasingly plague youth (Phillips, Phillips, Fixsen & Wolf, 1974).

We see then, an alternative way of thinking about serious emotional problems that takes more seriously the role of societal contributors in creating, perpetuating and maintaining the conditions. If it is true that cultural conditions are playing an increasing role in the literal ‘incubation’ of these problems, what then would be the concrete, practical implications for individuals facing such problems?

Implications for treatment and identity: Portrayal #2. One of the first consequences of this mindset relates to how individuals come to see themselves. Compared with emphasizing oneself as deficient and disordered, an emphasis on societal disorder naturally allows individuals to perhaps be a little kinder with themselves.

Indeed, given the intensity of surrounding conditions, it is becoming less and less ‘abnormal’ to struggle seriously with one’s emotions or thoughts. This is confirmed by statistical, epidemiological studies cited earlier that document a rise in prevalence and incidence across essentially all severe emotional problems. As Kabat-Zinn (2005) notes, for instance, “from [one] perspective, all Americans have some kind of attention deficit problem.”

If serious mental and emotional wrestles are less unusual than typically emphasized, afflicted individuals may thus come to see themselves differently. By recognizing cultural pathologies and deficiencies more seriously, individuals may potentially take the conditions less ‘personally’ and instead see other things about themselves.

Indeed, this shift in mindset may better highlight the strength, courage and capacity of these individuals. Writing to patients who are experiencing chronic pain of some sort, Jon Kabat-Zinn, Director of the University of

Massachusetts Medical Center Stress Reduction Clinic (1993) shares this reminder: “There is more right with you, than there is wrong, as long as you are breathing.”

This point can be made even more strongly. Several indicators suggest that individuals most vulnerable to experiencing serious emotional struggles are not necessarily those with inherent emotional deficiencies at all. For instance, in-depth qualitative and clinical eating disorder research confirms that it is often the especially high-achieving girls with unusual emotional depth who are *most vulnerable* to anorexia/bulimia (Maisel, Epston & Borden, 2004). Likewise, there is increasing realization that problems with depressive or anxious mood and cognition are only possible when there *already exists* a pre-requisite richness of affect, sensitivity or intellect relative to the rest of the population. Simply put, Homer Simpson never gets depressed...he’s incapable of it!



From this perspective, if youth or adults were duller, denser or more shallow, they might well hurt much less than they do!

From such a vantage point, the formal language used to characterize and describe the emotional problem itself might also shift. Instead of personally identifying with depression, bipolar or ADHD as something individuals ‘are,’ professionals and families might consider speaking about these as conditions as problems they are currently ‘facing’ or ‘fighting,’ (similar to ‘facing cancer’ or ‘fighting the flu’).

Like the previous mindset, this alternative view of emotional problems also brings with it particular implications for treatment. Most basically, an emphasis on surrounding conditions naturally leads families and practitioners to consider more sophisticated efforts to (a) change these same external conditions and/or (b) change how individuals relate to these surrounding conditions.



On the first point, the metaphor here is a fish-bowl. If a goldfish in the home aquarium were looking sick, should you treat the fish, or clean up the water? While the answer seems obvious for the distressed goldfish, this certainly has not been the case for those trying to help distressed humans.

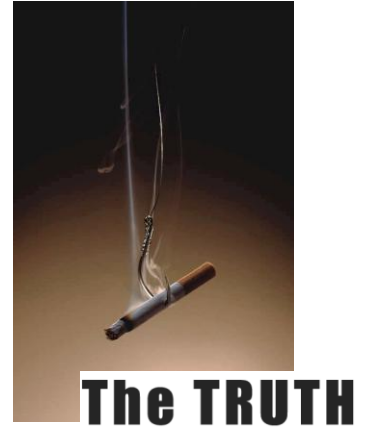
The impulse for anyone helping someone facing a problem like depression is, more often than not--for some of the reasons outlined earlier--to focus inwardly on correcting and adjusting personal dynamics of the mind, heart and body.

With some notable exceptions, of course, conventional medical systems have shown a similar emphasis on intervening to change internal problems associated with physical disorders. Public health, of course, has been applying a different mindset for over 150 years, to dramatic effect. Indeed, social historians point out that whenever a disease or illness has been eradicated from human communities it was systematic changes to public health--far more than primary care interventions--that made the difference (Rosen, Fee, Morman, 1993).

In light of this, what are the ‘public health’ style interventions that might make a more systematic difference for combating depression, anxiety and the like?



While the emotional/social equivalent of hand-washing campaigns, food sanitization and vaccination programs are few in number, those that exist are heartening—with recent years seeing an increasing number of creative moves in that direction. After the success of the “Truth campaign” to fight smoking (www.thetruth.com), for instance, similarly well-designed campaigns to invite more extensive critical thinking about social/emotional issues have also been developed.



Perhaps the best illustration comes in the educational campaigns to address prevailing body-image messages in the media. In 2004, Dove launched a highly acclaimed “Campaign for Real Beauty” described as “a global effort . . . intended to serve as a starting point for societal change and act as a catalyst for widening the definition and discussion of beauty.” This stated aim of this initiative is “making women feel more beautiful every day by challenging today’s stereotypical view of beauty and inspiring women to take great care of themselves” (see www.campaignforrealbeauty.com, and two powerful videos, “Beauty Pressure” and “Evolution” also available on Youtube).



In some cases, policy changes have accompanied the education. For example, some locations have recently begun banning underweight individuals from modeling competitions and venues:

The world's first ban on overly thin models at a top-level fashion show in Madrid has . . . raised the prospect of restrictions at other venues. Madrid's fashion week has turned away underweight models after protests that girls and young women were trying to copy their rail-thin looks and developing eating disorders. . . . Organizers say they want to project an image of beauty and health, rather than a waif-like, or heroin chic look. . . . The mayor of Milan, Italy, told an Italian newspaper . . . she would seek a similar ban for her city's show unless it could find a solution to "sick" looking models (CNN, 2006).

Cultural risk-factors associated with other emotional problems have been targeted by other educational initiatives. For instance, after sporadic efforts in previous history (e.g., Cheraskin, Ringsdorf & Brecher, 1974), the number of campaigns to educate people on the emotional impact of nutrition and exercise has expanded dramatically (e.g., Logan, 2006; Schmidt & Bland, 2006; Null, 2008; Leyse-Wallace, 2008; see Chapter 3). And in the wake of alarming trends of relationship fragmentation documented over the last 30 years (Putnam, 2000), others have proposed community-level efforts to re-prioritize family relationships and guard healthy neighborhood and home life more vigilantly. Dr. Bill Doherty, professor of Family Science at the University of Minnesota, for instance, has

been spearheading a multi-partisan, non-sectarian effort to “help parents reclaim family time” across the nation (Doherty & Carlson, 2002; see www.puttingfamilyfirst.org and Chapter 6 for elaboration).

Can such population-level interventions make a real difference? When the “Truth campaign” began in 1997 as a small state initiative in Florida, few could have imagined the rippling outcomes it would ultimately spawn across the nation (Siegel 2002; Niederdeppe, Farrelly & Haviland, 2004). Likewise, few could have imagined the dramatic implications of public health efforts when they were first conceptualized and developed. Where successful, these interventions ended up changing individuals’ relationships with destructive elements in the surrounding environment in a way that ‘inoculated’ or ‘vaccinated’ them against its influence. By the same principle, campaigns addressing the diverse range of social and emotional pathogens in the surrounding environment, may conceivably ‘inoculate’ individuals psychologically against problems that could and would otherwise overwhelm their emotional defenses.

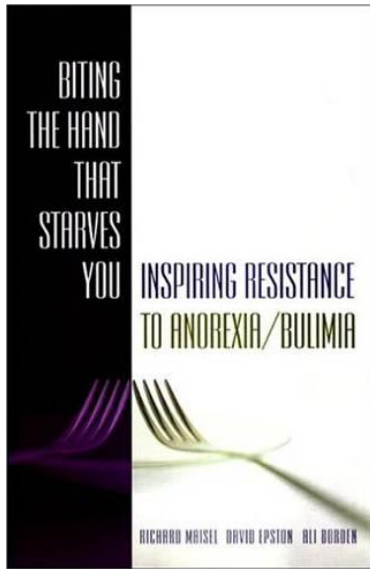
While the potential of such developments is real, especially in the long-term, it is worth asking how realistic is it to expect meaningful culture-wide changes to occur anytime soon? As a rule, change at this level seems to happen slowly and not always with immediate relevance to day-to-day circumstances of one’s own life and family. Furthermore, as noted above, although the potential of community-wide interventions are exciting, attention to such an approach, both financially and research-wise, is scarce. Health budgets of developed nations typically allocate only a very small percentage towards prevention initiatives and, by and large, there are many reasons to believe that many negative aspects of our consumer-driven, media saturated culture are here to stay for the time being.

For all these reasons, it becomes wise to direct educational efforts beyond merely a culture-wide, population level. Without losing hope in large-scale campaigns in schools or via mass media, more immediate impacts may be seen through other efforts a little closer to home.

Within one’s own circle of influence, whether that be as a therapist, parent or friend, are individuals looking for help now—individuals who can’t necessarily wait for a national campaign to take foot. For these persons, efforts to help them learn to individually relate differently to the surrounding culture can be powerful and transformative. In Chapter 4, for instance, we examine way of helping individuals learn to respond to signs of returning depression or anxiety itself when they do come. Rather than ‘change the storm,’ as the saying goes, this kind of effort aims to help people learn how to protect themselves and even ‘ride the waves’ when necessary—what Kabat-Zinn (2005a) calls “full-catastrophe living.”

To conclude this chapter, we mention a few additional examples of this kind of initiative. To encourage people to re-think their chosen pace of life in a speedy U.S. culture, there is a campaign to invite individuals to participate in a “slow movement” (Honore, 2004), with others calling families to resist the impulse to over-schedule their lives (Doherty & Carlson, 2002). A related “silence” movement (Prochnik, 2010) invites citizens to opt out of living in the random “noise” of the culture, while seeking to cultivate more contemplative time as a mental health intervention (Williams, Teasdale, Segal & Kabat-Zinn, 2007). And returning to the body image initiatives above, it would be more accurate to say that rather than attempting to change the media environment writ large, these educational efforts aim to educate individuals and parents in how to better respond to the more dominant media as ‘critical consumers’ of its messages.

Elaborating this issue of body image and eating problems, one innovative eating disorder treatment center in San Francisco has launched a broader effort to help girls resist anorexia and bulimia by turning them against the cultural “voice of eating disorders.” Accompanying their treatment book (Maisel, Epston & Borden, 2004), they maintain an



online “archive of anti-anorexia/anti-bulimia resistance” that includes many accounts attempting to “surface” and publically “unmask” the destructive messages implicit in anorexia/bulimia in a way that decreases their power over girls. They write, “This site is our effort to resource and disseminate hope so that you might reclaim the freedoms that you have been deprived of by anorexia/bulimia” (see: www.narrativeapproaches.com).

While larger-scale changes continue to evolve, individuals and families can thus proactively work *now* to create their own ‘micro-culture’ that promotes emotional and physical health and counteracts the effects of the larger culture. If families cannot change the whole world (right away), at least they can create a healthy atmosphere for those closest to them.

In summary, this chapter has begun to examine one primary dimension of the fundamental nature of emotional problems: where they originate. In particular, a case for more serious attention to the role of societal-level elements in the

development (and alleviation) of emotional problems has been made.

As reiterated earlier, any serious discussion of origin needs to account for how exactly these societal forces interact with physiological elements. In the next chapter, we take a closer look at this question.

Chapter 2: 'Now, how exactly are these problems biological?'

Reviewing the changing views on the relationship between emotional problems and the body

*"My definition of depression is that little glitch in my brain that's not producing the chemical that lets me be happy and content."
--45 year-old survivor of depression*

In understanding the nature and origin of severe emotional problems, dynamics both internal and external to individuals are clearly important. The previous chapter considered the extent to which societal, cultural contributors may be 'predisposing' problems like depression, eating disorders and ADHD. In this section, we turn to more internal predisposing factors that play an especially fascinating role in emotional problems: physiological functioning. In recent years, perhaps no area of psychology or science proper has generated as many sheer studies, as much controversy and as significant a series of discoveries as has research into human biology. From surprising insights in neuroscience, to paradigm shifts in genetics, the findings and views emerging from biological research over the last three decades are exciting and consequential.

One reason that this area is crucial is its implication for the relationship between personal agency, responsibility and emotional problems. A common experience for those facing severe emotional problems is hearing friends and family encourage you to "just choose to feel better." For years, my sister had people coming to her in the middle of her eating disorder and saying, in essence, "Just eat! . . . take care of your body!" One interview participant said:

Before I had my first depression, I believed that depression was a bunch of crap, you know, "pull yourself up by the boot straps, quit feeling sorry for yourself, go into a damn cancer ward for kids and you'll see something to be depressed about," you know, "what the *hell* do you have to be depressed about?" (12)

It goes without saying that when such a portrayal is manifest in someone's family, the actual burden of depression may be heightened as individuals feel unsupported, harshly judged and misunderstood. One young woman said, "It's hard for family and friends to understand that you are really, really, *really* not doing this intentionally" (16). As reflected earlier, friends and family are not the only ones that have a hard time understanding the limitations of emotional problems:

- I would always say to myself 'I'm a smart guy, why can't I control this?' You know, 'I'm an intelligent person'-- I have good morals and I take care of myself; 'why can't I handle this? I should be able to handle this!' . . . That's part of the reason that the depression hit me so hard (10).
- I just lay there feeling terrible about myself and wondering, 'What is my problem?' You know, 'why can't I just make myself shape up and do something?' . . . I got to the point where I'd just have to get angry with myself. It was the only way to get something accomplished (16).

Among other questions, this issue of individual agency makes the recent findings of neuroscience and genetics especially intriguing. In addition to providing confirmation of the real constraints of severe emotional problems, newer findings also offer an interesting provide an interesting explanation for how these constraints can change over time (see below).

While these findings have crucial implications for treatment and practice, what is perhaps most remarkable is how *little* this newer series of findings are actually known and discussed among the broader public. While *genetic predispositions* and *chemical imbalances* have become household terms, updated information on *epigenetics* and *neuroplasticity* remains largely removed from the consciousness of both practitioners and families facing severe emotional problems. The purpose of this chapter is to review several of the recent, key discoveries in psycho-

biological research and to consider what these findings mean for how best to intervene in alleviating emotional problems.

‘To be or not to be biological’: Is that the question? Accompanying the attention to sociological factors in the previous chapter was careful attention to the language and interpretations used to frame emotional problems. Similarly, in the context of biology, one of the problems that prevents greater public awareness of these newer findings is a prevailing discourse that arguably minimizes such distinctions. Among both practitioners and the lay public, discussion often centers on an underlying question taken for granted as crucial: *whether or not* certain emotional problems like depression or ADHD are ‘biological.’ Within this frame, conversants are forced into two mutually exclusive camps: ‘it is biological’ or ‘it is not biological’—i.e., ‘nature’ vs. ‘nurture.’

At a recent psychology conference, a prestigious neuroscientist reviewed multiple brain scans of youth who face challenges with attentiveness. At the conclusion of his slides, this researcher shared his ‘bottom line’ conclusion: “In summation, these findings reiterate the fact that ADHD is biological.” That was the message. As therapists and social workers left the presentation, it seemed clear they would relate the ‘news’ to patients: ‘guess what, you are facing something that is biological!’

The reality, of course, is that any human experience is biological in *some way*. Everything we do, we do in a body--be that eating dinner, driving a car, or sleeping at night--they all involve biological processes—from appetites and hormones, to chemical levels and neural pathways. In light of this, arguing that an emotional problem ‘is biological’ seems somewhat underwhelming in its significance.

More to the point, however, is that by remaining fixed on the question of *whether* a condition is biological, we inadvertently obscure and minimize fascinating distinctions emerging from a second question: *how exactly* are these different experiences biological? Inquiry and examination into *how* precisely conditions like depression, eating disorders or ADHD are associated with physiological conditions point towards some of the more exciting recent discoveries in modern psychological science.

Biological portrayal #1: Static and fixed physiological contributors. As recently as fifteen years ago, the prevailing view of physiological contributors to emotional problems was that the body and brain were largely static and unchanging. From genetic influences to particular chemical levels in the brain, human physiology was assumed to be fairly set and constant. This notion was galvanized in psychology’s history by early neuroanatomy researchers, including this conclusion in Cajal’s influential 1913 treatise: “In adult centres the nerve paths are something fixed, ended, immutable. Everything may die, nothing may be regenerated” (as cited in Schwartz & Begley, 2002, p. 130).

It was general knowledge, of course, that meaningful neurological changes occurred during the development of children and adolescents. The assumption, however, was that as individuals matured into their adult years, their brains became ‘set’ and fixed in ways that were fairly stable for the rest of one’s life. Summarizing this history, researchers Schwartz and Begley (2002) recount, “for decades, a key tenet of neuroscience held that although the organization and wiring of the infant brain are molded by its environment, the functional organization and structure of the adult brain are immutable” (p. 14).

Until recently, for instance, genes were framed as a kind of ‘blueprint’ that direct the unfolding of life in a fairly unilateral way (Marcus, 2004). ‘Chemical imbalances’ were also typically understood to be fairly permanent conditions that, without external intervention, would remain largely constant throughout life (Lacasse & Leo, 2005).

Among other things, this historical view of biological underpinnings for emotional problems has reinforced the widespread use of the classic ‘categorical’ diagnostic system that assigns discrete, fixed labels of disorders to those facing problems (Widiger & Sampson, 2005; Widiger & Trull, 2007).

A fixed view of biology is reflected in the opening quote, reflecting one woman’s answer to the question, “how do you define depression?” She responded, “Hmmm . . . it’s that little glitch in my brain that’s not producing the chemical that lets me be happy and content. I mean that’s at least the way I look at it now” (5).

Implications of a static, fixed portrayal. As in the previous chapter, our exploration of different ways of thinking here goes beyond a mere philosophical exercise, to an examination of the practical consequences associated with different mindsets. Specifically, we consider here what a static view of the brain mean for multiple aspects of an individual’s experience of emotional problems. These include the role of personal action and agency, societal forces and treatment in the context of neural rigidity.

1. Personal action and the fixed brain. The most obvious implication if this particular view of the brain and body is an understandable de-emphasis of personal agency or choice relative to either the problem’s development, or its resolution. This kind of empathy, of course, can be a welcome relief, in many cases, and even support a healing atmosphere of acceptance (see Chapters 4-5). Where a community accepts real limitations and constraints, victims may feel supported, understood and judged fairly.

When taken to an extreme, however, this view of agency can lead to some problems. One woman spoke of her brother trying to help her realize that depression “didn’t have anything to do” with her efforts and that recovery didn’t rely on her making any changes. Another woman spoke of her previous attempts to do anything to resist the onset of depression as woefully naïve. A third expressed gratitude for realizing that “there was nothing I could have done to keep me from getting depression . . . I mean, it’s not like if you don’t smoke you won’t get lung cancer, you know? I mean, it’s not that kind of a thing; you can’t say, ‘well it’s because I ate the wrong thing or, you know. . . it couldn’t be helped.’”

In their discourse analysis of newspaper representations of mental illness, Bilic and Georgaca (2007) document one of the characteristics of the prevailing discourse of treatment being “people with mental health problems as passive sufferers of their condition” (p. 167). From this particular view of agency and the brain, individuals may see themselves as having little potential of meaningfully impacting the going or coming of emotional problems, except in relation to treatment compliance itself (Valenstein, 1998).

2. Society and the fixed brain. From this vantage point, societal forces also have little, logical bearing on the biology. Although their role is acknowledged as one of the many ‘factors’ at play, their relevance is distinctly secondary. Indeed, from this perspective, environmental conditions are understood to be something of a ‘trigger’ to activate or aggravate underlying physiological deficiencies (in turn, causing a negative mood). After describing his conviction about genetics as the root of depression, one interview participant said, “I don’t think that’s the whole deal as far as what causes it though. . . certain events take place in one’s life that, you know, kind of make those weaknesses express themselves” (9). This is a good example of how many people speak of environmental factors, including professional use of the “diathesis-stress” model of illness development (Zuckerman, 1999).

3. Treatment and the fixed brain. Laying aside questions of agency, a second set of implications of this particular view of biology are particular views of treatment—i.e., what works to alleviate emotional problems and what doesn’t. To wit, for one who assumes such problems involve fairly permanent physiological deficiencies, it makes sense that

a generally permanent need for treatment would also ensue. Speaking of her depression, for instance, another woman emphasized, “it’s a *chemical* imbalance--it’s not gonna go away with...you know; I can’t--I’m not one of those that could take medication for a couple of years and then be good for five years. It’s...I’m stuck” (8).

The prospects of recovery associated with this particular viewpoint can be fairly disheartening. Said one mother: She’s schizoaffective bipolar; the prognosis is that there is no cure—that she needs to learn to live with it the best she can. I’m expecting her to regress. . . . Her brain is wired in a way that her mental illness will be a monkey on her back the rest of her life. It is unlikely she will ever be able to hold down a real job (64m).

As evident in this quote, a fixed view of biology naturally diminishes hope in the possibility of meaningful future recovery. Indeed, an emphasis on permanent physiological deficits can just as naturally reinforce a belief that medical treatments are a life-long necessity. One woman who had been taking medications for many years emphasized during her interview:

I’m a firm believer in medication because I don’t think, I mean, I think therapy is good, but it doesn’t help if you’re not calmed down, it doesn’t, I mean . . . *you can’t talk it out; it’s chemical!* Talking it out or going for a jog isn’t going to help the chemical imbalance that’s going on. . . . I just, like I said, I don’t . . . you can’t get better without medication. You can talk and talk and talk but you can’t get better without . . . if your chemicals are messed up! (7)

With similar conviction, one mother asserted, “The only way to manage a condition such as our daughter’s . . . it *has to be* the blend of the right medication and the therapeutic side . . . when not stable with the illness, her thinking patterns were completely off” (49m).

Psychotropic medications are seen here as correcting fundamental, inherent limitations in the body—i.e., ‘like insulin for diabetes.’ While biological limitations are clearly present, it is important to note the emphasis in these quotations that other interventions (alone) *cannot* impact physiological problems—i.e., ‘you can’t talk it out, it’s chemical!’⁶

This conclusion, of course, follows from the original view of the problem. As long as semi-permanent biological impairments are seen as underlying emotional or mental pain, it is not entirely clear why activities and interventions *not directly addressing* this biological deficiency would make much of a difference at all. With the exception of complying with medical treatment, this mindset suggests that emotional struggles unfold largely independent of personal action and behavior. From this vantage point, basic teaching and learning—whether in a clinical context or in the home—is understandably seen as less relevant to those facing serious emotional problems. Two mothers, for instance, emphasized that their daughter’s biological challenges prevented them from gaining much from teaching:

- Our daughter can parrot back what is said, but can she figure things out on her own? No . . . Because of the auditory processing problem, she is not able to process what she is being told; her brain scrambles it (120m).
- If you have a child with impaired functioning due to . . . brain problems, she cannot hear and process and understand. Yet we use only verbal/cognitive behavioral things to help her? (112mf)

As reviewed in the following section, the range of possible brain impairments clearly needs to be taken seriously as a constraining factor in treatment. For purposes here, however, we simply note the pattern wherein a problem associated with the brain or body is assumed to have little to do with personal actions or interactions with others.

⁶ In this, as in other medication mentions later in the text, questions are raised less about the overall use of psychotropics, as about the exact scope and details of their role. Since medication has proven a helpful, short-term relief for many, the text is clearly not ‘anti-medication.’

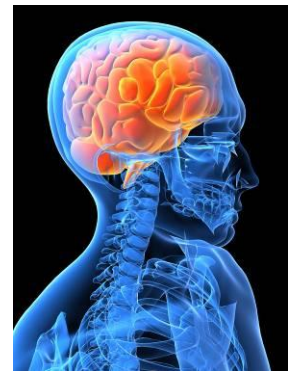
As mentioned earlier, a focus on medical interventions as the primary way to correct internal dysfunction flows naturally from this view of the problem. For some families, this belief can be so deeply rooted that when medications cease to have an effect, they assume that the next viable option is something with a greater direct impact on the body, such as vagus nerve stimulation or electroconvulsive therapy (ECT).

In light of the foregoing, it is important to emphasize that this view above is only *one way of thinking* about the biological underpinnings of emotional challenges. Whether or not it remains the best way of framing the evidence has been called into question by a series of recent research findings in neuroscience and genetics.

Biological portrayal #2: Fluid and dynamic physiological contributors. Over the last ten years, neuroscientists have been surprised to discover and document the degree to which the *mature, adult brain* continues to change over time, a phenomena known as *neuroplasticity* (Arbib & Amari, 2003). ‘Plastic’ here refers to the general malleability of brain networks, with neuroplasticity thus referring to “the ability of neurons to forge new connections, to blaze new paths through the cortex, even to assume new roles . . . [signifying a] rewiring of the brain” (Schwartz & Begley, 2002, p. 15). It was Canadian psychologist Donald Hebb who first proposed in 1949 that “learning and memory are based on the strengthening of synapses that occurs when pre- and postsynaptic neurons are simultaneously active”—a hypothesis subsequently known by the maxim, “cells that fire together, wire together” (Schwartz & Begley, p. 107).

When individuals learn a language, for instance, subsequent studies have confirmed that neural networks grow (Osterhout et al., 2008); when individuals participate in cognitive-behavioral therapy, their neural networks change (Goldapple, et al., 2004); when they begin a meditation practice, their neural networks also change (Lutz, Brefczynski-Lewis, Johnstone & Davidson, 2008). The same thing occurs for negative events. For instance, when children are abused, their neural networks can be harmed (Teicher et al., 2003). Schwartz and Begley (2002) continue, “Plasticity is induced by changes in the amount of sensory stimulation reaching the brain. Neuroplasticity can result not only in one region of the brain colonizing another . . . but also in the wholesale remodeling of neural networks” (p. 16). As Marcus (2004) states, “Nature bestows upon us a considerably complex brain, but one that is best seen as *prewired*—flexible and subject to change—rather than *hardwired*, fixed and immutable” (p. 12). He later continues:

The brain is capable of . . . impressive feats of experience-driven reorganization. . . . The structure of the brain is exquisitely sensitive to experience. Nature has been very clever indeed, endowing us with machinery not only so fantastic that it can organize itself but also so supple that it can refine and retune itself every day of our lives (pp. 45, 148).



Steve Yantis, a professor of brain sciences at Johns Hopkins University states, “The bottom line is, the brain is wired to adapt There’s no question that rewiring goes on all the time” (Connelly, 2010).

In the wake of this discovery, research teams have examined the role of ongoing neural network evolution in changing vulnerability to emotional problems over time. These include theories for how shifting neural networks are involved in clinical depression (Siegle, 1999; Ottowitz, Tondo, Dougherty, & Savage, 2002), general fear and anxiety (Stein, & Ludik, 1998; Hariri, Bookheimer, & Mazziotta, 2000), obsessive-compulsive disorder (Ludik & Stein, 1998), attention problems (Berger, & Posner, 2000; Rueda, et

al., 2004; Posnera, Sheesea, Odludaša, & Tangb, 2006) and delusional/schizophrenic issues (Chen, & Berrios, 1998; Vinogradov, Poole & Willis-Shore, 1998). Taken as a whole, these studies raise intriguing possibilities for the development of innovative approaches to both treating and assessing these conditions.

One research teams noted that, “A neural network approach to major depressive disorders . . . has ramifications for application of the medical disease model to psychiatric disorders,” suggesting specifically, that “a correlation of clinical criteria with demonstrable neural network dysfunction . . . is a missing link” in the adequate assessment of these conditions (Ottowitz, Tondo, Dougherty, & Savage, 2002, 94-95). Among other things, this way of thinking about the brain is consistent with efforts to adopt a more dimensional approach to assessment that better aligns with the possibility of ongoing change (Widiger & Sampson, 2005; Compton, 2007; Widiger & Trull, 2007).

In some cases, of course, brain conditions can clearly be more permanent than others. One mother, for instance, spoke of impaired functioning in her daughter due to prenatal exposure to alcohol (112mf). Speaking of her daughter’s struggles, another mother said, “She’s been in treatment for a long time and she’s been told for years, ‘you can control this, you can control this—you can control your anxiety, you can control your being out of control.’ But when you get so emotionally upset that your limbic system takes your frontal lobe hostage, you’re not able to access that capacity!” (196m). In the case of someone completely overcome in a moment by depression or panic attacks or eating disorders, it is true that he/she cannot simply *choose in the moment* to suddenly not be vulnerable or to suddenly halt the experience of painful feelings. For these individuals, the brain has perhaps arrived to a point where neural networks have little resistance and intense vulnerability. Like a bad e-mail filter or a broken down door that lets intruders in, emotional and neural defenses against one of these emotions sweeping over the brain have been worn down to almost nothing.

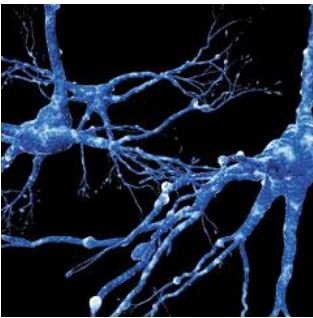
While the boundaries of neuroplasticity continue to be explored, some lines of research, however, confirm striking optimism for physiological impairments previously seen as fairly permanent. For instance, research in treatment for traumatic brain injury has confirmed heartening results from rehabilitation programs directed at restoring brain function (Wall, Xu & Wang, 2002). This consequently confirms an optimism of other possibilities still unknown, as Schwartz and Begley (2002) suggest, “The discovery that neuroplasticity can be induced in people who have suffered a stroke demonstrate[s], more than any other finding, the clinical power of a brain that can rewire itself” (p. 16).

It is not just the brain that is more dynamic than previously thought. Two decades ago, everyone was taught in junior high science class that genes were a ‘blueprint’ that predisposed certain characteristics/behaviors like a design map. While the general public still often talks this way, genetic researchers do not. Additional discoveries have confirmed what is called *epigenetics*—the finding that genes frequently manifest *differently* depending on individual lifestyles and actions—pointing to what Nobel Prize winner Barbara McClintock calls the “fluid genome.” The idea that psychological environments can affect gene activity has been discussed among neuroscientists for two decades (e.g., Meany, 1998). Over this time, the growing empirical evidence has been heartening. For instance, a recent study of men with prostate cancer supported by the National Academy of Sciences, showed that a diet high in fruits, vegetables and whole grains, combined with moderate exercise and meditation, not only decreased weight and improved blood pressure, but actually *changed the expression* of 500 genes: turning 48 preventive genes ‘on’ and 453 cancer-promoting genes ‘off’ (Ornish, 1995/2008). In summary, Marcus (2004) notes “just as a group of well-trained musicians can play a traditional piece or improvise a new one, suites of genes can play their standard tune or develop a new variation on a theme, as circumstances require” (p. 148).



In light of these findings, rather than consider childhood years as a restricted development time, the provocative idea is raised that physiological development in the brain and other areas of the body spans a lifetime. Jeffrey Schwartz, M.D., a research professor of psychiatry at the UCLA school of Medicine quoted above, became famous for developing a cognitive treatment for debilitating obsessive-compulsive disorder (OCD) that was surprisingly effective (Schwartz, 1997). By measuring brain patterns before and after the OCD treatment, Schwartz became one of the first to demonstrate that psychotherapy alone can change the brain. In a recent book in collaboration with Sharon Begley a science columnist from Newsweek, he summarizes the history of some of these discoveries:

A mere twenty years ago neuroscientists thought that the brain was structurally immutable by early childhood, and that its functions and abilities were programmed by genes. We now know that that is not so. To the contrary: the brain's ensembles of neurons change over time, forming new connections that become stronger with use, and letting unused synapses weaken until they are able to carry signals no better than a frayed string between two tin cans in the old game of telephone. The neurons that pack our brain at the moment of birth continue to weave themselves into circuits throughout our lives . . . as mutable as a map of congressional districts in the hands of gerrymanderers (Schwartz & Begley, 2002, p. 366).



Elsewhere, they write, “Contrary to the notion that the brain has fully matured by the age of eight or twelve . . . it turns out the brain is an ongoing construction site . . . Even the adult brain is surprisingly plastic . . . [with the] ability not only to repair damaged regions, but also to grow new neurons” (pp. 128, 130).

In the case of severe emotional problems like OCD, bipolar and depression, this changing view of the underlying biology may alter considerably how we understand their origin. For instance, increasing numbers of neuroscientists are questioning whether chemical imbalances are the permanent deficits they have been assumed to be (see Valenstein, 1998; Lacasse & Leo, 2005). And in the wake of initial evidence for brain plasticity, Dr. Gregory Miller, past president of the Society for Psychophysiological Research, wrote to colleagues:

Rather than attributing mood changes to activity in specific brain regions, why not attribute changes in brain activity to changes in mood? In light of EEG or behavioral data on regional brain activity in depression, are people depressed because of low activity in left frontal areas of the brain, or do they have low activity in these areas because they are depressed? (Miller & Keller, 2000, p. 214).

Further insight regarding the interaction between experience and the brain is one of the intriguing implications of these discoveries. In a recent study of “the neural network basis” for major depression published in the *Harvard Review of Psychiatry*, one research team examined the joint interaction of genes and experience in “building networks” associated with a vulnerability to depression (Ottowitz, Tondo, Dougherty, & Savage, 2002). After reviewing details of the interactive process contributing to maladjusted brain networks, these authors suggest that “a neural network model for behavior . . . has produced a paradigm shift for modern psychiatry,” wherein “psychiatric symptoms are now partly conceptualized as dysfunctions of networks and circuits that mediate particular behaviors” (p. 86).

Society and the malleable brain. Perhaps no area of research illustrates the dramatic implications of this new prominence of brain networks, than the literature on excessive media exposure and the brain. It goes without saying, perhaps, that the intensity of media exposure has skyrocketed in recent decades. According to one researcher, there is three times as much information is available to citizens in 2008, as compared with 1960, with another study documenting computer users at the office changing windows or checking e-mail 37 times an hour (Connelly, 2010). Referring to the “nonstop interactivity” in our current media environment, Adam Gazzaley,

neuroscientist at the University of California, San Francisco, suggests that the societal shift in this direction over the last several decades “is one of the most significant shifts ever in the human environment. . . . We are exposing our brains to an environment and asking them to do things we weren’t necessarily intended to do. We know already there are consequences” (as cited in Connely, 2010).

It is in this interface between sociological and neuroscientific research that we begin to see why scientists are calling this a “paradigm shift” for the treatment of emotional problems. In recent articles, two science reporters summarized the initial evidence: “The cellular structure of the human brain, scientists have discovered, adapts readily to the tools we use, including those for finding, storing and sharing information. By changing our habits of mind, each new technology strengthens certain neural pathways and weakens others.” Specific to the increasing frequency of ‘multi-tasking between multiple media sources (e.g., Ipods, radios, and multiple computer windows, etc.), he noted “The cellular alterations continue to shape the way we think even when we’re not using the technology.” Michael Merzenich, professor emeritus at the University of California in San Francisco, and a pioneer in neuroscience, was then quoted as suggesting that our brains are being “massively remodeled [by our] ever-intensifying use of the Web and related media” (Carr, 2010). About the same unprecedented technological exposure, Nora Volkow, director of the National Institute of Drug Abuse and another of the world’s leading brain scientists, has similarly warned, “The technology is rewiring our brains”—comparing the increasing amounts of digital stimulation to habits towards “food and sex, which are essential but counterproductive in excess” (Connelly, 2010).

If it is true that the brain can be substantially shaped by the surrounding environment and culture, this is certainly not bad news entirely—or even mostly. For practitioners that emphasize the role of teaching and family relationships, for instance, findings of an evolving brain and fluid genes offer much more than a warning about the potential impact of surrounding risk factors. Indeed, taken as whole, they become sweet confirmation of an oft-embattled belief that change is *possible*, even when seeming to be extremely difficult. Within a prevailing treatment culture often centered on symptom management, the implications of these findings can be both startling and refreshing. When my sister first learned about neural-plasticity, she responded, “Wow--that means I can *do* something.”

Implications of a fluid, dynamic portrayal. If the first portrayal of a fixed, static biology has such tangible implications for views of treatment and recovery, what are the practical consequences of this second, more fluid portrayal that appears to be emerging from recent studies? In this section, we extend prior examinations to consider further what these findings mean for behavioral and psychological issues. These include explorations of personal action, societal forces and treatment in the context of neural malleability.

1. Personal action and the malleable brain. For one, as reflected above, this view naturally prompts greater optimism about personal effort and actions not necessarily ‘directly’ addressing biological conditions. Stated more accurately, an appreciation of biological fluidity may potentially revise some long-held views of a very limited range treatments being effective—indeed, hinting that activities such as meditation, therapy, and academic learning, which have been shown to directly impact brain pathways (Osterhout et al., 2008; Goldapple, et al., 2004; Lutz, et al., 2008) may, in turn, also impact the emotional challenges associated with these brain networks. In the context of depression, it was Hollon’s research (1995) that first illustrated that “negative life events may alter biological factors that increase risk for depression” (p. 214, Miller & Keller, 2000). According to this data, life experiences can therefore shape the body in ways that subsequently shape future experiences. The first time a girl binges and purges, for example, her body reacts negatively to this unusual behavior. But as she turns to this coping mechanism again and again, gradually her body begins to attune and adjust to this behavior, until it can ultimately reinforce that very impulse to binge again. Other addictions towards drug use or risky sexual behavior may reflect similar progressions of an evolving

physiological ‘pull.’ Depending on choices made and the resulting direction of these changes, individual brains may thus become more or less vulnerable to particular emotional problems over time.

To make this pattern more concrete, we may first consider illustrations of this same process in day-to-day experiences with exercise and nutrition. For individuals who consistently eat a highly processed diet, for instance, their bodies may literally come to acclimate to that kind of food. In his experiment of eating only McDonald’s for one entire month, Morgan Spurlock (*Super Size Me*, 2004) eventually came to crave the same food that initially made him sick. Rather than uncovering a ‘genetic predisposition’ for McDonald’s, Spurlock’s experience surely reflects another case of appetite evolving in the direction of his choices. In the context of food, of course, the opposite can also be true, as individuals come to develop a taste and craving for whole-grain and raw foods previously seen as mundane and boring.



A second example involves a common experience for anyone who has been ‘out of shape.’ For those who have been in this common place, on the first day getting back into exercise, it is as if the body screams out ‘no!!’ Although the activity will ultimately ‘do a body good,’ at least initially, the physiology doesn’t seem to be happy—accustomed, as it has been, to the sedentary life. Alternatively, for someone involved in running and other sports, the craving for activity and a full breath of air in one’s lungs is a common sensation. Once again, the body can change one direction or another, depending on our moment-by-moment actions.

As seen here, one advantage of neuroplasticity is the way it explains the *real and legitimate constraints* of emotional problems, alongside the possibility of these same *constraints changing over time*. Rather than seeing personal agency and individual choice as ‘present or not,’ from this vantage point will-power and responsibility are more like a continuum, with a capacity that can rise and fall/ebb and flow *over time* depending on our actions *now* (see Williams, 1992; Abbey, 2004).

Among other things, this connection between personal choices and our own evolving physiological development, means that both the development and alleviation of severe emotional problems may involve rich meaning and lessons potentially available to be gained. Indeed, some practitioners suggest that different emotional problems be interpreted as a personal message, a veritable ‘warning system’ going off in the body, indicating to the afflicted individual areas of possible changes needed to alleviate the depression, anxiety, etc. (see Elias, et al., 2000).

2. *Society and the malleable brain, part II.* All this becomes further explanation as to why cultural elements reviewed in the previous chapter may do more than simply impinge on individuals or ‘trigger’ internal dysfunction. These findings suggest that societal forces can actually mold and shape physiological processes over time as individuals respond to these broader cultural prompts. A destructive home atmosphere, for instance, could literally shape brain pathways in a way that predisposes youth, in turn, to seek out particularly destructive behavior such as substance abuse.

From this vantage point, the culture itself comes to have a much larger role in shaping the brain, for better or worse. Going beyond their impact on the brain, we now return to more brain/media research to illustrate further the apparent rippling impact of brain changes on psychological and behavioral patterns. This is especially evident in research with children and adolescents. One article continues, “Researchers worry that constant digital stimulation like this creates attention problems for children with brains that are still developing, who already struggle to set

priorities and resist impulses”—illustrated by the story of a boy named Connor, whose troubles started late last year:

He could not focus on homework. No wonder, perhaps. On his bedroom desk sit two monitors, one with his music collection, one with Facebook and Reddit, a social site with news links that he and his father love. His iPhone availed him to relentless texting with his girlfriend. When he studied, “a little voice would be saying, ‘Look up’ at the computer, and I’d look up,” Connor said. “Normally, I’d say I want to only read for a few minutes, but I’d search every corner of Reddit and then check Facebook” (Connelly, 2010).

In a recent review of the literature, one author writes:

Today, the Internet grants us easy access to unprecedented amounts of information. But a growing body of scientific evidence suggests that the Net, with its constant distractions and interruptions, is also turning us into scattered and superficial thinkers. The picture emerging from the research is deeply troubling, at least to anyone who values the depth, rather than just the velocity, of human thought. People who read text studded with links, the studies show, comprehend less than those who read traditional linear text. People who watch busy multimedia presentations remember less than those who take in information in a more sedate and focused manner. People who are continually distracted by emails, alerts and other messages understand less than those who are able to concentrate. And people who juggle many tasks are less creative and less productive than those who do one thing at a time.

He continues:

The common thread in these disabilities is the division of attention. The richness of our thoughts, our memories and even our personalities hinges on our ability to focus the mind and sustain concentration. Only when we pay deep attention to a new piece of information are we able to associate it “meaningfully and systematically with knowledge already well established in memory,” writes the Nobel Prize-winning neuroscientist Eric Kandel. Such associations are essential to mastering complex concepts. When we’re constantly distracted and interrupted, as we tend to be online, our brains are unable to forge the strong and expansive neural connections that give depth and distinctiveness to our thinking. We become mere signal-processing units, quickly shepherding disjointed bits of information into and then out of short-term memory (Carr, 2010).

It was Dr. Scott Peck (1978/2003), in *The Road Less Traveled*, one of the most widely read psychology books of all time, who first suggested that a steady diet of rapidly shifting images on TV over a long period can lead to “emotional fragmentation” over time. Dr. Merzenich, cited earlier, spoke about being “profoundly worried about the cognitive consequences of the constant distractions and interruptions the Internet bombards us with.” The article continues, “The Web never encourages us to slow down. It keeps us in a state of perpetual mental locomotion. . . . The long-term effect on the quality of our intellectual lives, he said, could be “deadly.” What we seem to be sacrificing in all our surfing and searching is our capacity to engage in the quieter, attentive modes of thought that underpin contemplation, reflection and introspection” (Carr, 2010).

If the brain can be so dramatically shaped by the kind of media we use, the good news is that there are many kinds of media available. In fact, other evidence suggests that reading and contemplative activity such as meditation does exactly the reverse, helping brains become tighter and more coherent in a kind of ‘defragging’ of our neural hardware. Carr continues:

It is revealing and distressing to compare the cognitive effects of the Internet with those of an earlier information technology, the printed book. Whereas the Internet scatters our attention, the book focuses it. Unlike the screen, the page promotes contemplativeness. Reading a long sequence of pages helps us develop a rare kind of mental discipline. . . . We have to forge or strengthen the neural links needed to counter our

instinctive distractedness, thereby gaining greater control over our attention and our mind. It is this control, this mental discipline, that we are at risk of losing as we spend ever more time scanning and skimming online. If the slow progression of words across printed pages dampened our craving to be inundated by mental stimulation, the Internet indulges it . . . presenting us with far more distractions than our ancestors ever had to contend with (see Chapter 4 for further details on the neural impact of contemplative activity).

It is not hard to see how these findings on various kinds of media and the brain relate to emotional problems. As with a physical diet, choices in our ‘mental diet’ can theoretically have substantial implications over time for our vulnerability to emotional problems. On the other hand, as maladaptive pathways are allowed to atrophy and individuals exercise new neural pathways, significant levels of recovery may be possible (see Rosenzweig & Bennett, 1996). Both of these points are illustrated by research findings in two areas, in particular: new interventions that can support individuals in developing their attention spans over time and more details on how OCD may be alleviated.

3. *Treatment and the malleable brain.* A second vivid illustration of the consequence of neuroplasticity comes from studies on how to teach individuals to shift their attentiveness. In recent years, mounting evidence suggests a strong connection between continual and excessive media exposure and the fragmentation of attention over time (Carr, 2010; Connelly, 2010). In a study by University of Oregon neuroscientists entitled, “Analyzing and shaping human attentional networks,” researchers summarize their findings regarding “the developmental progression of executive attention”:

The relation of genetic factors to the functioning of the executive attention system does not mean that the system cannot be influenced by experience. Several training-oriented programs have been successful in improving attention in patients suffering from different pathologies. For example, the use of Attention Process Training (APT) has led to specific improvements in executive attention in patients with specific brain injury (Sohlberg, McLaughlin, Pavese, Heidrich, & Posner, 2000) as well as in children with Attention Deficit Hyperactivity Disorder (ADHD) (Kerns, Ezzo & Thompson, 1999). Work with ADHD children has also shown that working memory training can improve attention (Klingberg, Forssberg & Westerberg, 2002; Olesen, Westerberg, & Klingberg, 2004) [References are included in citation list at the end of the book].

They went on to describe their own five-day training intervention with computer exercises “to examine the role of experience on the executive attention network” for youth, which produced measurable neurological shifts (Rueda, Fan, et al., 2004) (p. 1426).

As a second example, in his research with severe obsessive-compulsive disorder mentioned earlier, Dr. Schwartz documented that as patients focused attention away from negative behaviors and toward positive ones, they were able to make permanent changes to their own neural pathways. Reflecting on these outcomes, he concludes:

Our physical brain alone does not shape our destiny. How can it, when the experiences we undergo, the choices we make, and the acts we undertake inscribe a diary on the living matter of our cortex? The brain continually refines its processing capacities to meet the challenges we present it, increasing the communicative power of neurons and circuits that respond to oft-received inputs or that are tapped for habitual outputs.

Here, we circle back to exploring further insights on ‘personal action and the brain.’ Citing “the brain’s astonishing power to learn and unlearn, to adapt and change, to carry with it the inscriptions of our experiences,” Schwartz and Begley suggest, “It is the life we lead that creates the brain we have.” More specifically, they explain, “The life we lead, in other words, leaves its mark in the form of enduring changes in the complex circuitry of the brain—footprints of the experiences we have and the actions we have taken. This is neuroplasticity” (Schwartz & Begley,

2002, pp. 366, 373). In a recent New York Times bestseller on the “female brain,” Dr. Louann Brizendine (2006) similarly summarizes the impact of plasticity on brain science:

If we acknowledge that our biology is influenced by other factors, including our sex hormones and their flux, we can prevent it from creating a fixed reality by which we are ruled. The brain is nothing if not a talented learning machine. Nothing is completely fixed. Biology powerfully affects but does not lock in our reality. We can alter that reality and use our intelligence and determination both to celebrate and, when necessary, to change the effects of [other factors] on brain structure, behavior, reality, creativity—and destiny (pp. 6-7).

As evident above, the new findings on the changeability of the body confirms a profound optimism at what may be possible. This includes a view of biology equally shaped by personal agency:

- You’re not gonna be able to let yourself get sleep deprived your whole life . . . you can’t. You’ve gotta kinda watch this and not think that you can go without sleep just because it feels like you could . . . (*laughs*) you can’t do that to your brain for years on end. You can’t not feed yourself. . . . You’ve got to take care of your body because your body takes care of your brain (2).
- If I go without sleep and start partying a lot and get over extended and stressed, yea, I’ll hit depression. . . I know I could bring myself another depression-- I know the recipe for madness. . . . I lose my sleep; I drink too much. . . . I get involved in too many things: that’s the recipe for madness for me (12).

If the brain can change, then actions in a large range of areas may shift one’s biological vulnerability over time. Like other physiological patterns, of course, well-worn neural networks cannot simply be “zapped” like tumors with chemotherapy—nor do these findings imply a solution of simply “choosing to be happy.” Yet this portrayal does appear to open up greater optimism about recovery—and correspond to growing evidence for a range of more gentle interventions that appear to have a surprisingly significant impact on emotional problems. From nutritional adjustments, to exercise, to meditation and other contemplative moments, the variety of choice-points that can directly and indirectly impact upon depression and other challenges is exciting (see Chapters 3 & 4 for details). This approach also reinforces a variety of other interesting ways of attempting direct changes to brain patterns being pioneered, from neurofeedback (Hammond, 2005) and mindfulness training (Williams, Teasdale, Segal & Kabat-Zinn, 2007), to a unique form of therapy that prompts neurological shifts called Neurolinguistic Programming (NLP) (Andreas & Faulkner, 1994).

As individuals come to appreciate the range of potential actions that may alleviate a given emotional problem, there is a natural lessening of dependence on any one treatment. In particular, the aforementioned reliance on medication as the exclusive way of altering one’s biological conditions is no longer logical. Dr. Miller, cited earlier, recently chided his fellow neuroscience researchers for “the assumption that dysfunctions conceptualized biologically require biological interventions,” elaborating as follows:

The best way to alter one system may be a direct intervention in another system. Even, for example, if the chemistry of catecholamines (chemicals used for communication to nerve, muscle and other cells) were the best place to intervene in schizophrenia, it does not follow that a direct biological intervention in that system would be optimal. A variety of experiences . . . may prompt the adrenal glands to flood [these areas] with catecholamines. There are psychological interventions associated with this chemistry that can work more effectively or with fewer side effects than interventions aimed directly at the chemistry (Miller & Keller, 2000, p. 214).

As illustrated here, findings about neuroplasticity alter the role that medication is seen to play in treatment. At a general level, since biological problems as serious as traumatic brain injuries are no longer seen as inevitably permanent, any treatment for the same (psychotherapy, nutritional therapy, pharmacotherapy) is likewise no longer

necessarily an indispensable life-long requirement. In each case, the needed treatment may come to be seen as more of a temporary support to assist the body in adjusting to the point when it no longer requires such formal assistance. And in some cases where medications were assumed to be the only option, this perspective may open up other possibilities. After commenting that medication was initially helpful in “working to bring me down,” one person added, “I think if I had been weaned off the benzodiazepine and put in a nurturing environment . . . it would have done the same thing” (12).

Among other things, insights such as these are helpful in confirming a more sensible and comprehensive way of thinking about the role of psychiatric medication in the treatment of youth facing serious emotional problems (Hess & Lacasse, in press).

The goal of this chapter has been to make sense of the enormous amounts of biological research associated with emotional problems, especially in its implications for practice. We specifically consider what recent groundbreaking findings mean for emotional treatment and prognosis associated with emotional problems. At this point, we turn to a closer examination of the interventions and ways of seeking relief for those facing emotional problems.

Part II. Making sense of the answers: 'What do we do?'

In Part I, we considered a number of issues involved in how emotional problems are understood, including their fundamental origin and nature. While these issues are important in their own right, it is their implications for actual interventions that make them especially meaningful. Depending on whether problems are seen as primarily caused by internal issues versus external conditions, for instance, has implications for what families attempt to do in response. And depending on whether biological conditions are seen as fixed and static, or malleable and dynamic, implies equally significant implications for what families seek in terms of solutions.

In Part II, we now turn full attention to the range of solutions available to those seeking help for a serious emotional problem. In addition to those helping individuals in a professional capacity, this discussion aims to support families and friends offering their own support to the distressed individual. In the context of families, the experience of a youth suffering with depression, anxiety, eating disorder and other emotional conflicts is obviously painful for more than just the child. In the context of eating disorders, Tierney (2005) reports a parent's grief witnessing a child "just deteriorating before our eyes" and their pain of uncertainty: "You sort of think, 'what on earth is going to happen next with this?'—[It's hard] not being able to plan anything" (p. 376).

In the emotional strain of such moments, great urgency to take *some kind* of action can be felt. In the face of her own depression, Sarah, cited earlier, described hurting "so bad" that she initially used illegal drugs and cutting to stop it—since there was "no other way to hurt less" (6). Similar desperation can be felt by family members. After sharing thoughts of suicide with his mother, one youth shared her reaction: "At that point my mom decided . . . 'We have *got* to do something about this. . . . We just *have* to do something.' And so she took me to a doctor" (9).



Separate from this kind of natural urgency is a second level of emotional strain that can develop when attempted solutions do not bring the desired relief. Some families may feel helpless in their efforts, perceiving "any attempt to help on their part as unproductive," as noted by parents who say, "I try to do what I think is right at the time but it always seems so wrong" and "Nothing we do or say makes a difference" (Whitney et al., 2005, p. 445). Speaking of her daughter's struggles, one mother said, "It was excruciating, because you do every damn thing you can try, and it doesn't work, and then you do something else" (18m). A second parent said, "We didn't know if treatment would work and whether we were making the right choices. At the end of the road, I remember not knowing if she was going to come out of it" (25m). Another mother recounted her own family's journey:

It was very exhausting for us; I was travelling every two weeks, going to therapists, visiting schools. . . . The most important thing I can say is that I never saw any improvements; nothing was helping—no matter how much money and time was poured into it. . . . A lot of people who worked in these facilities were wonderful people and wanted to help the kids, but there is only so much they can do. . . . But nothing we did worked or helped her . . . it just made her feel crazy and have identity issues (47m).

This mother went on to share a vivid metaphor to describe her feelings during this period:

I feel like I was trying so desperately to help our daughter and like everything I did was destructive. It was like you are sitting watching TV one night, and thinking, "I want to go get something to drink." So you get something in a glass bottle, but somehow drop it. When you bend down, you cut yourself and then lie on the

floor bleeding to death, when the only thing you wanted was to get was a drink. That's how it felt with my daughter. Things accelerated and one thing led to the next. It seemed like a nightmare (47m).

Aggravating the pain of the problem itself, then, is treatment frustration and dissatisfaction sometimes felt by individuals and their loved ones. It is against this backdrop that we turn to several key issues differentiating between diverging ways of intervening in severe emotional problems. These include:

3. The possibility of full recovery: Is it possible? What does it look like? (Chapter 3)
4. The possibility of relapse: Potential answers from Eastern philosophy? (Chapter 4)
5. The role of families, friends and community in healing: How can they best help? (Chapter 5)
6. The challenges to cultivating a healing environment: What barriers exist for families? (Chapter 6)

Chapter 3: 'Is there a getting better from this, or not?' Exploring the meaning and possibility of recovery

"You bring them home from the hospital, nurse them and dream that they will be successful . . . but then they come down with a mental illness that is there to stay life-long. Your hopes and dreams die away." —Mother of 16 year-old girl

Not knowing whether one's child will ever *fully recover* can be a heavy burden for parents to bear. As evident in the opening quote, when a family believes that no such recovery is possible, dreams and plans can dissipate. Sarah, quoted earlier about her feelings of being diagnosed, further acknowledged a mixture of relief and sorrow:

Two really conflicting emotions came up when I was diagnosed—one was 'God, thank you!' . . . you know, "I'm not insane—this is a real thing. It's in a book somewhere; we can start working on it." There was a relief that I wasn't alone, totally, anymore. . . . But then on the other hand, it was so defeating . . . I was like... 'this is something that's going to be with me for good. . . . It's not a cold that's just going to go away--this is me,' you know—and that's sad. You feel like you lose yourself, almost...like a part of you dies when you're diagnosed (6).



Prior to exploring a number of specific interventions for serious emotional problems, there is perhaps no more important question to examine than the nature of recovery itself: Is it possible? If so, what does it look like? On an issue as seemingly simple as this, the diversity of opinions and views is striking. In what follows, we first examine different positions on the possibility of full recovery from serious emotional problems, including potential consequences of

contrasting views for those facing such challenges. Next, we begin to examine evidence associated with the surprising range of options available for those seeking recovery. In conclusion, we consider two distinct views of what it means to 'recover' from this kind of a problem.

The possibility of full recovery: "Do people ever get totally better from this?" Across the range of serious emotional problems (depression, severe anxiety, eating disorders, ADHD, etc.), the first question considered here is whether recovery in its fullest sense is even possible. During dissertation interviews, each person was asked: "Do you ever talk about 'getting better' from depression?" Two responded:

- I don't think that's possible. I just . . . I *want to*, but I don't think that I...I think, just a couple years ago I just faced it that I'm just always gonna have to have something (8).
- Is there a getting better from this or not? I mean, they told me in the beginning there wasn't...[but] I'm hoping that I can make improvements that are permanent . . . I don't know how much better, you know (2).

The second participant was then asked, "Who told you that you don't get better?" She responded, "Well my initial diagnosis--they said this is something permanent. They told me, 'This isn't something that you'll ever not have'" (2).

A similar theme emerged in family interviews. One mother said, "With our daughter, we were told by professionals from a very young age, 'I don't know what's wrong; she will never be mainstream'" (18m). A therapist reported that girl had been told by her own father, "You are never going to recover." Several other parents shared similar prognoses:

- Susan is just a difficult case. . . . I don't know how solvable the problem really is (56f).

- I have come to believe that there are mental illnesses that are nearly impossible to treat (71m).
- I don't think there's going to be a time that she's going to be well. We're going to have to stay on it, stay on it, stay on it forever (135f).
- As with all these children who have issues that will cause them to be sent away, she will have issues all her life. . . . This is a lifelong battle for people with emotional issues. . . this girl has issues (154m).



For some, this view of the future emerges understandably from long, grinding years of struggle. When asked whether she thought recovery was possible, another individual said, “No, not really. I mean, I, uh. . . I just don't know. . . I've fought with it so long that I just don't know that that'll ever happen” (9).

For others, however, their doubt about recovery appears to be closely intertwined to their view of the brain. As quoted earlier, one mother said this about her daughter:

She's schizoaffective bipolar; the prognosis is that there is no cure—that she needs to learn to live with it the best she can. I'm expecting her to regress . . . Her brain is wired in a way that her mental illness will be a monkey on her back the rest of her life. It is unlikely she will ever be able to hold down a real job (64m).

As discussed in the previous chapter, once individuals see the brain (and other aspects of the body) as fixed and permanent, they obviously become more inclined to see overall possibilities of recovery more dimly.

Whatever its source, this particular view of recovery can have substantial consequences. Last year, I was invited to give a presentation about my graduate research on depression treatment at a local Kiwanis club. Afterwards, I was approached by a woman who told me, with emotion in her voice, about her friend in Arizona that had wrestled with bipolar depression for many years. This friend, a young married mother of several kids, had been seeking help from a psychiatrist, but had recently struggled with some of the side-effects she was experiencing. In a visit two months before with the doctor, she had shared these concerns with him about how the drug was affecting other areas of her life. In response, she was told, in essence, that the problem was something she would probably have to face the rest of her life—and something that would, consequently, require her to get used to the side-effects she was experiencing. Hearing this message was so disheartening to her that she went home, wrote a long note to her husband and kids and then shot herself.⁷

While few will likely take such extreme action, for anyone facing the fearful pain of severe emotional problems, the message that there is little or no hope for full recovery can nonetheless affix a real, added burden. Dr. Daniel Fisher, Ph.D., M.D., a board-certified psychiatrist, was told he couldn't recover after his own diagnosis with schizophrenia years earlier. He reflected:

This view that if one becomes mentally ill one will *always be sick* not only interferes with emotional recovery but also prevents one from identifying as a contributing member of society, . . . striving to return to work, or establishing long-term relationships, which are essential aspects of recovery (Fisher, 2010a).

After graduating from Princeton University, Fisher completed his Ph.D. in biochemistry at the University of Wisconsin and began work as a biomedical researcher at the National Institute of Mental Health. While there, at age 25, Fisher had a complete psychotic breakdown, including hallucinations and delusions. This led to involuntarily

⁷ It is unlikely, of course, that the psychiatrist interpreted this event beyond an especially tragic consequence of ravaging bipolar disorder. Like individuals and families themselves, professional helpers can be blinded to the power of their own narratives when shared with patients.

hospitalizations three times, with one three month inpatient stay that included forced seclusion and administration of the antipsychotic medication, Haloperidol. He was discharged with a diagnosis of schizophrenia.

After Fisher was released from treatment, his struggles with delusions eventually passed and he went on to finish his Ph.D. Following the trauma of treatment, he decided to go to medical school at George Washington University, followed by a psychiatric residency at Harvard Medical School. After completing his training, he worked as the director of a community mental health agency for several years before co-founding a new research organization in 1992. Since that time, the National Empowerment Center (NEC) has worked to conduct research and encourage public and professional education about the possibility of recovery. Based on the success of these early efforts, Fisher was appointed to the U.S. President's New Freedom Commission on Mental Health in 2003, where he played a major role in orienting the focus of the national system towards more recovery-oriented services. Because of Fisher's sizeable impact on the U.S. mental health discourse, his writings are cited extensively in what follows.

The 'recovery movement.' Fisher's story is reflective of a much larger movement that has occurred in recent decades. Beginning in the 1980s and 1990s, a loose coalition of professionals, researchers and former patients began advocating for greater public openness to the idea that recovery is possible. Describing this trend in a recent medical journal article, one doctor wrote, "The recovery movement in mental health is part of a larger social movement of empowerment and self-determination" and "embodies democratic principles of self-determination, as well as scientific issues concerning the possibility of recovery." A second doctor elaborated, "The recovery movement is rooted in the experience of consumers. They have heard professionals say that a diagnosis of schizophrenia is a lifelong sentence with no hope of recovery. Often, consumers are directed to choices . . . that many find demeaning and demoralizing. Mental health staff frequently interact with them on the basis of their deficits, not their strengths" (Mulligan, 2003, p. 10).

A 1999 report from the U.S. Surgeon General gave the following historical background for the recovery movement:
Until recently, some severe mental disorders were generally considered to be marked by lifelong deterioration. Schizophrenia, for instance, was seen by the mental health profession as having a uniformly downhill course. . . . Negative conceptions of severe mental illness,⁸ perpetuated in textbooks for decades . . . dampened consumers' and families' expectations, leaving them without hope (no page listed).

Of course, if it were true that research confirmed that recovery from severe emotional distress happened in only a small percentage of cases, then individuals and families would deserve to hear this so they can learn to cope with and manage the problem as best they can. But, as reviewed in detail earlier, current biological findings are suggesting otherwise.

In addition to these discoveries of neuroplasticity and epigenetics, major clinical research findings over the last 40 years have provided increasing cause for hope in the possibility of recovery. Continuing the Surgeon General's review, it notes: "Recovery developments were fueled by a number of long term outcome studies. . . . [This] research provided a scientific basis for and supported a more optimistic view of the possibility of recovering function." Interest was initially piqued by heartening early results from long-term, but small clinical studies of therapy outcomes for severe emotional problems (Bleuler, 1974), followed by confirmatory epidemiological

⁸ Although an image of "illness" can be helpful to convey both the real limitations and the organic aspects of these conditions, it is curious why such a term is so often seen as an indicator of permanent dysfunction. As touched upon in Chapter 1, in the realm of purely physical disease, for instance, we often speak of "illness" as something that comes and then passes. From colds to the flu, the assumption is that something can eventually pass given the right care. By contrast, "mental illness" more often than not continues to be seen as something largely permanent.

findings in Europe (Ciompi & Moller, 1976). At this point, the World Health Organization (WHO) set out to conduct systematic and large-scale studies examining how frequently individuals with severe emotional problems were recovering. Summarizing these studies, the Surgeon General report notes as follows:

Long-term outcome studies . . . uncover[ed] a more positive course for a significant number of patients with severe mental illness in populations from virtually every continent, including landmark cross national studies by the World Health Organization from the 1970s and 1990s, showing unexpectedly high rates of complete or partial recovery, with exact statistics varying by region and the criteria used (World Health Organization, 1979; Jablensky, Sartorius, Ernberg, et al., 1992).

Since surprising findings from the initial 1979 WHO study were received by many with skepticism, a second, ten-country study with better methodological design was subsequently undertaken ten years later. This study tracked patients diagnosed with schizophrenia over a period of five years. Once again, the researchers were surprised to find a majority of people diagnosed with this condition going on to achieve significant or complete degrees of recovery. Other studies, including a fourth epidemiological study in the U.S. (Harding, Brooks, Ashikaga, Strauss & Brier, 1987; Harding et al., 1992) and several, more recent, longitudinal studies in different locations (Fisher & Deegan, 1999; Harrow et al., 1997) have provided additional support for the idea that in the case of debilitating emotional problems like schizophrenia, higher percentages of people than previously expected go on to eventually recover.⁹

While the cumulative impact of this research was significant, The Surgeon General report went on to emphasize that it was the experiences of former patients themselves who had regained emotional well-being over time that provided the primary impetus for the movement (e.g., Deegan 1988/1997; Fisher, 2006). Looking toward the future, “Champions of recovery . . . envision services being structured to be recovery-oriented to ensure that recovery takes place. They envision mental health professionals believing in and supporting consumers in their quest to recover” (Office of the Surgeon General, 1999).

By multiple indicators, this vision appears to be gaining an early foothold. Some of the earlier shifts in practice happened abroad, particularly in countries linked to the United Kingdom. Since 1998, for instance, New Zealand has required all government mental health services to use a recovery approach, with associated professionals expected to demonstrate competence in the recovery model (O'Hagan, 2004). Other examples follow:

- Australia's recent “National Mental Health Plan 2003-2008 states that services should adopt a recovery orientation (Australian Government Department of Health and Aging, 2010).
- The Scottish Executive has included the promotion and support of recovery as one of its four key mental health aims and funded a new network to facilitate this (Scottish Recovery Network, 2009).
- The British National Health Service has similarly developed a new professional role of “Support Time and Recovery Worker” as part of its implementing a recovery approach in some regions (NHS website, 2010).
- Some parts of the Canadian Mental Health Association, including the Ontario region, have adopted recovery as a guiding principle for reforming and developing the mental health system (Canadian Mental Health Association, 2003).

⁹ Some might wonder, ‘our family isn’t facing schizophrenia . . . how is any of this relevant to us?’ Recovery researchers have historically targeted schizophrenia because it has been viewed as the most *severe* of emotional problem, with little hope of recovery. In recent years, other conditions believed to be linked to biological underpinnings like ADHD and bipolar disorder, have increasingly been described using similar language of life-long impairment. Accordingly, if studies continue to confirm that a majority of people with schizophrenia do, in fact, go on to achieve complete or significant degrees of recovery, it is not hard to imagine even higher rates for bipolar, ADHD, etc.

In the U.S., the White House's (2003) "New Freedom Commission" on Mental Health proposed the national mental health system shift away from traditional management services towards a restoration of functioning. That commission's report begins with this statement: "We envision a future when everyone with a mental illness will recover." Since then, some U.S. states, such as Wisconsin, Ohio, and California have taken steps to "redesign their mental health systems to stress recovery-model values like hope, healing, empowerment, social connectedness, human rights, and recovery-oriented services" (e.g., the California Mental Health Services Act) (Jacobson & Greenley, 2001). As noted in a non-profit policy paper recently, the recovery approach appears to be an "idea whose time has come" (Shepherd, Boardman & Slade, 2008).

Implications of a belief in recovery. This all becomes welcome news, of course, for those who have long endured the pain of a severe emotional problem, *and* a permanent prognosis. The impact of specific beliefs on treatment itself has been the subject of a great deal of research over recent years. Whether or not recovery is seen as a possibility has obvious implications in this regard. Indeed, whether or not individuals believe that recovery is possible may have substantial consequences for whether that recovery, in fact, occurs.

For instance, at a broad level, for instance, there is some historical evidence that rates of recovery in the U.S. improved during an earlier epochs such as the early to mid 19th century when a more optimistic view of mental health recovery existed (Borthwick et al., 2001). In an interesting study several decades ago, Harding and colleagues (1987) compared recovery rates between east coast states, and were surprised to find significantly higher rates in Vermont than in Maine. In a later report 32 years after the study started, these authors concluded that "the major difference between the two states was that Vermont had recovery and self-sufficiency as the goals of their mental health care system, while Maine's goals involved maintenance, stabilization, and medication compliance" (Desisto, Harding, McCormick, Ashikaga & Brooks, 1995, as cited in Fisher & Deegan, 2001, p. 27). Similar discrepancies in treatment outcomes between recovery rates in the U.S. and other countries have been explained as a function of the different 'narratives' of recovery in the different cultures. In foreign countries, those facing severe emotional distress are "popularly viewed as experiencing an acute spiritual problem and accordingly are expected to recover, like those who suffer from other acute disorders." And compared with industrialized nations, "In developing countries, the familial and community responses to people with mental illnesses encourage normalization and discourage the disabled role" (Waxler, 1979, as cited in Ahern & Fisher, 2001, p. 25).

On a more personal level, the idea that recovery is possible can be impactful for those who have lived for years without believing such an option was even plausible. Fisher notes (2010a) that "the belief that one can recover from mental illness is well established as an important aspect of the healing experience," noting from his own interviewing research with distressed individuals, "Over and over again, we heard, 'I needed someone to believe in me'" (Mulligan, 2001). As one former patient wrote, "Having some hope is crucial to recovery; none of us would strive if we believed it a futile effort" (Leete, 1989, p. 32). Another individual who had faced severe depression remarked, "The important thing is that I know that it won't last forever. Before, I had no hope. I couldn't see a light at the end of the tunnel" (3). Summarizing some of the NEC study findings, Dr. Fisher notes:

The most important finding in our research is that people who have shown significant or complete recovery from severe mental illness . . . have cited hope as an extraordinarily important component in their recovery. Part of the recovery was being around people who saw their condition as not permanent, a condition from which they could take increasing control of their life and reestablish a place in society (Medscape, 2005).

Several interview participants spoke fondly of the moment they first made the realization that they might be able to recover to a substantial degree. One woman who had faced both schizophrenic and depressive symptoms, spoke of participating in Mary Ellen Copeland's (1997) *Wellness Recovery Action Plan*, a recovery-oriented treatment program

during one of her many stays in a psychiatric hospital. In one of the sessions, she heard the story of a woman who had faced similar difficult circumstances:

Kate had been hospitalized in the late 50's out east in a state hospital. The family was told that there was no hope for her recovery that they should just go and forget about her. And after eight years Kate started to get well, and the staff realized that she was having conversations with little groups of people, getting together for conversation and that she'd help the staff with little things. And they realized that Kate was well enough to go home. Kate went home; she worked for 22 years as a school dietician in an inner-city type school. She helped her son raise 7 children as a single parent and was never hospitalized again.

This woman continued, "This was the first seed of hope. . . . I thought, 'if Kate could get well after 8 years maybe I could get well after 2 or 3'. . . . I remember a conversation with the psychiatrist out there saying 'I have faith the size of a mustard seed to begin rebuilding my life and if you can work with that little, I will try living one more time.'" After recounting gradually successful efforts to regain the capacity to take care of herself, this woman spoke of a second turning point involving a unique recovery seminar that had a unique impact: "This particular video is finally what counteracted 'you'll never live independently again.' It was that first conclusive evidence that people really do recover...there really is something beyond 'you can never live independently'" (13).

Another participant spoke of discovering the National Empowerment Center's website, directed by Daniel Fisher:

The site is all about, um, is all about recovery, that recovery *is real*. . . . You know, once someone is diagnosed they say 'it's a lifetime illness. *Lifetime*. Never get better.' Well, Daniel Fisher says 'No, uh uh, you *can* get better and you can *stay better*.' Um, and there's wonderful articles on there by different people who have recovered twenty years, thirty years, what they did. . . . That site was really *encouraging*. . . because until I got to that site, all you heard was drilled into people 'Lifetime, Lifetime, it's a lifetime illness, you're forever going to need meds, you've got to stay on your meds...' Um, there's no hope there...for recovery (12).

The first woman reiterated the impact of surrounding messages that real recovery was not possible. "There's a lot of people that don't understand that you can recover. . . . This doctor told my family that I would never be able to live independently again. . . . Even though I have made progress over the last 4 or 5 years, there's still *always* that seed of doubt that was planted, you know 'can I really take care of myself?'... That's a *long time* to have one remark [influence things]. But it was said by the doctor, so it had so much *power* and so much influence" (13).

Skepticism about the possibility of recovery. In spite of the research findings noted above, an overall narrative of permanence has remained for many, perhaps most families and professionals dealing with serious emotional problems in the U.S. Fisher himself laments, "Even though the weight of personal testimony and epidemiological studies argues that most people are able to regain a productive role in society and recover from mental illness, most people in this country still believe that when a person has been labeled with mental illness they can never fully recover" suggesting that "they are more comfortable thinking that those of us who have displayed severe emotional distress are qualitatively different than they are, that somehow we have a genetically-based brain disorder that they don't have." More than simply a public perception, Fisher notes "even most rehabilitation professionals believe that mental illness is a permanent condition," adding, "The mental health field, in particular, persists in a belief that mental illness is a permanent condition" (Fisher & Ahern, 2010).

As evident above, it remains a painful irony that sometimes the very individuals designated to help distressed individuals and families are the ones sending the message that these problems will be 'life-long.' A personal friend who struggled with depression was told by her doctor, "This will be something you face the rest of your life." A neighbor's son who wrestled with some delusional problems was told by his therapist, "This will be something you

struggle with the rest of your life.” In situations like these, individuals and families come away from professional encounters with a version of literal “learned helplessness” (Peterson, Maier, & Seligman, 1995).

To be fair, professionals who are conveying these kinds of prognoses are not intending to communicate a hopeless message. While not believing a complete recovery is possible, the message is that there is still hope because of treatment that can manage symptoms; as reviewed later in the chapter, this vision is often presented as a kind of recovery itself. In addition, many of these professional stories occurred prior to the dramatic paradigm shift in neuroscience and genetics reviewed earlier. In light of these findings, however, there seems to be little excuse for sending this kind of message to patients any longer. As education about biological discoveries spreads, perhaps pessimism among professionals may give way to warranted hope in, at least, the *possibility* of full recovery.

‘So is there anything else we can do?’ Discovering a smorgasbord of options in the research literature. If research continues to bear out the truth of these recovery possibilities, it begs the question of how exactly individuals should go about seeking such an outcome? As indicated in Chapter 1, wide-ranging reviews of the research literature have confirmed multiple areas of ‘risk factors’ for severe emotional problems. From depression and anxiety, to eating disorders and ADHD, a comprehensive look at these studies confirms a remarkable ‘smorgasbord’ of potential ways to alleviate these serious problems.

As mentioned earlier, Utah Youth Village is currently reviewing the research literature on a) anything that had been shown to cause serious emotional problems and b) anything that had been shown to alleviate these problems in order to identify key areas of risk, as the basis for future family classes. After Dr. Nedley (2005) completed a similar review across hundreds of studies, he identified 10 different areas of risk or vulnerability to depression, ranging from genetic and developmental contributors, to nutritional, exercise and toxicity, to environmental things that are being shown to impact our frontal lobe functioning over time. From this review, Nedley hypothesized that multiple interlocking risk factors lead to depression, with no single factor enough to cause the problem alone. Information from these categories was subsequently distilled into the development of an 8 week class on depression recovery that brings together anything that the research literature has confirmed can potentially contribute to an eventual reduction in vulnerability and risk. With an intended audience of both individuals facing depression and their loved ones, this course is becoming available across the nation, with courses starting here in Utah recently.

I had the opportunity to personally teach a version of this course twice over recent years to nearly 50 individuals; these included those who had faced depression in the past, as well as husbands, wives, siblings and friends. The course begins with a general assessment across the 10 categories, in which participants self-identify different areas of vulnerability. To illustrate, there is increasing evidence that nutritional deficits in the average American diet may contribute to and even predispose the development of severe emotional problems (Logan, 2006; Schmidt & Bland, 2006; Lakhan & Viereira, 2008; Null, 2008; Leyse-Wallace, 2008). These kinds of findings may not be surprising to those familiar with the average



American diet. My wife Monique Moore, who studies nutrition and wellness, recently participated in a collaborative statistical review of the top 500 foods most commonly bought in U.S. grocery stores. Any guesses? The top 10 most popular grocery store ‘foods’ in the U.S. include the following:

1. Coke Classic
2. Diet Coke
3. Pepsi
4. Dr. Pepper
5. Mountain Dew
6. Diet Pepsi
7. Sprite
8. Philadelphia cream cheese
9. Potato chips (Lays)
10. Oreo cookies (Nabisco)

Moving beyond nutrition, other risk-factor topics include exposure to certain toxins in the environment, amount of sunlight, amount/quality of sleep, contemplative quiet time and the amount/ type of exercise. Various aspects of relationship quality and activities that impact the cognitive/neural habits of the brain are also reviewed.



The class, once again, emphasizes that for most individuals, there are likely many things they can do to help alleviate depression and reduce their vulnerability to it over time. Rather than raising any single area as the miracle answer or “panacea,” the focus becomes offering a comprehensive array of options to individuals and families, out of which they can craft the response that works best for them. Furthermore, instead of naively promising a quick recovery or immediate relief, the program involves the tough work of changes in habits and lifestyle, with results emerging over a number of months.

Although preliminary results of these courses have been exciting, rigorous evaluation research is still needed. Beginning this summer, I will be collaborating on a formal evaluation of depression recovery courses in Utah to assess the long-term impact of these depression courses years later. In the meantime, Nedley’s own preliminary outcomes justify some tentative optimism. Of the individuals taking his class and applying its comprehensive approach to date, 80-90% of them are reported to be finding substantial relief from the depression, with many finding the problem dissipate for good. Compared to the 8 or 9 total risk factors that most people begin the course identifying, Nedley found that depression is most likely to pass when risk factors are reduced down to 3 or 4 total. Parallel to this example, other researchers have taken a similar, comprehensive approach to developing educational materials for those facing depression (O’Connor, 1997; Yapko, 1998; Addis & Martell, 2004; Gordon, 2008), with comparable examples emerging other conditions as well (e.g., Logan, 2006; Schmidt & Bland, 2006; Null, 2008; Leyse-Wallace, 2008; Greenspan & Greenspan, 2009).

While the idea of multiple ways of causing and alleviating a problem like depression may sound obvious, a surprising number of class participants had heard little about the range of legitimate options available to them. Most interview participants likewise spoke of their emotional problem as primarily linked to one major cause, with correspondingly limited options for relieving it.

The idea that other non-professional interventions can make a substantial impact for those facing emotional problems can be almost confusing to some. At a recent Chicago conference on ADHD interventions, one psychiatric researcher was reviewing some recent data confirming troubling side-effects with medications designed to address attention problems. At the close of his talk, this man was asked by an audience member, “but if not medication, what can we offer kids facing ADHD?” Somewhat perplexed, the researcher turned to the individual and said, “*All of life!* Getting outside more, enjoying the sun and fresh air in nature, better nutrition, loving relationships... all aspects of life could potentially make a difference in helping a child’s attentiveness shift!”

For individuals accustomed to focusing on one kind of intervention, realizing the scope of options can be refreshing in itself. After my own first session of the depression recovery course, a woman who had faced this problem for 15 years came up to me and said with excitement, “I have 9 different areas of vulnerability according to the survey!” For years she had believed that her emotional well-being was primarily reliant on one or two things, especially getting her dosage level “just right.” To learn that there were multiple areas of risk and multiple areas of action was stimulating, to say the least. Knowing that she could *do something*...and that based on these actions, it was likely that her vulnerability could change over time, prompted a new level of personal effort and hope.

It is one thing, of course, to raise expectations of recovery out of naïve optimism, and quite another to base such messages on legitimate, rigorous evidence. After completing our own extensive reviews of the research literature, Utah Youth Village will be collaborating with other professionals (counselors, nutritionists, doctors) to create courses on ADHD, severe anxiety and eating disorders for our youth and parents. In addition to offering these to families and professionals in Utah, we plan to also make them available online. In order to document the true course impact, every individual or family participating in a class will complete a pre-assessment and a follow-up evaluation 6 and 12 months later.

What does it mean to ‘get better’ anyway? Definitions of ‘recovery.’ While the recovery possibilities implicit in current research findings are intriguing, details of what this recovery looks like are not clear. It is one thing to believe someone can recover; it is quite another to specify what precisely that looks like. In the last half of this chapter, we turn to the actual nature of recovery: “What are we talking about when we say ‘recovery’?”

As noted earlier, substantial confusion has existed on this issue over recent decades. In the Surgeon General report (1999), for instance, they state “Recovery is variously called a process, an outlook, a vision, a guiding principle. There is neither a single agreed-upon definition of recovery nor a single way to measure it.” In response to the call by the White House New Freedom Commission for Mental Health for more “recovery-oriented services,” a group of top researchers involved in the project noted:

It is not entirely clear what the term “recovery” means in this context or what precisely is to be entailed in transforming America’s mental health system to promote it. This lack of clarity is likely related to a deeper ambiguity about what the term recovery means as applied to mental illness. Recovery, which has been used with various connotations for the past two decades, has been the object of debate among advocates, providers, family members, and other stakeholders. The only thing about which these diverse groups appear to agree at present is that the term can be confusing and, at times, even contradictory (Davidson, O’Connell, Tondora, Styron, & Kangas, 2006, p. 640).

Interview studies including my own, confirm a range of thoughts on this issue as well, from an emphasis on managing the depression and being able to function, to an emphasis on feeling joy again in life (see also Ridge & Ziebland, 2006). If nothing else is clear, it can be said conclusively that there are *fundamentally different ways of thinking about recovery*. Among the diversity of views, at least two general portrayals are evident:

One view of recovery: ‘There is hope because there is treatment.’ Perhaps the most common way of thinking about recovery is what Fisher (2006) calls a ‘rehabilitation’ portrayal of recovery. This view refers to “a recovery of function despite still having the permanent impairment of mental illness.” Illustrating this view is the following definition from a recent national study on recovery indicators:

Recovery is an ongoing, dynamic, interactional process that occurs between a person’s strengths, vulnerabilities, resources, and the environment. It involves a personal journey of actively self-managing a psychiatric disorder while reclaiming, gaining, and maintaining a positive sense of self, roles, and life beyond the mental health system, in spite of the challenges of psychiatric disability (Mulligan, 2003, p. 10).

Also called a ‘disability model’ of recovery, this view asserts that with sufficient support, individuals with emotional problems “can regain some social functioning, despite having symptoms, limitations, medication, and remaining mentally ill.” The metaphor here is a catastrophic injury, where individuals have a permanent impairment, but can return to a good quality of life with adequate support and assistance: “According to this view, people can have mental illness in the same way people can have a severed spinal cord

resulting in paralysis. According to the disability perspective, people are always recovering from their mental illnesses” (Ahern & Fisher, 2001, p. 6).

Alongside day-to-day functioning, the basic goals of this approach are to help individuals ‘cope with’ and ‘manage’ their ongoing challenge. In a text on “psychiatric rehabilitation,” the concept of recovery thus refers to “managing symptoms, reducing psychosocial disability, and improving role performance” (Pratt, Gill, Barrett, Hull & Roberts, 2002). This includes interventions for what has been called ‘illness management’ to continually monitor and address troubling symptoms that arise. Said one professional, “Like people who have had an amputation, those with a serious mental illness learn tricks about how to cope with their particular disability” (Mulligan, 2003, p. 10). Consistent with this view, several participants saw recovery as essentially a matter of regaining basic functioning in life.

In this way, families are encouraged to accept that ‘the problem will always be there . . . *but* you can learn to cope and live again.’ While the active challenge of the problem may subside for a time, the expectation is not that it will never go away for good. Implicit in this recovery perspective is coming to accept a new view of one’s identity—even a “reconstruction of a sense of self” (Davidson & Strauss, 1992)—e.g., Sarah’s quote, “we had to reinvent and restructure this new being, almost” (6). From this vantage point, those facing this problem are considered to be somewhat defined by the presence of the problem (e.g., ‘individuals with mental disabilities’) and their need for treatment (‘consumers’) (U.S. Dept of Health and Human Services and SAMHSA, 2004).

Once a problem is viewed as fairly permanent, it is understandable the interventions and treatment become trusted as a similarly permanent fixture of one’s life—i.e., “we had to restructure this new being . . . giving her the tools and the revenues, making sure she had insurance all the time, you know?” (6). Although this approach aims to restore real functioning, that does not typically imply a functioning and well-being independent of ongoing treatment (Deegan, 1997). For some, the resulting dependence can be intense:

- My doctor said . . . that I could live a fairly normal life if I could stick with my medications and stay on them . . . [he said] “you’re so far ahead, you can live a fairly normal life with the medications available.” (2)
- I’m permanently going to have depression and I’ll be on meds my whole life and . . . it took a mind change for me to finally get to where I could say ‘I’m grateful that I was born in this day and age where I could get the medication that I need so that I wouldn’t be locked up in the attic somewhere, or indisposed all the time.’ (7)

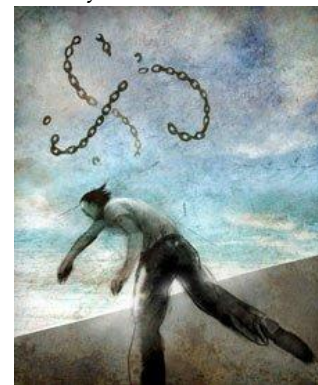
In conjunction with portrayals discussed in Chapters 1 & 2, this way of thinking reinforces a belief that medication is a long-term necessity to cope, rather than a short-term support. One girl said, “I’ve had lots of doctors tell me, ‘you will need to be on these meds the rest of your life’” (2d). Several interviews reflected similarly long durations of medical treatment for youth:

- I’ve been on medications since 4th grade (7d).
- She has been on psychotropic meds since she was 2 years old (121staff).
- She has been with professional therapists and psychiatrists since 1st grade (95m).

A second view of recovery: ‘There is hope because the problem itself can change.’ In contrast to the rehabilitation/disability view above is a second portrayal. In addition to a return of functioning, this view aims at “regaining membership in society and regaining a sense of being a whole-person.” Fisher (2006) calls this an ‘empowerment’ view of recovery, suggesting that individuals with severe emotional problems can recover in a deep and genuine way, wherein “the person has regained a meaningful role in society, can cope with life’s stresses, and is not considered sick by others around them.”

The words to describe this notion vary from empowerment to ‘holistic’ or ‘comprehensive’ recovery. Regardless of the specific terms used, their meaning shares a common emphasis on belief in the possibility of a comprehensive and lasting recovery. As indicated in the Surgeon General Report (1999), for this recovery movement “the overarching message is that hope and restoration of a meaningful life are possible.” The report continues, “Instead of focusing primarily on symptom relief . . . recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.” Another former patient describes recovery as the ‘lived experience’ of gaining a new and valued sense of self and of purpose (Deegan, 1988).

At root then, this view of recovery encourages individuals to attempt to regain a full and meaningful life. One woman said, “To me, knowing when you’ve gotten better is when you’re able to really laugh--and not only laugh on the outside but on the inside too. Recovery is when you’re able to find pleasure and joy And you know that you can’t be happy all the time and you’re okay with that” (3).



Based on qualitative research by NEC conducted with former patients, the following characteristics differentiating between those who are still ill, versus those considered to be fully recovered, have been identified:

Characteristics	‘Still ill’	‘In recovery’
Overall functioning? [based on Global Assessment of Functioning (GAF) score]	Functioning poorly (60 or below)	Functioning fairly well (score of 61 or above)
Observable public behavior?	An untrained person would describe the person as sick	An untrained person would describe the person as not sick (normal)
Orientation of control?	See self as primarily dependent	See self as primarily self-determining
Primary support?	Mental health system is most crucial	Network of friends and family is most crucial
Identity?	As largely a ‘consumer’ or patient	As a worker, parent, student, etc.
Relationship with medication?	Essential component to be okay	One tool that may be chosen
How painful emotions are treated?	As symptoms by professionals	As something that can be worked through and communicated with peers or family
Sense of ‘self’?	Weak sense of self defined by authority	Strong sense of self defined from within and from one’s most important relationships
Future orientation?	Little future direction	Strong sense of purpose and future

Adapted from Fisher (2006)

As illustrated here, an empowerment view of recovery is not necessarily competing with concurrent medical care. Fisher himself is a psychiatrist who prescribes medications as a temporary support when needed. The difference is the precise role medication is understood to play in recovery. As noted in Chapter 1, some come to see medications as indispensable to recovery over the long-term, with the possibility of tapering seen as almost equivalent to a return of the problem. By contrast, others do not necessarily feel themselves fully ‘recovered’ until they are able to function independent of the temporary support medication had provided.

Although not as dominant as the disability/rehabilitation view, the foregoing portrayal of recovery has become increasingly embraced by large health institutions across the nation. In the U.S. Department of Health and Human

Services and SAMHSA (2004) “National Consensus Statement on Mental Health Recovery,” for instance, the following two characteristics of recovery are emphasized:

- *Holistic*: Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- *Strengths-Based*: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

As reflected here, a recovery emphasis focuses on wellness more than illness (Anthony, Cohen, Farkas & Gagne, 2002). This holistic, strength-based approach also emphasizes gentle ways of helping empower the individual’s heart, mind and body in its intrinsic capacity to heal (see Chapter 4 for more examination of this point).

Questions, concerns and expectations about ‘full recovery.’ To conclude this chapter, we examine some of the conflict and controversy between these two competing views. On one hand, in spite of the growing evidence warranting such optimism, a rehabilitation view of recovery remains the norm. Similar to the skepticism about recovery generally, a view of permanence has become so widespread that sometimes those who believe they have experienced full recovery are dismissed as unusual exceptions. Fisher (2010b) writes:

A friend of mine, during a discussion in a psychology class said she knew someone who had schizophrenia, but recovered and became a psychiatrist. “He must have been misdiagnosed,” was the professor’s response. So my friend [visited me] and reviewed my earlier symptoms with me. I met the DSM IV criteria for schizophrenia in the interval from 1969-74. When she presented my history to her professor, he reversed his position and said that the diagnosis of schizophrenia must have been correct, but he doubted that I had recovered and said, “We now have a case of an impaired physician.”

Fisher notes, “By having earned board certification in psychiatry, having worked as medical director of a community mental health center for 11 years and having directed the National Empowerment Center for 3 years, I have proven that I am not an impaired physician. This episode reveals the depth of negative expectations which are taught to students. After all, mental illness is considered a terminal condition for which there is no cure. Therefore anyone who appears to have recovered must not have been sick.” He then shares this testimony:

We who have recovered from mental illness know from our personal experience that recovery is real. We know that recovery is more than remission with a brooding disease hidden in our hearts. We have experienced healing and we are whole where we were broken. Yet we are frequently confronted by unconvinced professionals who ask, “How can you have recovered from such a hopeless situation?” When we present them with our testimonies they say that we are exceptions. They call us pseudo-consumers. They say that our experience does not relate to that of their seriously, biologically ill, inpatients (Fisher, 2010b).

While this perspective on recovery has been seen as naïve in the past, as evident above, biological and clinical findings have converged to increasingly confirm that recovery and empowerment are “not the privilege of a few but a process that is possible for everyone to embark on and find help with” (NEC). Rather than simply a rallying cry for patients, some of the top researchers in the field are beginning to advocate for it. Some of the leading cognitive psychologists in the nation, for instance, have created new treatment protocols designed to help individuals achieve

substantial “freedom” from a problem like severe depression (Segal, Williams & Teasdale, 2001; Williams, Teasdale, Segal & Kabat-Zinn, 2007).

In spite of such validation, some have interpreted the recovery model as suggesting that everyone can fully recover through sheer ‘will power’—therefore offering false hope to some and blaming others who do not achieve such recovery (Torrey, 2003). This fear has some legitimacy. Sarah, who has faced emotional problems for years since her early abuse, said: “Everybody makes that promise, ‘it’ll get better.’ And when it’s not getting better, you know, and . . . you’ve been hurting alone for so long, that promise really . . . holds no weight. You know what I mean? Because you’re like ‘no, I’ve been dealing with this for, you know, ten years by myself, and hurting that long for that bad, you think you can turn it around in a few months?’” (6).

Proponents counter that the model is intended to support a person in their personal journey rather than expecting a given outcome (McLean, 2003) and that freedom, when it comes, does not imply a naïve picture of zero struggle in the future. Similar to alcoholics going to AA (12-step groups), there is an understanding here that life will continue to involve facing some turbulence. This is illustrated vividly in the story of John Nash, depicted in the recent film, “A Beautiful Mind.” While delusional thoughts were still occasionally present in his life, by a practiced attention directed away from such thoughts, his brain adjusted to the point where they no longer overwhelmed him.



Any process of meaningful recovery, of course, also involves natural, recurring challenge. One research team writes, “Recovery is not *linear*; recovery takes place as a series of small steps” (Anthony, Cohen, Farkas & Gagne, 2002). The consensus statement by the U.S. Department of Health and Human Services likewise notes, “Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience.”



Deegan (1988) says, “At times our course is erratic and we falter, slide back, regroup and start again” (p. 15). As Maisel and colleagues (2004) point out, successful recovery from eating disorders, rather than evincing absolute, unwavering resolution, more often reflect a determination that ebbs and flows like the tides of the ocean, *as it gradually rises*: “In our experience, it is more realistic, at least initially, to think in terms of moments of anti-anorexia/bulimia clarity rather than a once-and-for-all realization . . . [and] subsequent unwavering rejection of it.” They go on to speak of a “back-and-forth rhythm of recovery” that comes in waves (pp. 92, 185).

Based on a five year study into what people need for mental health care, one research team proposed a similar approach to recovery known as the *Tidal Model* that has been put into practice in a number of settings across several countries (Barker, 2008). After noting the continuous process of change inherent in all people, they encourage families to “Craft the step beyond,” with “the helper and the person working together to construct an appreciation of what needs to be done ‘now’” (Barker & Buchanan-Barker, 2005).

Obviously many questions remain. At a minimum, the foregoing analyses call for greater care in drawing rigid conclusions about whether recovery is possible and what recovery means—even more so in offering them to others. As evident across these accounts, the way recovery is defined may have significant influence on the experience of those facing severe emotional problems. As reflected in the stories cited earlier, one comment can have a significant

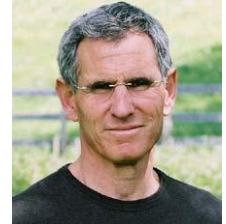
influence on an individual's experience. A statement by a doctor that one woman would never live independently, for instance, was taken by this individual and her family as a fact for years. As cited earlier, she said, "Even though I have made progress over the last 4 or 5 years, there's still *always* that seed of doubt that was planted, you know 'can I really take care of myself?'" She acknowledged, "But it was said by the doctor, so it had so much *power* and so much influence." She then continued, "And you know if you went back and asked him, he probably wouldn't even remember having *said that* and yet it's had all these ripples for the last several years." I then asked her to clarify, "You said this planted a seed of doubt in your family?" She responded, "In my family and in myself too. Um, hmm. One of the things that I've learned since then...is that you can *never predict* the recovery of another individual" (13).

Chapter 4: 'But what if it comes back again?!' Facing the disheartening prospect of relapse

- ✚ “There’s just nothing scarier Really deep depression is about the scariest thing I’ve ever experienced. . . . I’m scared to death of going into a depression It’s something that I’m scared to death of now” (2).
- ✚ “I’m not gonna (sigh) . . . I can’t go back to what I was. . . . I can’t because it scared me so bad” (4).
- ✚ “I mean, you just know what’s coming. . . . When things start to go wrong, I’m just like, ‘Don’t get depressed, don’t get depressed’” (9).
- ✚ “Every once and a while, I will feel that feeling. It may be a particular day where those feelings come back, and it’s scary. And I think, ‘Oh no!’” (16).
--Four depression survivors

The previous chapter took on the overarching question of recovery from severe emotional problems—exploring contrasting positions and considering available evidence. That there are compelling reasons to be optimistic about the possibility of reaching an authentic level of well-being is clear. In spite of this, however, one major concern remains: What happens if the problem comes back? Williams and colleagues (2007), write, “The sad fact of the matter is that once you have been depressed, it tends to return, even if you have been feeling better for months” (p. 1). Even those who make comprehensive life changes that reduce their vulnerability to a problem like depression cannot entirely escape the possibility of its return. What happens, then, when the pull towards depression or panic attacks or bulimia returns? Are there ways that individuals can become better prepared to face something like this when it comes back?

It is this issue that has prompted new developments in psychology being hailed as a major breakthrough in relapse prevention. Stepping back, first, some history is necessary. In the 1970’s Dr. Jon Kabat-Zinn, professor at the University of Massachusetts Medical Center, began testing the effects of an eastern, mindfulness-based intervention for chronic pain patients. What he found was surprising: as patients learned a fundamentally different way of relating to their pain, it decreased significantly. Since that time, his “Mindfulness Based Stress Reduction” (MBSR) class has spread to clinics and hospitals across the nation, with heartening results documented across grueling and relentless chronic physical pain associated with cancer, back problems, etc. (Kabat-Zinn, et al., 1992; Kabat-Zinn, 2005a).



Over the same period, several top cognitive psychologists in the U.S. had been exploring the common struggle patients have with relapse once therapy was over. While changing one’s thoughts during cognitive-behavioral treatment was helpful for a time, underlying emotional turmoil would often drag individuals downward and backwards again. After learning of Kabat-Zinn’s work, these researchers believed it might hold a clue to resolving the relapse problem. Subsequently, these two research programs joined forces to develop a joint treatment approach addressing core emotional patterns often driving destructive behavioral habits and relapse itself.



Alongside therapy and classroom based protocols for depression (Segal, Williams & Teasdale, 2001; Williams, Teasdale, Segal & Kabat-Zinn, 2007), the same basic approach is now being applied to eating disorders, and schizophrenia as well (Kabat-Zinn et al., 1992; Kristeller Baer & Quillian-Wolever 2006).

The following chapter constitutes a whirl-wind tour of mindfulness-based approaches, examining specifically why they seem to hold such promise for facilitating long-term and authentic recovery. Point by point, general contours and key highlights of a ‘mindful way’ through depression or panic attacks or anorexia are reviewed. Because Kabat-Zinn has been the one primarily responsible for ‘translating’ mindfulness into something clear and accessible to

Americans (rather than something ‘Buddhist’ and foreign), priority is given to commentary from he and his research collaborators in what follows.

To begin, whether in the face of chronic physical pain or persisting emotional struggle, this type of approach sets itself apart generally, by its departure from broader cultural mindsets in which Americans find themselves inevitably embedded. Western assumptions about thinking and feeling, in particular--ideas often taken for granted--are called into careful scrutiny for the subtle role they might play in predisposing emotional problems.

1. Appraising ‘over-striving’: ‘You just need to work and try harder.’ When depression returns, a common and understandable reaction is to fight and ‘do something’ to try and make the feeling go away. As cited earlier, one individual who had faced depression said:

Things had gotten so bad for me that I said, “I’ll do anything . . . I will do anything if you tell me that it will make me feel better,” you know. If you told me the problem lived in my finger and I had to cut it off, I would really . . . I would have done anything to make that go away (10).

Reflecting our basic physiological impulses towards “fight or flight” when threatened, this tendency is further reinforced by the western cultural values of working hard, fixing problems and controlling life conditions. While effort applied to various lifestyle changes, as we have observed, can make a difference for emotional problems, when this effort ‘to do’ becomes inordinate and excessive, it can lead to inadvertent consequences. Similar to ‘trying harder’ to get to sleep on a night during a moment of insomnia, the ‘trying harder’ to get out of depression or anxiety can similarly exacerbate the intensity of the problem. Williams and colleagues (2007) describe the characteristic rumination of facing depression, with “thoughts going round and round as you try to find a deeper meaning, to understand once and for all why you feel so bad. . . . If you can’t come up with a satisfactory answer, you might feel even more empty and desperate. Ultimately, you may become convinced that there is something fundamentally wrong with you.” They continue, “But what if there is nothing ‘wrong’ with you at all? What if, like virtually everybody else who suffers repeatedly from depression, you have become a victim of your own very sensible, even heroic, efforts to free yourself—like someone pulled even deeper into quicksand by the struggling intended to get you out” (pp. 1-2).



A friend who struggled with severe anxiety in dating relationships came to me once and reported that he was “working hard” at a number of things to “make the anxiety go away,” including the memorization of positive thoughts and religious exercises to directly combat negative thoughts. While some of these efforts may have positive results, as I told this friend, attempting to pulverize painful feelings or ‘make-them-stop’ might ultimately feed these same emotions and make them worse.

Given our natural desire to do something in the face of distress, the beginning premise of mindfulness then, is striking: we can *make problems worse* by over-aggressive efforts to *make them better*. But why and how would our valiant efforts turn into quicksand? Williams and colleagues elaborate:

When depression starts to pull us down, we often react, for very understandable reasons, by trying to get rid of our feelings by suppressing them or by trying to think our way out of them. In the process we dredge up past regrets and conjure up future worries. In our heads, we try out this solution and that solution, and it doesn’t take long for us to start feeling bad for failing to come up with a way to alleviate the painful emotions we’re feeling. . . . Nothing we *do* when we start to go down seems to help because trying to get rid of depression in the usual problem-solving way, trying to “fix what’s wrong” with us, just digs us in deeper. The

3:00 A.M. obsessing over the state of our lives . . . the self-criticism for our “weakness” when we feel ourselves slipping into sadness . . . the desperate attempts to talk our hearts and bodies out of feeling the way they do—all are mental gyrations that lead nowhere but farther down. Anyone who has tossed and turned night after sleepless night or been distracted from everything else in life by endless brooding knows well how fruitless these efforts are. Yet we also know how easy it is to get trapped in these habits of the mind. (pp. 2, 5)

If individuals facing an emotional problem have this knee-jerk tendency to fight and fix their problem, their family and friends are obviously not immune to the same impulses and can feel an acute urgency to make something change. As quoted earlier, in part, after one man contemplated suicide for the first time, he said, “that really, really scared me because here I was at a point where I could have killed myself, I could have done it.” He continued, “At that point my mom decided, she’s like, ‘We have *got* to do something about this. We’ve *got to*. And it’s just . . . it’s hanging on too long, and you’re just, you’re gonna . . . you’re having trouble with this. And we just, we just *have to* do something.’ And so she, um, took me to a doctor” (9). For a situation where a child is in danger of harming himself/herself or someone else, the impulse to take action is understandable and often justified. Even so, the general literature around family therapy confirms that in crisis situations, well-intentioned family members can very often become involved in ways that are inadvertently debilitating and defeating to the individual in crisis—including over-eager attempts to ‘fix’ a problem (Coyne, Wortman & Lehman, 1988).

Whether with individuals or their loved ones, if overly forceful efforts can potentially make things worse, what is the alternative?

2. *Practicing being (present): ‘Wherever you go, there you are.’* At this point, a ‘mindful way’ through emotional problems veers off the beaten path enough to start feeling quite counter-intuitive to a Western mind. Rather than fight or flight or try harder or work more, we are invited to do something else: stop. Kabat-Zinn (2005b) writes:

To allow ourselves to be truly in touch with where we already are, no matter where that is, we have got to pause in our experience long enough to let the present moment sink in; long enough to actually feel the present moment, to see it in its fullness, to hold it in awareness and thereby come to know and understand it better.

In place of working harder, fighting more and ruminating longer, the invitation of mindfulness is to stop . . . if only for a moment. Kabat-Zinn then asks, “Are you able to come to a stop in your life, even for one moment? . . . What would happen if you did?” In a culture obsessed with doing more, he goes on to encourage individuals to “take a few moments to [step out of] the rush of time”: “Just watch this moment, without trying to change it at all. What is happening? What do you feel? What do you see? What do you hear?”

These moments, when practiced intermittently over days and weeks cultivate a state of mind and being that Eastern philosophy terms *mindfulness*. Kabat-Zinn (2006) defines mindfulness as “paying attention, in the present moment, on purpose, non-judgmentally, as if your life depended on it.” A second, more compact definition attributed to the writer Jiddu Krishnamurti is “conscious affectionate awareness of the moment.”

‘Hold on,’ the Western mind says, ‘why would anyone want to be more *present* to the pain of anxiety or depression?! Are you crazy?’ On a most basic level, the systematic practice of being present can have an immediate effect on the intensity of an emotion. Just as chronic back pain can decrease considerably as individuals stop obsessing about it, as individuals stop the anxiety about their anxiety, the panic about their panic, and the sadness about their depression, a surprising relief can come.

While the precise reasons for this relief are still being investigated, what is known so far is that cultivating mindfulness can and does make a startling difference for many facing emotional problems (see Kabat-Zinn et al., 1992; Miller, Fletcher, & Kabat-Zinn, 1998, Segal, Williams & Teasdale, 2001; Baer, 2003; Kristeller Baer & Quillian-Wolever, 2006). From offering immediate reprieve to preventing relapse, the cultivation of mindfulness can be an effective treatment supplement on several levels. As Williams and colleagues (2007) note, “there is an unsuspected power in inhabiting the moment you’re living in right now with full awareness” (p. 7).

Part of the explanation, perhaps, may be found in how being fully present can change day-to-day events:

The funny thing about stopping is that as soon as you do it, here you are. Things get simpler. . . . Maybe you don't need to make one more phone call right now, even if you think you do. Maybe you don't need to read something just now, or run one more errand. . . . You actually become more alive now. This is what stopping can do. There is nothing passive about it. And when you decide to go, it's a different kind of going because you stopped. (Kabat-Zinn, 2005b)

As reflected here, a deliberate practice of “stopping”—whether in meditation, prayer or a conversation with loved ones—is different from laziness or resignation in the face of circumstances. Ultimately, this kind of a calm, present-focused state of mind may lead to different choices in response to major challenges. When we are present, Kabat-Zinn (2005b) notes, “Only then can we accept the truth of this moment of our life, learn from it, and move on. Instead, it often seems as if we are preoccupied with the past, with what has already happened, or with a future that hasn't arrived yet. We look for someplace else to stand, where we hope things will be better, happier, more the way we want them to be, or the way they used to be.”

While this may seem, once again, like a nice way to improve the general quality of one’s life, some might continue to justifiably wonder: How would this make any difference in something like depression, anxiety or eating disorders?

To provide further illustration, stories of those who have faced years of debilitating emotional problems can be helpful. An acquaintance who currently works as a therapist in Southern California, Arline Curtis, struggled with bipolar depression for 40 years, much of her adult life (Curtis, 2001). During this time, Arline was often told, “this is just your genetic make-up--something you’re going to need to manage and cope with for good.” While some interventions helped for a time, the intense swings of sorrow would always come back—a moment she would dread. To illustrate her helplessness, she writes of one such memory:

It had snowed a rare eighteen inches in Washington, D.C., and I love the snow. The first few flakes of any snowstorm fall directly into my heart. My husband and I are spending the weekend with another couple, our best friends. Between us we have a gaggle of preteens who are busy building a snow fort outside, while we four adults are toasting our toes in front of a cheery fire, chatting cozily. The snow is still sifting down from a billowy gray sky that looks like it was painted long ago on Chinese silk. A beautiful day. A perfect day. My husband throws back his head and laughs at his buddy’s joke. I too am smiling broadly. Then the smile slides off my face as I feel my inner self suddenly give that downward jerk. In a nanosecond everything good is gone. I am submerging into that empty pain, sinking helplessly into myself, going further and further away from everybody. Faster and faster I am sucked into that alternate universe of agonizing, utter loneliness called depression. They don’t notice. They are laughing and passing me the cheese and crackers and they don’t know I am no longer here. I have gone to misery. I go up to my room, and crawl under the covers (pp. 40-41).

Arline writes of her own former experience, “Once I felt depressed, I took it for granted that I *was depressed*. . . . that was my foregone conclusion.” She lived in fear of its return like a battered wife anticipates her husband coming

home again. No matter how right and wonderful surrounding family circumstances were, when the depression came back it often swept her away.

Arline goes on to tell the story of depression coming back once so intensely that she fell to her knees begging for mercy. She was not a religious woman, but threw up a prayer to a God. The next week, a set of Eastern philosophy books came into her possession where she began to learn, among other things, a completely different way of *thinking about thinking*. As further illustrated below, this shift changed everything.

3. Learning a fundamentally new way to think about thinking: ‘You are not what you think?’ In Western culture, we grown up with a belief that our thoughts and feelings are, by and large, a reflection of *ourselves* or our *reality*—e.g., “you are what you think.”

While there can be benefits to this way of thinking in some contexts, in others, it can cause problems. In the case of depression or anxiety, for instance, this mindset can lead individuals to see disturbing thoughts and feelings as some kind of a literal reflection of themselves or their reality—i.e., coming *from them* or saying something *about them*. As Arline notes above, once an individual ‘feels depressed,’ they may therefore take for granted that they ‘are depressed.’ As one interview participant said, “Before treatment . . . I just thought that whatever I thought was true” (4).

By contrast, Eastern philosophy reflects a striking departure from these taken-for-granted assumptions. From this perspective, thoughts...are *thoughts*. Feelings... are *feelings*. While they *may* reflect upon reality and teach us something of ourselves, they *do not necessarily* fulfill either function.

Instead, this approach understands that thoughts and feelings can come and go, *not always* linked to our own behavior and circumstances. To convey this idea, Buddhists talk of “mind-weather”—reflecting the way thoughts or feelings can change, moment-by-moment, like weather patterns or clouds passing in the sky. Some days, our mind-weather is sunny—everything is easy and unusually calm. Other days, the storm hits, for no apparent reason. This type of an experience is perhaps common for most people: waking up, going to work as normal, then suddenly being barraged by an array of emotions and thoughts associated with an uncomfortable event from the past—or perhaps not linked to anything reasonable at all.

Psychology calls these unwanted thoughts “intrusive thoughts,” defined as “distinct thoughts, images or impulses that enter conscious awareness on a recurring basis, are difficult to control, and interfere with ongoing cognitive and behavioral activity” [e.g., Clark, D. PhD (2005) *Intrusive thoughts in clinical disorders: Theory, research and treatment*. New York. Guilford Press].



Metaphor #2: "Thought-spam"



Another helpful metaphor is 'thought spam.' Regardless of our filtering system, the amount of junk e-mail that sometimes floods our boxes can be overwhelming and burdensome.

However we describe them, when we are not responding to rushing thoughts and emotions in a calm, non-judgmental way, they can easily sweep us away. When we "momentarily lose touch with ourselves," Kabat-Zinn (2005b) observes, we can "fall into a robot like way of seeing and thinking and doing." It is in these moments that we can "find ourselves taken hostage and carried away by the thought stream." It is not difficult to see the implications and

rippling effects of this "mindlessness" on emotion and thought:

When not examined in the larger field of awareness, thinking can run amok. . . . When we lose ourselves in thought. . . it can sweep our mind and carry it away, and in a very short time, we can be carried far indeed. We hop a train of association, not knowing that we have hopped on, and certainly not knowing the destination. Somewhere down the line, we may wake up and realize . . . that we have been taken for a ride. And when we step down from the train, it may be in a very different mental environment from where we jumped aboard (Williams et al., 2007, p. 169).

Lack of awareness itself can thus potentially be another powerful risk factor for emotional problems. This process described above, "can wind up . . . imprisoning us, causing great suffering."

For now, however, we turn to the urgent question at hand. If it is true that thoughts and feelings are like 'mind-weather' and if it is true that we often get swept away as we identify and cling to it, then what can we do? How can we escape this pattern and avoid being swept away?

4. Practicing a new relationship to our thoughts: 'The depression passed . . .' Reflecting an earlier point, this may seem like a time to work harder at keeping our thoughts from straying. Why not apply some more effort into controlling our thoughts? The subtle difficulties of such an effort are illustrated in an ancient parable recounted in Williams and colleagues' (2007) book:

In a time-honored story set in an ancient Himalayan kingdom, a novice monk was excited at the prospect of meeting his teacher for the first time. He was on fire with questions but sensed that this was not the time to ask them. Instead, he listened carefully to the teacher's instructions. They were brief and to the point. "Get up early tomorrow and climb to a cave you'll find at the top of this mountain. Sit from dawn to dusk and have no thoughts. Use any method you wish to banish thought. When the day is over, come and tell me how it went."



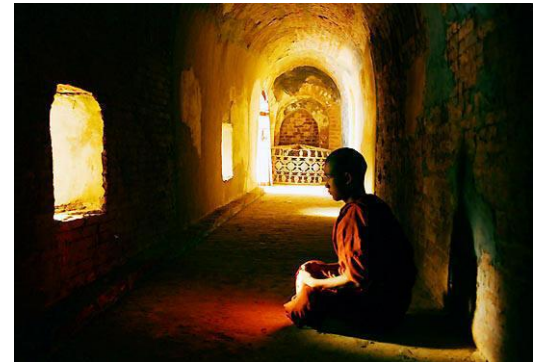
At dawn the next day the novice found the cave, made himself comfortable, and waited for his mind to settle. He thought that if he sat long enough it would become blank. Instead, his mind was crowded with thoughts. Soon he started to worry about failing the task he had been set. He tried to force the thoughts out of his mind, but that just produced more thoughts. He shouted at them to "Go away," but the words echoed noisily in the cave. He jumped up and down, held his breath, and shook his head. Nothing seemed to work. He'd never known such a bombardment of thoughts in his life.

At the end of the day he climbed back down, completely dispirited, wondering what his teacher's response would be. Perhaps he'd be dismissed as a failure, unsuitable for further training. But the teacher just burst out laughing at the tale of his mental and physical gymnastics. "Very good! You have tried really hard and done well. Tomorrow you should go back to the cave. Sit from dawn to dusk having nothing but thoughts. Think of anything you like all day long, but allow no gaps to occur between your thoughts."

The novice was really pleased. This would be easy. He was bound to succeed. After all, "having thoughts" is what had been happening to him all day.

The next day saw him climbing with confidence up to his cave and taking his seat. After a little while he realized that all was not well. His thoughts started to slow down. Occasionally, a pleasant thought would come to mind and he would decide to follow it for awhile. But soon it dried up. He tried to think grand thoughts, philosophical speculations, to worry about the state of the universe. Anything. He started to run low on things to think about and even got a little bored. Where had all his thinking gone? Soon the "best" thoughts he could get seemed a little worn, like an old coat that had become threadbare. Then he noticed gaps in his thinking. Oh dear, this was what he had been told to avoid. Another failure.

At the end of the day he felt pretty wretched. He'd failed again. He climbed down the mountain and went to find his teacher, who burst out laughing again. "Congratulations! Wonderful! Now you know how to practice perfectly." He didn't understand why the teacher was so pleased. What on earth had he learned? (pp. 73-74).



The authors expound, "The teacher was pleased because the novice was now ready to recognize something of real significance: *You cannot force the mind. And if you try to, you won't like what comes of it*" (their italics). A simpler version of this same experiment is simply to "look away from the book and think of anything you like, but try not to think of a white bear."



As illustrated by research from Wegner and colleagues, "when we try to suppress thoughts like this, *what we resist persists*: our attempts to force the mind can rebound in exactly the opposite direction from the one we want." They continue, "If this is true for neutral thoughts and images such as bears, it's not difficult to imagine what happens when we try to suppress negative thoughts, images and memories of a very personal nature." While it is understandable for those facing depression and anxiety to work hard at keeping negative thoughts and feelings at bay, research by Wenzlaff, Bates, and colleagues demonstrates "that this can work for a little while—but at a huge cost; those who put more effort into keeping negatives out of mind end up being more depressed than those who do not" (p. 75).

If not trying to fight, fix or control unwanted "mind-weather" or "thought-spam," what then are we to do? Williams and colleagues go on to detail throughout their book a process of learning and practicing a fundamentally new way of relating to thought and emotion—starting with the fundamental *re-thinking how we think about thinking*, described earlier. As long as we view thoughts as a simple reflection of ourselves or reality, then we are (by virtue of that assumption), beholden to their 'reality' to some degree. However, when we begin to consider these thoughts *as thoughts*, like weather patterns in the sky, we may watch them come, then go. By coming to see thoughts in a new

way, we may therefore change our relationship with these thoughts. Rather than always trying to ‘figure out’ where different thoughts or feelings come from, we might learn to sometimes simply let them pass. The same can be said for unwanted feelings.

In spite of earlier comments about work, practicing this new way of relating to thought and emotion is not easy and takes real effort and work—albeit of a different kind. Automatic habits of our mind and thoughts can be ‘exceedingly tenacious,’ with a force that makes a re-direction of attention sometimes feel like swimming upstream. Not only does mindfulness challenge us to be present with painful things (when our tendency is to numb out or seek distractions), but also to try and not fight or run from them (when our tendency is to do just that). The good news is if individuals give their ‘mindfulness muscle’ the sustained exercise it deserves, when the depressive thoughts/feelings come, *they will be ready*.

This is precisely what Arline, whose story is described earlier, learned for herself. Rather than fighting, forcing or giving in to the depression when it came, she began experimenting with this new way of responding to these feelings and thoughts. The next time she noticed the coming of depression “like a cool wind,” she remained calm in acknowledging its arrival, before deliberately turning her attention to something else—anything else—to occupy her attention. The first time, she thought of whatever came to mind, “green frog, green frog, green frog.” She later would use favorite passages of poetry and jokes on the internet. After experimenting with directing her thinking elsewhere for the first time, she was surprised to find that after ten minutes, the depression *passed*. When the depression returned a week later, she tried the experiment again, with the same result.

She could hardly believe it. After 40 years of assuming that there was no way to respond to depressive thoughts and feelings, she had just learned otherwise. As reflected here, a dispassionate and directed awareness of our thoughts and emotions can act as a stabilizing force until the thoughts and/or emotions pass. Like sediment in a swirling glass of water, as we stop our over-aggressive stirring and simply observe the glass, dirt will eventually settle down and leave the glass clear. As we learn this skill, challenging thoughts or feelings can come and go like the ebbing waters of a capricious sea. They note, “When we stop trying to force pleasant feelings, they are freer to emerge on their own. When we stop trying to resist unpleasant feelings, we may find that they can drift away by themselves” (p. 109).

The freedom of her own ‘mindful way’ through severe bipolar depression was so complete and thorough that Arline Curtis went back to school and became a therapist—most recently finishing her second book. In that text, she details the neuroscience behind this skill of being able to let distressing emotions pass (Curtis, 2006). To wit, when depression, anxiety and other painful emotions arise, they appear to emerge through the basal part of the brain that some scientists call the ‘animal brain.’ As it travels up the brain to our frontal lobes where we think and process, if we can direct our thinking away to any other object of attention, we can literally *jam* or *short-circuit* the neural pathways so that distressing emotions cannot pass. Since the human mind can only focus on one object at once, as long as it is ‘tied up’ in other pursuits, the depression or anxiety is required to ‘stay on hold.’ Like a car stopped by a moving train crossing its path, depression is stopped in its tracks when the neural network it *has to travel on* becomes occupied. Curtis’ (2001/2006) own term for this mindful practice “directed thinking.” If this purposeful preoccupation of the mind continues long enough, the unwanted emotion will simply reverse its direction and subside completely.

As individuals generally learn to exercise their own mindful capacity to calmly observe, acknowledge and direct their thoughts, they can potentially then apply this same capacity to whatever emotional struggles arise—especially when the initial signs of the problem first begin. Given its literal ‘counter-cultural’ flair, this process sometimes takes courageous effort and some willingness to trust the process. A friend came to me recently feeling the signs of

depression coming on and asked, “What do I do? What do I do? My family is saying I’ve got to start something and do something differently?” Knowing of his background in meditation, I reassured him that the feelings would pass if he kept taking care of himself and stayed calm: “Just like if you were feeling symptoms of the flu coming on, take extra precautions and take good care of yourself: good food, exercise, sunlight, etc. Stay mindful, but don’t do anything aggressive. It will pass.” “Are you sure, are you sure?” he asked anxiously? I assured him, “yes.”

Within several days, his wrestle with depression had passed. Like a bout with the flu, this period of his body and mind’s unique vulnerability to the hijack of depression faded away. As refreshing as other aspects of mindfulness might be, the most exciting implication of its practice is that individuals can learn the skill of letting unwanted thoughts and feelings pass.

5. The influence of mindfulness over time: ‘I struggle less with depression now . . .’ As individuals cultivate and practice mindfulness over a period of time, surprising changes can take place.

Although mindfulness can be practiced in any activity (brushing teeth, working), meditation is one of the more common ways to practice. Through meditation, we can gently practice guiding our thoughts in the direction we want, but not in an extreme and controlling way. Kabat-Zinn (2006) teaches, “One way to envision how mindfulness works is to think of the mind as the surface of a lake or ocean. There are always waves, sometimes big, sometimes small. Many people think the goal of meditation is to stop the waves so that the water will be flat, peaceful, and tranquil--but that is not so.” He continues, “Meditation is not about shutting off our thinking, not about shutting down our thinking; it’s not saying ‘it would be better if you didn’t think’ and that we’re trying to just suppress all thought and have the mind be silent. If you try to suppress your thoughts, you’re going to wind up with a gigantic headache. It’s like trying to stop the ocean from waving; it’s in the nature of the surface of the mind to wave, secrete these little thoughts; these bubbles coming off a pot of water.”

Over time, this kind of practice can improve one’s fundamental emotional capacity to be calm in the face of struggle. Research and stories like these lead some to call mindfulness a great ‘mood stabilizer’ (McManamy, 2008). This explains, in part, why this process of learning and practicing this capacity has been emphasized as key to relapse prevention (Williams et al., 2007). Additionally, these kinds of techniques have shown substantial impact on helping people respond to addictive or cravings of different kinds in a way that decreases their intensity over time (Marlatt & Donovan, 2007). These researchers explain, “[The goal is to] stabilize and deepen our capacity for paying attention . . . to train the mind to be less scattered and more ‘present’ . . . so we are not perpetually at the mercy of the mind’s ingrained habits of reactivity” (p. 73). Kabat-Zinn continues:

As with any instrument, you have to actually calibrate [the mind] and stabilize the platform on which it sits so that you can get reliable readings. . . . If trying to look at the moon and put the telescope on a waterbed, every time you find the moon, every time you shifted your posture every little bit, you’d lose the moon in the telescope. It’s the same with the mind. Meditation is about learning the rudiments of stabilizing the mind enough so that it can actually do the work of paying attention and being aware of what’s actually going on beneath the surface of our own mind’s activities (which is often what thwarts us).

In exploring this approach, one might also justifiably ask, but is this stuff even applicable to youth? In recent years, practitioners and researchers have found simple and effective ways to apply it to adolescents and even children, including applications of Acceptance Therapy (Greco & Hayes, 2008) and Dialectical Behavioral Therapy (Dimeff, Koerner, & Linehan, 2007). There are increasing numbers of quality resources, as well, for parents wanting to better set up their home and interact in ways that cultivate calmer, more present-



focused attitudes among youth (Kabat-Zinn & Kabat-Zinn, 1998; McKay, Wood, & Brantley, 2007; McCurry & Hayes, 2009; Geoff Bell-Devaney, 2009; Greenland, 2010).

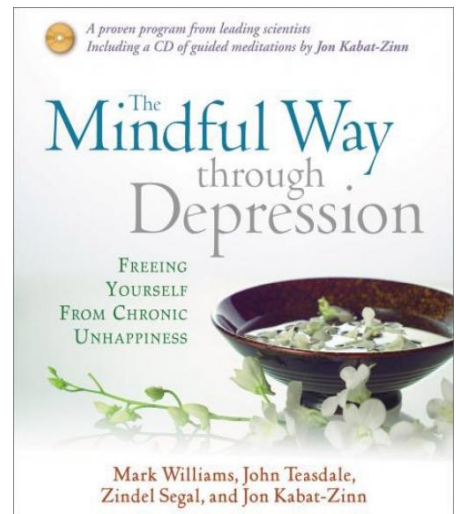
It is learning to cultivate greater mindfulness that has helped my sister a great deal—helping her regain quality of life and approach the eating disorder in a completely different way, as she learned to let thoughts of ‘binge and purge’ pass. There was also evidence of mindfulness impacting several youth interviewed in the two studies. One graduate noted from her own experience that “Depression is one of those things that will suck you in and not let you leave...Once you are depressed, like an uninvited houseguest, it does not leave. . . . Once you let it in, it lingers.” She went on to speak of learning how to “make it take a vacation”...“It may not leave the house permanently, but you can kick it out” (158d). One interview participant said, “For me, depression was a way of life, and now it’s not anymore . . . so now when I look at things in my life, I realize . . . I see many more possibilities, you know. Depression was one possibility of many...it wasn’t just ‘the way things were’” (10). Another girl also spoke of how mindfulness empowered her to let her painful emotions pass:

It’s been a lot easier dealing with myself; handling myself is not as difficult. I do not get sucked back into cycles of depression anymore. I’m always going to be vulnerable to it. . . . Some people have hard-core addictions they struggle with (I have to deal with a constant sadness). However, I can now catch it early on so I am not sucked in. . . . What triggered it didn’t matter; instead of holding onto it and making it this giant, nightmare of a thing, I observe it—e.g., ‘this is anxiety about this...this is a fear of this’; then I let it go; it just kind of passes. Being able to look at what it is and recognize it and move on . . . instead of avoiding it. When we fear something, we want to avoid it . . . but it’s not good for anyone to avoid anything. Letting it pass... part of being able to let it pass is sitting and having to look at it and recognize it, instead of noticing that it is there and not doing anything about it or avoiding it. (144d)

Over time, this kind of directed attention does more than change one’s emotional and mental capacity. Circling back to our earlier discussion, research over the last ten years has confirmed that this kind of directed attention can lead to lasting changes in the brain itself. In their discussion of neuroplasticity, Schwartz and Begley (2002) eventually talk extensively about its relationship with mindfulness itself. Based on their review of the evidence, they note, “The power of attention not only allows us to choose what mental direction we will take. It also allows us, by actively focusing attention on one rivulet in the stream of consciousness, to change—in scientifically demonstrable ways—the systematic functioning of our own neural circuitry” (p. 367). At another point, they explain further, “Directed, willed mental activity can clearly and systematically alter brain function; the exertion of willful effort generates a *physical force*, has the power to change how the brain works and even its physical structure” (p. 18). They later add, by “generating the mental energy necessary to sustain mindfulness and so activate, strengthen, and stabilize the healthy circuitry . . . this force, in its turn, produces plastic and enduring changes in the brain and hence the mind.” They go on to call this resulting outcome “directed neuroplasticity” (pp. 18, 360).

To elaborate, they cite another research team, Merzenich and deCharms (1996) as suggesting that directed attention allow us, moment by moment, to “choose and sculpt how our ever-changing minds will work, [to] choose who we will be the next moment in a very real sense. . . . Those choices are left embossed in physical form on our material selves” (p. 18). Rather than reflecting an easy path, they acknowledge, “For the stroke victim, the OCD patient, and the depressive, intense effort is required to bring about the requisite refocusing of attention—a refocusing that will, in turn, sculpt anew the ever-changing brain” (Schwartz & Begley, 2002). In this way, they point out, “The willful focusing of attention is not only a psychological intervention. It is also a biological one. Through changes in the way we focus attention, we have the capacity to make choices about what mental direction we will take; more than that, we also change, in scientifically demonstrable ways, the systematic functioning of neural circuitry” (pp. 368).

In this way, not only can mindfulness help someone in the moment jam their neural network so depression passes, over time the circuitry itself can change to make it less likely for depression to find a welcome pathway in our brain! It is for all these reasons that mindfulness further confirms the recovery optimism explored in the previous chapter. Rather than ‘coping with’ or ‘managing’ depression, the goal of such approaches is clear: whether it is chronic unhappiness, anxiety or addiction problems it is “*freedom*” that these practitioners and researchers invite people towards (Williams et al., 2007).



Chapter 5: 'Okay, it's time we fixed this problem...' Considering three different ways others may intervene

- ✚ *"I kept my daughter alive through hell . . . not knowing if she was alive or dead . . . having no control, not knowing how to help her, and struggling to find help for her was the hardest thing. . . . For 3 weeks, I drove every afternoon to another city to visit her when she was in the hospital. People sometimes say, 'I admire the fight you've put up for your daughter.' I say, 'What fight? You do what you have to do'" (108m).*
- ✚ *"It was sheer hell when she was younger. We were all convinced that she was going to die . . . that either she was going to be gang-raped and killed, or die through drugs and alcohol. . . . One way or another, we thought it would end in a violent death" (136m).
--Two parents of adolescent girls*

The grief and heartache of parents at witnessing a child's severe emotional struggle can be intense. Along the journey to an answer, the love and commitment required of families is tremendous. This is not always how families of youth facing serious emotional problems are perceived, however. Dating back to Freud, parents of youth with emotional problems have often been stereotyped as largely deficient and blameworthy for pains their child was facing.

With few exceptions, our own experience interviewing 84 mothers and 42 fathers of girls formerly in treatment has confirmed quite a different picture. While any family naturally has things to improve upon, the degree of concentrated love and continued desire to help their child was remarkable to hear. It was normal in interviews to hear stories of relentless courage, compassion and 'holding on' through grueling experiences with a child.

To this point, the manuscript has focused primarily on the needs and issues directly linked to individuals facing severe emotional problems themselves. Here and in the following chapter, we turn attention to issues and needs more relevant to those who love these distressed individuals the most.

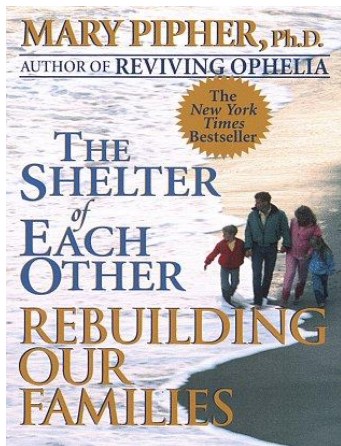
The presence of others who believe in someone's potential and stand by the person is often emphasized as essential to the recovery process (Anthony, Cohen, Farkas & Gagne, 2002; Repper & Perkins, 2006). Dr. Pipher (1996) notes, "People cannot be whole and healthy unless they connect their lives to something larger than their own personal happiness" (p. 32). Dr. Fisher, highlighted earlier, was told during his medical training, "You can't talk to an illness." But in his own recovery from severe delusions, he reports being especially impacted by those who showed him sincere care and hope that he might still someday recover (Fisher, 2010a). While professionals can provide powerful support and reinforcement over a period, relationships with family and friends hold even greater potential in this regard.

The impact of families on the emotional well-being of their children, of course, is rarely simple and linear. As Pipher further observed, in the current epoch, "Parents, many of whom are trying harder than their parents tried, are having more trouble with their children." In previous generations, "Most parents could be good enough parents. Ordinary people with ordinary skills could raise decent children. . . . [But now], some of the unhappiest children I know come from the families of sensitive, child-focused parents. . . . Well-meaning families sometimes have extraordinarily bad luck with their children, while slapdash parents may raise highly successful children" (pp. 3, 16-17, 21).

Partial explanation for such discrepancies, of course, is that families are not operating in a vacuum. On multiple levels, the influence of the surrounding culture impinges on the home atmosphere and exerts an influence on the family that continues to grow. Pipher again notes:

The problems in any given family are not just the result of cultural forces or just the result of family dynamics. Both the culture and the family influence the development of children. When one factor is examined exclusively, the picture is incomplete. Focusing solely on family dynamics, we let the culture off the hook, and focusing exclusively on the culture lets the family off the hook. Somehow we need to attend to the interaction of the cultural and familial factors (p. 18).

As one who has seen the impact of these cultural dynamics on hundreds of client families and who approaches these issues from a nonpartisan, open view accessible to a diverse audience, Dr. Mary Pipher’s insights are cited extensively in what follows. In her new book, *The Shelter of Each Other*, she examines unique dynamics at play in current U.S. culture that are challenging *all families* in their basic capacity to provide healthy support to each other:



For the first time in two thousand years of Western civilization, families live in houses without walls . . . [and] a world in which walls offer no protection. . . . Electronic media seeps into the interstices of homes and teaches children ways of thinking, feeling and behaving that are at odds with common sense. Families are reeling under the pressures of a culture they can’t control (pp. 10, 12-13; see Ch.1).

Set against the backdrop of these cultural forces at work within homes, we consider below how families are variously responding—specifically, when one of their own members becomes emotionally poisoned or oppressed by this larger society to the point of developing a severe emotional/biological vulnerability to sorrow, anxiety, addiction, etc.

For those facing a severe emotional problem like depression, friends and family are often experienced in very different ways. On one hand, they can primarily buffer against emotional pain as they extend love, trust and unconditional support. On the other hand, friends or family can contribute to emotional pain as they show skepticism, harsh judgment or blame, as well as being overly-forceful in recommendations. In most accounts, participants spoke of a mixture of positive and negative instances.

More than in previous chapters, this exploration draws liberally on our 176 interviews with Alpine Academy parents and girls. Given the richness of qualitative data, these chapters read more like research reports than the others, with a few statistical trends detailed as well. We begin by reviewing three different patterns or ‘ways of being’ identified across interviews in how families attempt to support a member who is struggling emotionally, both during and after treatment. In the following chapter (6), we then turn to examine a series of common challenges identified in interviews—specific barriers families encounter in their attempts to provide effective support to a child who is facing serious emotional issues.

Even with sincere desires to help, well-intentioned efforts by friends or family can aggravate a situation (Rorty et al., 1993). For this reason, we spend some time considering what it means to ‘help’ someone facing a severe emotional problem in the context of both formal and informal helpers. To begin, attempts commonly fall into two opposite extremes: over-helping and under-helping.

1. She’ll thank me for this one day’: Over-involved helping. The first pattern was briefly noted twice in this book earlier. For some loved ones, understandably strong desires of helping an individual who is struggling, be that a child, spouse, sibling or friend, can turn into an overdone and aggressive attempt to fix or control a situation—i.e., “We have *got* to do something about this. We’ve *got to*. . . . And we just, we just *have* to do something” (9). In



this way, loved ones can become over-involved in assisting an individual who is struggling: checking in too frequently and encouraging personal changes or treatment at every opportunity. Sometimes, such encouragement can simply become overbearing and overdone. In the eating disorder study, one girl noted:

I was losing more weight and my mom got more worried. She said she was going to take over. . . . [and] started forcing me to drink three glasses of whole milk and eat two tablespoons of peanut butter every day. She still let me run a half an hour a day, but, for every extra half- hour of exercise I had to eat another tablespoon of peanut butter and whole milk.

The general literature around family therapy confirms that in crisis situations, family members often become involved in ways that are literally debilitating and defeating to the individual in crisis—including over-eager attempts to “fix” a problem (Coyne, Wortman, & Lehman, 1988).

In terms of the parent-child relationship, this pattern of over-involvement is reflected in one particular “parenting style.”¹⁰ Parents with an “authoritarian” style are “obedience- and status-oriented, and expect their orders to be obeyed without explanation” (Baumrind, 1991, p. 62). The intensity of authoritarian parenting can range from uncomfortable directiveness to an autocratic use of power:

The authoritarian parent attempts to shape, control, and evaluate the behavior and attitudes of the child in accordance with a set standard of conduct, usually an absolute standard. . . . [The parent] values obedience as a virtue and favors punitive, forceful measures to curb self-will at points where the child's actions or beliefs conflict with what she thinks is right conduct. . . . [The parent] regards the preservation of order and traditional structure as a highly valued end in itself. . . not encourag[ing] verbal give and take, and believing that the child should accept her word for what is right (Baumrind, 1997, p. 890).

Of past parents eligible for our own study, 23/132 (17%) were rated as having a largely ‘authoritarian’ parenting style generally (high demandingness, low responsiveness), with roughly the same number showing evidence of excessive involvement in the treatment process of their daughter. Although other parenting styles also reflect high expectations of appropriate behavior, an ‘authoritarian’ style stands apart for its expectation of youth accepting parental judgments, values, and goals largely *without questioning*. Other styles reviewed below reflect greater appreciation for the give-and-take of dialogue involved in teaching, as well as much less psychological control of the child.

While over-involvement may be stern and demanding, it may manifest in ways that are less harsh as well. For instance, a parent or other loved one may remain gentle and tender, but raise such an over-abundance of questions, tips, suggestions and advice, that an individual may feel embattled and pressured.

On the level of formal, professional help, some interventions can likewise be used in an instrumental, forceful attempt to ‘make the problem go away.’ From behavioral modification techniques applied in a harsh way to the use

¹⁰ While specific behaviors or practices in parenting can be important, developmental psychologists have found that it is the broader *orientation* of a parent or one’s ‘parenting style’ that is most predictive of different child outcomes. These parenting styles reflect different naturally occurring variations in parents’ attempts to guide and socialize their children (including values, practices, and behaviors). Among the many variations proposed, Diana Baumrind’s (1967/1991) typology of authoritarian, authoritative and permissive parenting has become the most referenced. Her categorization captures two important elements of parenting, what researchers call ‘responsiveness’ and ‘demandingness’ (Maccoby & Martin, 1983). Parental responsiveness (also referred to as parental warmth or supportiveness) refers to the extent to which parents intentionally foster a child’s well-being and development “by being attuned, supportive, and acquiescent to children’s special needs” (Baumrind, 1991, p. 62). Parental demandingness (also referred to as household structure) refers to “the claims parents make on children to become integrated into the family whole, by their . . . supervision, disciplinary efforts and willingness to confront the child who [ignores rules]” (Baumrind, 1991, pp. 61-62).

of multiple, potent medications at one time, aggressive formal interventions may prompt problems longer-term, even if they alter the situation for the moment. Among other things, this suggests more thoughtful attention be given to the question of treatment outcomes and effectiveness. Specifically, rather than only focusing on whether an intervention ‘works’ or not, more careful deliberation is needed as to what exactly it *means* for something to be ‘effective’ (Hess & Lacasse, in press).

As illustrated in the previous chapter, there are psychological reasons that such a tendency to ‘make something go away,’ can provoke even worse mental and emotional turmoil. Over-eager attempts to ‘fix’ a problem during a crisis situation can inadvertently interfere with a more natural progression of healing and may provoke even further difficulties down the road (Coyne, Wortman & Lehman, 1988)—highlighted by noted linkages between family response and treatment outcomes (Whitney et al., 2005). An authoritarian parenting style, for instance, has been found to predict a number of poor outcomes in children ranging from social capacity and academic performance, to psychosocial development and general problem behaviors. In particular, studies have consistently found that children and adolescents in primarily authoritarian homes tend to perform moderately well in school and have poorer social skills, lower self-esteem, and higher levels of depression and anxiety. Poor reactions to frustration are especially common among these youth, with girls more likely to give up and boys becoming especially hostile (Darling, 1993).

Our own Alpine Academy statistics confirm that girls whose parents reflected this style did the worst in terms of outcomes across all categories of girls, both short and long-term:

- Girls of parents identified as having an authoritarian parenting style were 31% less likely to graduate from the Alpine treatment program [X^2 of 6.3 ($p=.04$), Cramer’s V of .23 ($p=.04$)] and 20% less likely to be doing well long-term [X^2 of 8.2 ($p = .08^{**}$), Cramer’s V of .18 ($p=.08^{**}$)], when compared with girls of a parent reflecting a more balanced (“authoritative”) style ($N=115$).
- Girls of parents identified as particularly controlling during treatment were also 68% less likely to graduate from Alpine [X^2 of 21.7 ($p=.001$), Cramer’s V of .43 ($p=.001$)] and 46% less likely to be doing well long-term [X^2 of 17.2 ($p=.01$); Cramer’s V of .27 ($p=.01$)], when compared with girls of a parent more balanced and supportive during treatment ($N=101$).¹¹

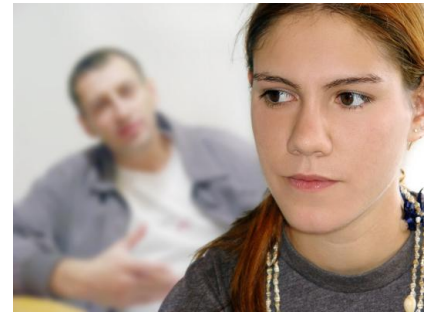
In light of these consequences, the good news is that parenting style can change over time. Like the malleability of youth’s own behaviors, emotions and brain patterns, mothers and fathers can also experience substantial shifts in their basic way of being a parent. In conjunction with their daughter’s treatment experience, for instance, several parents spoke of learning how to change their formerly authoritarian ways:

- We’ve got concepts now as parents, such as coming up with consequences that are not overly severe. Before, she racked up such severe consequences, that it contributed to her depression. Some of the time she doesn’t accept things and has a meltdown, but most of the time she does okay (82f).
- I learned to stop for awhile and think about it. We are trying to listen more, be consistent . . . and not get angry. We also learned about letting her make her own choices—encouraging her on good choices and not doing a terrible berating on ones we don’t think would be good (138f).

¹¹ The Chi-squared test (X^2) determines how likely it would be to see this distribution of numbers at random. A higher X^2 value indicates the particular numbers observed reflect a valid correlation (confirmed by a p value less than at least .05 to be considered ‘statistically significant’). In cases where the chi-squared suggests a correlation is present, the Cramer’s V stat indicates the strength of the relationship (ranging between -1 and +1, with numbers closer to 1 reflecting a stronger association). [While most non-significant correlations are not shared in this review, those that seemed relevant to still share are marked by a double asterisk** ←].

2. ***'I don't want to make things worse': Under-involved helping.*** Loved ones may fall into an opposite extreme as well: under-involvement—rarely checking in, distancing themselves from an individual and paying little direct attention to the problem generally.

Under-involvement may emerge for a variety of reasons. Sometimes a loved one can be initially involved and supportive until individuals resist their help or react negatively. In this case, some family and friends may back off and avoid the subject further in hopes of preserving a relationship, while others may react with hostility or resentment, 'giving up' on a person for a time in frustration (Coyne et al., 1988).



One woman acknowledged:

When you're dealing with depression, it is all about you. I've spent so many years trying to . . . get well, physically and emotionally, that it *has* been all about me . . . in the midst of your illness, the world is *only as big as you*. The only thing that you can understand is what you need or what you want and you have *no comprehension* that your episode has made somebody else late to work or caused them to have to take time off from work to drive you to a treatment or go pick you up. (13)

Referring to a similar pattern, another individual spoke of its potential consequences: "They [friends and family] stay away. Um, I've discovered . . . I became a very needy friend, which drives people away. . . you lose friends--not that they're not your friends anymore--they just don't . . . you know, you're just closed in" (7).

For this, or other reasons, some family may come to feel general disinterest or discomfort in being involved. In reflecting on her experience fighting depression, one woman reported that her husband "didn't want me taking that time" to go to support group meetings and when she asked him to come with her said, "oh that stuff isn't for him" (4). Speaking of her spouse, another woman said: "His solution was to not deal with it and so he'd find excuses to be out of the home" (3).

For a child facing severe emotional distress, one or both parents can be fairly uninvolved in assisting the healing process. About one girl, a staff member reported, "Her dad was not involved; as far as learning and trying to adapt things, he didn't do that" (28). Of parents eligible for the study, 32/132 (24%) were rated as fairly uninvolved in their daughter's treatment. Such lack of involvement may reflect a larger pattern of 'hands-off' parenting generally—at least in terms of generally offering guidance, teaching or structure to their children (see *Chapter 6, Barrier #6 below*).

Even when an individual has continued to be open to help, it can be painful for him/her to sense some friends or family growing weary of offering support after long years of struggle. Speaking of her family, one woman said: Well . . . it's been eight years and . . . I mean, it just gets old. They just don't wanna hear about it anymore, so I have tried to talk to them about it . . . I got my husband a book on, you know, living with somebody [who was depressed]. I had to read him everything that he's read out of it. He hasn't read it, [even though] he reads every night for an hour (2).

As reflected here, some families may simply lose interest in talking about 'the problem' and not want to acknowledge it seriously at all. An even more painful manifestation of resignation can similarly occur after long years of struggle, when surrounding friends and family simply 'get used' to an individual living in pain, accepting that the person will *always be that way*.

Whether from fatigue, disinterest, or strategy, lack of involvement from those around can obviously also impact the person facing a severe emotional problem. Whereas over-involvement can fuel a worsening of the problem directly, this pattern may intensify it by sheer inattention. The larger literature that confirms children and adolescents whose parents are generally *uninvolved*, for instance, perform most poorly across essentially all domains.

While involved relationships and community interaction seems important for anyone, for those facing severe emotional problems it appears to be especially crucial. Reflecting on their experiences with eating disorders and depression, several individuals recount their feelings:

- As the journey with bulimia washed me more and more into my little seashell, I became further withdrawn spending every hour sitting in my bedroom. Some nights I would lie in bed in tears (37/ED study).
- For a long time I cried alone. I lived in a world that no one knew about and I wasn't going to let anyone in. My world was hate and guilt and sadness and depression. How could no one see it? . . . This is part of a poem I wrote . . . “I smile with you all, but do you know how I cry, completely alone, wanting to die” (15/ ED study).
- You begin to feel (pause) just completely disconnected from your own life and from the people around you. . . I felt like I was in a place that no one else could reach. . . you know *they don't know how I feel* . . . they can't possibly understand (10).
- I think depression for me .. the word that always comes to mind is “detachment,” when you become alone—it’s the sad, the dark place. But the biggest word, I think, is “alone”: how cut off from everything you either make yourself or they make themselves .. *so alone, yeah—frightfully alone* (6).

As reflected here, patterns of isolation and disconnection are well-known among those facing emotional problems (Karp, 1997; Hetherington & Stoppard, 2002). In addition to emerging from the depression itself, this distance and isolation is often sought out actively by individuals themselves:

- I didn't want friends, they were too complicated and they might find out. I earned the nickname the "Ice Princess" and was happy that no one tried to get too close. (4/ED study)
- I didn't really choose to talk about it a lot with friends because I know it's a depressing . . . depression is a depressing subject, and I didn't want to, I don't know, I didn't want to subject them to that. I didn't want them to feel sorry for me and not know what to do. So, I can be a really good faker when I want to. People can sense when they're around you something is wrong, and I didn't want that, so I stopped going to you know . . . sport activities and things like that (16).
- The first skill I acquired was how to keep people from asking questions. . . . just little misdirection: ‘Oh, I'm sick today, uh I got a cold today, oh man I didn't sleep at all last night.’ Just give somebody an excuse to ride it off . . . I would walk around with my sweatshirt on and my hood pulled down. . . . you'd be amazed how easily a person can disappear if they want to . . . the right combination of clothing . . . colors and keeping your head down, you can become a ghost and I did and I got very, very good at it (10).

In addition to avoiding interaction generally, we see here individuals systematically attempting to hide their feelings and put on a mask for others. Given this trend among those facing emotional problems, we can see, at a minimum, that when surrounding friends and family begin to isolate, distance and disconnect, it can naturally aggravate the problem of isolation even more—deepening and reinforcing the distance already in place.

Another individual reflected, “I just started learning how to become better at hiding what I was going through . . . I just learned how to read the people that wanted to help me, and how I could be what they [expected] . . . how I could spend as little time as possible with them. . . . You learn how, with everybody around you just how to make it go away for their sake more . . . than to ever get better . . . completely, like to start working on it.” This young woman then shared her previous rationale for hiding the pain:

The thing is, that when you love people, and they love you, and you know that, I mean . . . you come to them at first, and you're like, "this is where I'm at and I can't do anything, please help." And you see them working trying to do what they can, but you're not feeling better, you know, and you might even be getting worse. And you just see that look of frustration, or, like, they don't know what else to do, and it's not that they're mad at you. It's just, you just see that look [on their face] like "gosh, I've done everything," you know, "We've worked on this for so long, why isn't it changing?" I mean, you just start feeling so awful and you don't want them to feel that, you know? So instead of both of you feeling that. . . . eventually [I was]. . . like, "no, I'm fine". . . so, at least one of us isn't hurting, you know. And a lot of people [facing these problems] are doing that. (6)

In light of such feelings, why not leave such individuals alone? While space obviously needs to be respected, it is important to point out that individuals often experience an ongoing tension between such isolation and a recurring desire for community connection. That is, they frequently seek this distance *even when* social connection is earnestly desired (Karp, 1997). One woman said, "I hid bulimia from everybody, and at the same time I was furious that no one knew, that no one cared enough to notice" (15/ED study). The young woman quoted above as avoiding sharing so others wouldn't hurt, went on to reflect upon her hope during this previous period that people would also *see through* her attempt to be isolated and cover up the abuse associated with her emotional struggles: "I just kept hoping that maybe [they]...would see through my lies, you know, of me going, 'I'm fine.'" Even when finally disclosing the abuse to her therapist, this woman recounted the deep ambivalence that remained:

When I finally opened up with the therapist, I was almost like, "was it worth it?" Like . . . for so long, I have been able to suppress it and pretend it never happened. . . . was that worth it to not just let everyone else . . . just go on without knowing and I'd be the only one hurting, you know? Because I hate knowing now that I worry people, you know? . . . I almost think I should have just shut my mouth and kept going . . . because even though it hurt, it wasn't hurting everybody else. (6)

As reflected here, although friends and family may have many reasons to distance themselves from someone facing a severe emotional problem, this may be exactly what that person *does not* need.

3. 'I'm here when you need me. . .': 'Just right' help and involvement. Compared with the patterns above, many interviews reflected an alternative approach that avoids both over-involved and under-involved extremes.



One girl said, "there are only a select few who are 'there for you' through thick and thin and if all else fails. . . . The amazing family I do have, *never* left my side. They are the ones I thank today for dealing with me and knowing I had potential and helping me through everything I have gone through" (73d). A young man who struggled over a long period with severe depression, said the following about his parents: "It must have been awful for them, but nonetheless they stood by me and backed me up. They

said, 'Anything you need we'll get it; we don't care how much it costs. We don't care where we have to go, you know, if you gotta fly to India to see the best doctor in the world we'll go.' And they backed me up 100% they said whatever you gotta do to take care of this we'll be there right there with you." He summarized, "They're the only reason I made it through all this" (10).

In contrast to distancing, ignoring, pressuring, or trying to "make things all better," a third approach encourages families and friends consistently *being available, being interested, and being concerned*. More than simply 'hanging out,' *being there* calls for surrounding loved ones to remain proactive in honestly inquiring and gently encouraging in a way

respectful of personal agency. Describing this kind of hardy and resilient family atmosphere, Dr. Pipher (1996) notes:

Families love one another even when that requires sacrifice. Family means that if you disagree, you still stay together. Families are the people for whom it matters if you have a cold, are feuding with your mate or training a new puppy. Family members use magnets to fasten the newspaper clippings about your bowling team on the refrigerator door. They save your drawings and homemade pottery. They like to hear stories about when you were young. They'll help you can tomatoes or change the oil in your car. They're the people who will come visit you in the hospital, will talk to you when you call with "a dark night of the soul" and will loan you money to pay the rent if you lose your job. Whether or not they are biologically related to each other, the people who do these things are family (pp. 21-22).

She then shares some basic advice often given in her therapy practice:

I encourage families to increase their expressions of affection. Families often need to be reminded to hug each other, to complement each other and to say how they feel about each other. I encourage people to write notes, make short phone calls, do small favors and express affection in whatever ways it can be received. . . . I advise families to buy the plane tickets, take the cross-town bus or drive the hundred miles out of the way to see the grand-aunts and visit cousins. . . . As Ursula K. Le Guin said, "Love doesn't just sit there like a stone. It has to be made like bread, remade all the time, made new."

One girl said, "One of the things that really needs to keep up after treatment is support—people just *being there* just to talk to you . . . It is so easy to revert back to things if you are not supported. This includes positive incentives, encouragement and praise" (158d). Several parents commented on seeking this kind of an atmosphere:

- When she calls, we're just being there and reminding her she can do it, reminding her that we are there (18m).
- Coming home, she had my total support. She absolutely knew I was there. . . . I hope she felt that way. . . . My children come first . . . that's my mantra and it underlies everything for me (30m).

One mother spoke of the importance of "finding ways of connecting"—and "being so solid with her that she experiences with us slowly the ability to trust and experience that people are on her side" (18m). Another mother said, "She had loving family who supported her. . . . We had a strong family and great marriage and we got through it." She then reflected, "Where the damage is done is where family members go into their own unhealthy behaviors instead of supporting each other" (25m). Pipher summarizes, "Freud postulated a great need for sex; I say our greatest human need is for love. We need to be reconnected one with another" (p. 32, 148, 256).



In terms of children and adolescents, alongside the presence of authentic, consistent parental love, a healthy degree of accountability was also emphasized by families reflecting these patterns. Sharkey-Orgero (1999) describes family willingness to approach individuals with compassion, honesty and firmness as a turning point in individual progress. One mother who was successful in establishing an atmosphere of home accountability after treatment said, "It takes time and the willingness to say no when your daughter says, 'but everyone else's parents are letting them' 'No.' For parents who don't know how to do that . . . it becomes harder." Overall, she then emphasized, "It is very important when your child comes home to have a stable environment and parents trying to do things in a

[better] way, because if they don't she's going to relapse" (154m). One mother described handling a potentially dangerous downturn with contingencies:

I don't know if it was partly her testing—to see what she could get away with . . . she started to slip back into some former problems. . . . We woke up and in the middle of the night, found her on the internet—took and saw history that had been on *Myspace* . . . and was meeting boys . . . We found out very early, however, and got on top of that. We told her, "You lost our trust again Carey...that's hard to get back, it takes some time." . . . There were consequences, but we didn't go overboard . . . We agreed her internet would be restricted and her lap-top supervised. We got beyond it . . . and she finished her sophomore year and her behavior around the house became much better again. (167m)

Baumrind (1991) called this healthy blend of love and structure an "authoritative" style of parenting. Parents with an authoritative approach are both demanding and responsive: "They monitor and impart clear standards for their children's conduct. They are assertive, but not intrusive and restrictive. Their disciplinary methods are supportive, rather than punitive" (p. 62). Several years later (1997), she elaborated, "The authoritative parent attempts to direct the child's activities, but in a rational, issue-oriented manner"—elaborating on the openness of communication as follows: "She [the parent] encourages verbal give and take, shares with the child the reasoning behind her policy, and solicits his objections when he refuses to conform. Both autonomous self-will and disciplined conformity are valued.... Therefore, she exerts firm control at points of parent-child divergence, but does not hem the child in with restrictions." In summary, an authoritative parent is described as "enforc[ing] her own perspective as an adult, but recogniz[ing] the child's individual interests and special ways. The authoritative parent affirms the child's present qualities, but also sets standards for future conduct" (p. 891). In our Utah Youth Village research, 20% of parents (28/138) were identified as reflecting a largely authoritative parenting style.

Positive consequences of finding this balance. As with other approaches above, this authoritative combination of love and structure can have tangible consequences for individuals who are struggling. One mother said, "At times, she would get upset and seem like she forgot about everything she learned at Alpine . . . and then she would come back. It was those times when she would need her father or I to talk with her and comfort her" (170m). One girl said, "Sometimes that's all you need, like during a humongous panic attack when you feel like it's all going to end. If you can think just for one second, 'I'm okay because this person loves me,' sometimes that keeps you around" (6).

As reflected here, ultimately, loved ones may become powerful supports. Other accounts confirm the potential of committed loved ones to nourish hope (Claude–Pierre, 1997; Sharkey-Orghero, 1999). This kind of support may also function preventively, as parents help a child work through early exposure to destructive ideas:

In fourth or fifth grade I had become a little pudgy, but it was not something I worried about every minute. Then my classmates thought it was their responsibility to tell me everyday how fat I was. This began to tear me apart. I would go home and cry to my mom who always understood and would listen to me and tell that she thought I was beautiful and that I should try to not let them hurt me, because they were not important (19/ED study).

In addition to parents, siblings and extended family members can sometimes provide equally intense support. One mother related how her brother (the girl's uncle) played a major role: "He went to visit her every place she was . . . he does love her; she loves him. . . . She's open to the love of the family" (148m). In another account of a girl's battle with an eating disorder, the older brother made the difference: "My coach noticed. My parents knew but tried to deny. My brother was scared. . . . His begging for me to eat became a daily routine. He would stand by my locker with his teammates yelling down the hall for him, and beg me to eat. I never would." She continued:

When I hit my lowest weight ever in the beginning of sophomore year, I was sent to the hospital. I went without protest but I definitely didn't want to go. . . . I have only seen my brother cry once. I was lying in my

hospital bed bawling as they tried to stick the IV in my arm. I turned to look at my family and beg them to take me home. I opened my eyes, and in between my stone-cold parents stood my brother, big man on campus Tom, with tears streaming down his cheeks. I made a silent vow that I would get better. . . . It took four hospitalizations and hundreds of therapy sessions, but I got well. Looking back, I think, the only thing that kept me eating was Tom's late night phone calls from his dorm room at college. I needed to get well for him.” (Hess, Moore, Brahm, Judd, Petroske, & Klok, 2008, p. 14).

Once again, the authoritative combination of love and structure is evident here. In the context of eating disorders, Sharkey-Orngero (1999) describes family willingness to approach individuals with a combination of genuine compassion, honesty and firmness as a specific turning point in individual progress.

Girls also commented on feeling this way with some of the Alpine Academy parents. One girl said “my parents have never been really helpful my entire life . . . My mom is an alcoholic and my dad in prison.” She then said, “One of the good things about Alpine was the people I was with—Corrie and Brad taught me there is such thing as a real family. . . I know what it feels like to not have anyone—and then when you finally find that . . . you feel ‘wow!’” She continued, by reflecting on the same balance she saw in their home:

I felt comfortable with Brad and Corrie. They would sit and listen . . . and not judge me. . . They told me, “No matter what, you can always talk with us.” . . . On the other hand, if they needed to tell me something bluntly, they would. And I would respect that. . . . Corrie shared feedback in a way that I knew she cared.

This girl went on to share what had made the most difference in this home:

I think I felt comfortable with them, because they loved me. . . . Sometimes Brad & Corrie would take an individual girl out for a milkshake. . . . One time, they took me (*just me*) out! . . . You can tell if someone truly loves you or not . . . you can tell. There are people who say, “I love you”—but they [don't really mean it]. But with Brad and Corrie . . . they cried for me when I left! . . . She made us all a quilt for when we graduated.

After emphasizing how Brad became a real father figure to her, she said, “Corrie was also more like a mom than my mom is. . . . My mom loves me, but she's the kind of woman whose drinking takes over everything else; it's hard to get along with a woman like that.” She then concluded, “If I could choose anything in the world, it would be to have you guys being my real family—to adopt me.”

This girl, who is currently doing well in her life, was then asked, “So without a lot of family support outside of Alpine, how have you done so well?” She answered, “I don't feel like there is any reason to let Brad and Corrie down . . . or to let myself down” (104d).

As evident in this story, once again, a healthy combination of love and structure was especially helpful to someone in recovery. Research has consistently confirmed that parents who are able to combine both structure and love in a healthy balance, find success more often, with children who doing well in a variety of areas. This includes more happiness and self-confidence about abilities to master tasks, better developed emotion regulation and social skills, and less rigidity about gender-typed traits—i.e., more sensitivity in boys and more independence in girls (Baumrind, 1991; Darling, 1993; Miller et al., 1993; Weiss & Schwarz, 1996).

Our own statistics reflect this same pattern, with girls whose parents were involved in more healthy and balanced ways doing *remarkably* better in both short and long-term outcomes.

- Girls of parents with a balanced, “authoritative” parenting style were 25-31% more likely to graduate from Alpine [X^2 of 6.3 ($p=.04$), Cramer's V of .23 ($p=.04$)] and 20-22% more likely to be doing well long-term [X^2

of 8.2 ($p=.08^{**}$), Cramer's V of .18 ($p=.08^{**}$), when compared with girls of a parent reflecting either permissive or authoritarian parenting styles ($N=115$).

- Girls of parents who were supportive and appropriately involved during treatment were 41-68% more likely to graduate from Alpine [X^2 of 21.7 ($p=.001$), Cramer's V of .43 ($p=.00$)] and 32-46% more likely to be doing well long-term [X^2 of 17.2 ($p=.01$); Cramer's V of .27 ($p=.01$)], when compared with girls of a parent either more controlling or more passive during treatment ($N=101$).

As demonstrated by both stories and statistics above, substantial implications appear to follow from families' fundamental style of parenting. Beyond unique technique or behavioral patterns, parenting style reflects, by definition, a deeper orientation in how mothers and fathers interact with their child. Another way to speak about this deeper level is to what existential philosophers call "way of being."

As the next chapter will detail, the pathway to cultivating a more authoritative and responsive home atmosphere is not without its fears and barriers. Nonetheless, as families learn to cultivate an open, soft and affectionate way of being with each other, the difference it can make for a youth struggling with emotional problems (and for everyone else) is thrilling—and comparable to the shift that mindfulness can make for someone individually. Because of the rich potential of this kind of atmosphere, quality educational programs have been developed in recent years that focus on teaching individuals and families how to make this shift to a more 'responsive' and open way of being (Warner, 2001; Arlinger Institute, 2006). Both the mindfulness curriculum described in Chapter 4 and this Arlinger curriculum share a focus on attending more deeply to distinct qualities of being—qualities that can, according to multiple indicators, make all the difference in the world.

Chapter 6: 'But I'm not a therapist... I'm just a mom!'

Seven challenges to creating a healing atmosphere

In the previous chapter, three different patterns of family/friend involvement were reviewed, alongside some evidence of implications for those seeking recovery from severe emotional problems. In this final chapter, we take up a number of specific challenges that are facing families and friends who seek to support an individual through this process. Although these challenges are relevant to community support generally (neighbors, friends, caregivers), they are here discussed in the context of a family itself—specifically, for parent-child relationships. These include: [1-2] parental fears at relapse and feelings of incompetence in their own abilities to support a child; [3-5] family habits that can interfere (parent conflict, resistance to change, and lack of time together); and [6-7] hesitations among parents about intervening either more or less than they currently are. In these seven themes, we extend our exploration of interviews, to consider some of the turbulence that can arise while seeking a responsive, and healing home environment.

1. 'But what if she falls back into it?': Fear and panic. The first challenge is an understandable one, especially in the face of the real threat of relapse (see Chapter 4). After an adolescent had made progress in overcoming emotional struggles, parents spoke of the fear they sometimes continued to face:

- I would question [my daughter's] responses, over and over, even those that were solid . . . wanting verification . . . that "yes, this was normal."
- Anytime it looked like something was going a little wrong, I found myself holding my breath and expecting the worst—"What do we do? What do we do?"

Ironically, perhaps the biggest danger of parents operating out of this fear-of-regression is prompting some of that very regression in their kids. Speaking of her feelings after successful treatment, another girl said, "The biggest thing a kid wants from parents is to treat them like they are normal again. I knew I was better—but if my parents don't and are constantly questioning, it kind of breaks your confidence a little." This girl, who had struggled with eating issues, said, "If I wasn't hungry and parents jumped on me—that would be really, really frustrating" (143d). In her own interview, this girl's mother agreed, "I can't reiterate strongly enough [the importance of] having an up-front conversation [making sure] parents are prepared to let go [of fears]." She insisted, "If parents can't let it go, the girls are more vulnerable." This mother continued to reflect, "If there is still anger or resentment—if the parent hasn't gotten through the heartbreak or the fear of the heartbreak again, kids are always going to sense that. In a certain sense, a self-fulfilling prophecy—'she expects me to fail' . . . expectations are there to follow" (143m). Although his daughter was "very tolerant" with these kind of parental worries, this woman's husband cautioned that "if the kid is not as tolerant," they can "perceive [such behavior] as mistrust" and it can thus easily become "a source of friction" (143f). Several parents suggested ways that a lack of trust can provoke actual worsening behavior. One father related, "Sometimes we will wake up going, 'here we go again' and it can become a horrific self-fulfilling prophecy. Kids can read it on [parents'] faces—utter panic." He illustrated, "A kid is out past curfew and doesn't call back, but parents feel utter terror. . . . There is a difference between panic and concern." He went on to emphasize that, in reality, this is "a problem that a *parent* has to solve" (176f).

Speaking to parents, Pipher (1996) writes:

When you are backpacking in the wilderness, the first rule in any crisis is "Don't panic." The greatest danger is losing one's head. Panic disorganizes thinking and leads to self-defeating behavior. . . . When we panic, we act hastily, make mistakes and get ourselves in even worse trouble. We can work our way out of the woods if we think carefully, talk calmly and work together (p. 252).

If panic provokes added burden to someone in the recovery process, the opposite seems also to be the case. Authentic trust, that is, appeared to add a significant lift to the family atmosphere. One father commented on a sense he got from his daughter of worrying she had lost out on her dreams, “Am I totally screwed now ‘for life’?” He continued, “Some of their cohorts might be gone from school—[it’s easy for] hopelessness and resignation to set in for a 15 year old.” Based on his own experience, this father encouraged other parents to, “give your child the psychological reassurance that her goals are still very obtainable . . . you know, things which we know because we’re older, [like] ‘it doesn’t really matter at what age you graduate.’” By sharing this kind of faith, he argued that families could better avoid the “drag” of the past, “becom[ing] a self-fulfilling prophecy” (176f). Another father said, “We have great hopes that she will achieve great things, and make something of her life; if that happens, all of this will have been worthwhile.” He continued, “We see all these little positive signs: she is paying her bills; she is well on her way to college; she is not pregnant; not on drugs; not smoking . . . and she is artistic. She draws, some of which are wonderful” (23f). This kind of a parent who still believes in a child may become a source of real, tangible comfort to a youth struggling to regain his/her life.

Hoping and trusting, of course, is not always contingent on things going well. Rather, it is an acceptance that things will be okay, even when struggles come along. One mother said, “We all need to remind ourselves that we are works in progress and remember that when difficulties . . . come up, we have tools; and to always remember that an argument, sadness—the stuff of daily, human emotions—*doesn’t mean crisis*.” One girl said, “Expect for the kid to mess up at least once. . . . Once is not a big deal; when you get out of the bubble, you are going to test out the waters, to learn for yourself: ‘I don’t want that,’ etc. With a [parent’s] expectation of perfection, girls are more likely to keep secrets” (140d).

Even trust, of course, has a balance. Indeed, an acceptance of turbulence is not the same as naiveté. While one father encouraged making sure “set-backs are just treated as set-backs,” he then continued, “but be wise. That takes vigilance and reality-checking” (176f). A mother suggested that other parents “look out for common antecedents of negative spirals such as a stressful day” (143m).

Arriving to this point can take work and time. Some moments can remain tense. One father spoke of his discomfort in navigating these moments: “The tension—I feel it; it’s palpable” (26f). Another parent said, “it took a year for everyone to feel comfortable with each other again.” A mother said, “This step begins with making a commitment to letting go of the fear.” She continued, “My daughter was really good. She would see a little panic in my eyes” and do things to reassure me. During one anxious moment, one mother told of her daughter putting “both hands on my cheeks . . . looking me squarely in the eye and reassuring me she was better, ‘Mom, you don’t have to worry. I’m okay.’” She reiterated, “There was a lot of reassurance from her, but it also took a heck of a lot of commitment to letting it go. Close the book—the past is past . . . you’ve done 9 months to overcome that—they would not let you come home if they didn’t think you could succeed. Therefore you will succeed.” She concluded, “Leave the past behind and do not . . . bring it into the present. . . [Try to] trust all the work she did and all the work we did as a family” (143m).

Another mother said, “We realized *we can do this!* and started to trust her to make good decisions. . . . As a parent, you’ve got to believe you can do it [too].”

2. ‘But I’m not a therapist!’ Feeling incompetent as helpers. If it is important that parents have such a belief in their capacity as parents, interviews suggest that this might be a real barrier for some families. One theme that stood out across interviews was parent fear of not being capable of helping their daughter. These feelings often involved an overt comparison between themselves and professional helpers. Two mothers remarked:

- While she was doing well in a structured setting, when she came home there was no way to replicate that kind of setting. . . . She needs a trained program, and staff that can't be burned out (22m).
- She was used to having someone around 24/7 who was trained to deal with the ups and downs emotionally. My husband and I are not trained in that (142m).

Another mother elaborated her own similar feelings:

No home can simulate a residential treatment center. . . . You can't put in place the same degree of intensity and supervision and contractual arrangements in just your own home; it just doesn't fit. . . . I can't put in place their tricks of the trade and programmatic things. . . . in just my own home. I'm not them. I'm not a therapist; I'm just a mom" (125m).

Laying aside technical or therapeutic aspects of residential treatment, some parents went even further to claim that some of the basic *family practices* at Alpine were impossibilities in their home. One mother said, "At Alpine they cook and eat together. They all work together as a family in a nurturing home life," before adding, "In reality, that doesn't happen in our household. That's not real." Although acknowledging that "she's the type of kid that needs the nurturing environment," this mother emphasized, "I can't reproduce the same structure Alpine offers." Two other parents shared similar comments:

- At home our family is wired differently. I don't have tender patience to be with someone all the time suffering with emotional problems—e.g., saying something a certain way, etc (83m).
- Family teachers. . . . were able to do things that we could not do for her as parents. . . . they knew when she was acting out and when she needed to be disciplined. They knew when she needed to have a discussion; they knew when they needed to act strictly. . . . These are things that we couldn't get away with as parents (170f).

Compared with previous comments about the difficulty of maintaining contingencies or programmatic elements of treatment, these parent remarks here stand out for the nature of the activities emphasized as *outside* the bounds of parent competencies. Paraphrased from the quotes above, these activities include:

- ✓ Regularly 'cooking and eating together.'
- ✓ Doing work together as a family.
- ✓ Maintaining 'tender patience' around a child still struggling emotionally.
- ✓ Taking care with a child to 'saying something in a certain way'
- ✓ Being aware when a child was 'acting out' and needed to be disciplined.
- ✓ Knowing when a child needed a chance to talk.

Fifteen years ago, Dr. John McKnight, a researcher from Northwestern University, published a provocative book in which he proposed that given the right circumstances, natural support systems like friends, families and neighbors could inadvertently come to *forget their own capacity to help each other*. This could happen, McKnight hypothesized, if they became so accustomed to relying on professional support that they no longer experienced their own informal support system enough to see it as important (McKnight, 1995). In light of parent comments above disavowing their capacities in relation to some of the most basic functions of any family, McKnight's thesis seems compelling.

While surrounding professional systems clearly can facilitate and strengthen families' own capacity to face such challenges, their over-emphasis can be problematic—especially if it distracts from the centrality of parents' own actions.

3. 'Her father and I just don't get along': Marital quality and youth well-being. Much of the focus above has been on how parents treat children. While this is the natural focus of this kind of manuscript, it neglects a second,

perhaps equally important connection: parents' relationship with each other. It is no longer a secret what marital conflict means for children in that family (e.g., Wallerstein, Lewis & Blakeslee, 2000). One mother said:

Even if things are not perfect in the family, for a child there is something about having a Mom and Dad that you belong to and they belong to you. When that breaks, anything can break. It does tremendous destruction to these kids. [Family conflict] really sends them into tailspin. . . . It completely breaks their security and trust. It's like, for adults, you get up every morning and the sky is blue and every night the sun sets and moon comes out. It would be like all of a sudden, you get up and there is no moon or sun anymore. Youth depend on the family so much . . . But we [many adults in today's society] take that from them; their whole base of security . . . shattering. You look at some of the stuff that goes on in these families, and think—how could these kids *not* go crazy? (47m)

The impact of marital quality was clear in our own statistics:

- Girls of parents in an unhappy parent relationship were 21% less likely to graduate from Alpine [X^2 of 3.1 ($p=.2^{**}$), Cramer's V of .16 ($p=.2^{**}$)], and 37% less likely to be doing well long-term [X^2 of 14.31 ($p=.007$), Cramer's V of .35 ($p=.007$)], when compared with girls of parents with a happier relationship together ($N=110$).
- Girls of parents in a 'cooperative' (post-divorce) relationship fared better, slightly less likely (6%) to graduate from Alpine ($p=.2^{**}$), and 17% less likely to be doing well long-term ($p=.007$), when compared with girls of parents with a happier relationship together [statistical details are the same as above].
- Girls of parents in a 'happy' marital relationship fared the best, 6-21% more likely to graduate from Alpine ($p=.2^{**}$) and 17-37% more likely to be doing well long-term ($p=.007$), when compared with girls of parents with either an unhappy relationship or a cooperative post-divorce relationship together.

As reflected here, there was a full 37% *difference* between girls doing well long-term, when comparing happy and unhappy marriages. As evident here, the quality of parent relationships is relevant during treatment and after treatment as well. One mother said, "If you don't have both parents on the same team, it is a great disservice to your daughter during treatment" (134m). Describing experiences post-Alpine, a second mother reported, "She's sad about her family, [especially] her Mom and Dad's break-up. . . . She won't talk with me" (183m).

We conclude this section with a more optimistic description of how parents can relate to each other during such a crisis situation. The mother of one girl doing very well long-term said:

It was a long, hard journey—both her father and I being here for her. . . . Believe me, my husband and I just committed to maintaining the household. We could have divorced and moved apart, but we didn't. She was in really bad shape and I just couldn't see locking away my daughter for life. She had suicidal ideation for 3 years; it was just very, very bad. They were going to commit our daughter permanently; it was that bad—we said, "No, we're going to bring our daughter home"—really, we were just not giving up; the both of us—it took the both of us. He was the white knight; I was the researcher—it took the both of us to do it—being the both of us together to do it. In fact, there is work I have to do for her still (59m).

4. 'But I'm not the one in treatment!' Resistance to broader family change. As reflected in the opening chapter, it can be tempting to attribute the source of emotional problems primarily to internal dynamics within the individuals who are afflicted. One girl whose struggles were linked to difficulties in her home life said she sometimes felt that "kids were blamed, rather than parents"—"They said we were responsible for our actions, but in my opinion, if we were taught to act like that by our parents, then is it necessarily all our fault?" (178d). Commenting on her treatment experience, another girl said:

I just remember saying, “I don’t need to be here; my parents are the ones causing my problems; *they* need to be in therapy, not me.” Even though the intent was not right at the time I said it . . . if you think about it, there’s something to it. I definitely needed to be in therapy, but they did as well. We *all* did. I really do believe . . . that if the kid has to go into treatment, the parents should [as well]. . . . They should take at least a week or two to be in a similar setting and try to understand what was going on (158d).

Some parents appear to do precisely this, as they seek their own change concurrent with their daughter’s treatment:

- Alpine impacted my parents. We worked more as a team and there was not as much triangulation. . . . They learned how to talk with me . . . and a more natural way to confront me and learn how to do things. And I would listen to them, feel better and follow instructions (7d).
- I credit Alpine staff teaching me how to be as a parent and how to respond to a lot of situations, introducing new ways of being to shift our patterns. We tried to get as much out of it as our daughter. . . . It was wonderful! (18m)
- I had to do a lot of soul-searching myself, a lot of consciousness changing to help me understand the whole milieu of both of my kids and how they process and how they grew up, including what holes were created in them [by tough family experiences] and how they tried to fill them with other things. (38m)
- The whole time she was there to therapy, my husband and I regularly went to therapy and family sessions. . . . We’d say things, for instance, and it sounded accusatory; we learned the ways to say things to encourage the communication instead of . . . coming across as accusing (67m).
- Alpine helped me help her too. I saw other parents willing to make changes and it gave me strength. . . . I needed to put my values in their proper context (54f).

One girl said, “I saw very good changes in my parents” (162d). A second girl said:

Our family relationships are definitely better—nothing like they used to be. . . . My Mom used to be physically and verbally abusive and she hasn’t done any of that since Alpine. . . . She’s just trying to be the best Mom she can and she’s been trying to have a relationship with me that we never had. My Dad is also more supportive and open; Alpine impacted my parents to make those changes (164d).

In one especially touching story, one father described committing to giving up alcohol in order to provide extra reinforcement for his daughter’s own change: “I haven’t had a drink since.” He then explained, “It is easy for parents to say, ‘She screwed up; my daughter needs to change’ . . . but that’s ridiculous . . . you have to look at your part in the situation. Each parent individually.” He continued, “The family dynamics need to be fully modified . . . otherwise, there will be regression.”

In this family, this father’s action appeared to reinforce the rest of the family doing the same. In a separate interview, his wife admitted that they had made mistakes earlier, before adding with excitement “but we changed!” She reflected, “We can do research, we can learn and change . . . that was the key: loving your child enough that you do it. We were motivated to change ourselves so it could help change our daughter.” In a touching interview with the daughter, she went on to independently retell the story of her father quitting alcohol for her, with a sense of love and pride. Then likewise remarked, “Parents need to work on themselves [too] . . . it’s not a one-way change; everyone has to change” (Alpine Transition Report, p. 23).¹²

Not incidentally, literally every girl whose family has been quoted above as reporting parental change is doing well long-term. Some parents shared regrets at not taking advantage of the learning more, “Now that we are out of it

¹² If you would like a copy of the full transition monograph completed last year, [‘*Okay, now what do we do?!*’ *Examining successful transition. In their own words: Parents and daughters on coming home*], e-mail Jacob at jhess@youthvillage.org.

and we reflect back, if we would have just stopped and reflected . . . ‘look what she’s doing.’ . . . Maybe we could have learned a few skills” (143m). On other cases, one parent makes shifts, while the other parent does not. One girl said, “We have been continuing to process and work. My Dad was pretty supportive of Alpine—‘Oh, okay . . . let’s use the *I feel* statements instead of accusing’ . . . If I mention something, he will work on it.” But she added:

Some parents will work on it, and some won’t. My step-mom refused to go to therapy after Alpine, “the only reason she was doing the therapy,” she said, “was because . . . I was in therapy and she had to.” So it was saying “I don’t have issues—you have issues”. . . It was kind of an “I was only there to support you and change you” mentality. But my whole family had issues—I had issues, my Dad had issues . . . no one gets off scot free. My Dad was willing to admit that.

Lastly, this girl said:

I was expecting my Dad to be the one who said, “I don’t need it” My Dad was prideful—he didn’t like to think that he was doing anything wrong. But as soon as he realized I needed help, he realized that he probably did have something to do with it. He humbled himself and has changed a lot. My step mom, however, stayed the same . . . blaming me for needing a divorce. . . . Mom went right back to how she was before Alpine, which was hard because she and I always had conflict. (158d)

As reflected here, not everyone in a family seeks change and not all of these shifts are necessarily genuine. One mother said, “If you’re not authentic—if you don’t really mean it . . . kids are smart. They know if you’re just doing what you’re supposed to do . . . and going through the motions.” She illustrated with the challenge of “*really* listening—not just hearing what people say, but taking it in . . . taking the time to do that. It is easy to go about life and not pay attention to whether you are listening, or whether you are present with them . . . making them feel important and not being afraid to say you’re sorry if you’re out of line as a parent.” She elaborated:

Kids know if you are . . . just practicing the skills, or whether you are *living* the skills. At a certain level, you have to assimilate them both—she has to and we have to. . . . If we haven’t done that, we’re still going through the motions. In your everyday life—not just in dealings with child—taking in everything you’ve done and changing yourself . . . otherwise, [the skills/lessons] are not in your core, not who you are . . . and not genuine. I think you have to start by practicing them. The more you do that, the more they don’t become practice—they become the way you live . . . your way of being (143m).

One of the clearest indications of counterfeit change, of course, is its temporariness. One mother spoke of making efforts to change afterwards, “I try to listen to her a lot more when she talks instead of just blowing it off. One thing that is still hard is looking at her as an adult. When the kids were growing up I was a screamer” (178m). In a separate interview, however, this woman’s daughter said, “I don’t think the parents make changes they need to . . . maybe for awhile (you can’t teach old dogs new tricks).” She continued:

My Mom didn’t stick with it . . . she acted like she wanted me to be back, saying “I’m going to support you and help you with this and do what I can.” . . . But when I came back, things kind of went back to normal . . . including weird control things. . . . She made efforts at first, but kind of gradually went back to normal (178d).

In a similar story, another girl spoke of some larger factors potentially influencing such back-stepping over time:

The first 6 months are easier because your family is still in the Alpine mindset for at least the first 6 months (the really supportive mindset). For the first 6 months, my step-mom was *really* supportive of me. If I did something similar to pre-Alpine days, she would call me out, but not get upset--and we would work on it. They were supportive like that for the first 6 months. After a certain amount of time, though, they started to slip back. . . . into old behaviors, and when that happens, the girls follow suit. Parents start reverting to old behaviors and girls can only last so long before they revert back too. . . . After a certain amount of time, it was

like, “Alpine was good for that time, but now we don’t really need to look at it.” If I bring up stuff from Alpine now, Dad is like, “oh, I remember” but we don’t really talk about it (158d).

Several other individuals warned of the consequences of the larger family atmosphere not changing. One father in the transition study warned that if parents treat their daughter the same way they did before, “what advantages you gained will shrivel away.” His wife said, “If parents have not bought into working on the family and just saying, ‘okay, you just need to fix my daughter,’ . . . it is a recipe for disaster. If they are not willing to change, the same triggers are there and the manipulation will come back.” Others similarly cautioned:

- Consider the family . . . consider what girls have to go back to. Even if they made some incredible changes, if the family hasn’t adjusted, it can be hard (38m).
- It doesn’t do any good for a kid to go to some kind of intensive therapy and go back home to parents who haven’t changed one bit and haven’t learned to communicate (67m).
- A major aspect of treatment is, “yes the kids have to do it . . . it’s their deal.” But if they go home and the family hasn’t changed a lot, they will fail. . . . If the family is not willing to change, then change will not occur on all levels (144d).
- It is very important when a child comes home to have a stable environment and parents trying to do things in a different way, because if they don’t, she’s going to relapse (154m).

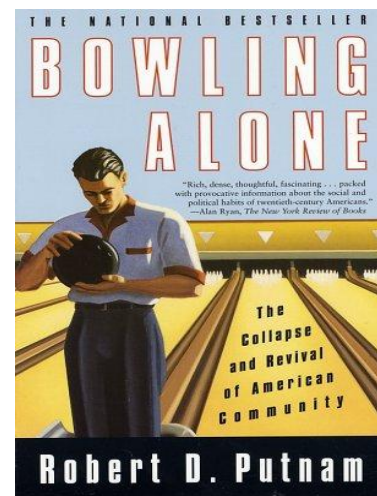
Another father in the transition study was cited as saying, “We all have issues—whether we admit it or not. We’re all messed up. If the child gives 110% and admits she has issues and works on them—and the parents give 110% . . . it works. If the parent says, it is not my problem—and the child comes home, it won’t work. When both parties admit they have a piece of the problem, it works. It’s that simple. *No more words.*”

5. ‘We’re just all so busy. . .’: Lack of time. While major changes of habit or lifestyle will be necessary in some families, for others it may be small and simple changes that can make a large difference. Several girls spoke of their family simply not having enough time to spend together when they returned home. For instance, one girl said, “My parents are retired, so I don’t see them a lot. My dad is out on a boat; I don’t get to talk with him a lot. My brother and sister are really busy with work and don’t have time to talk. . . I see my sister once in awhile, but my other brother does not want to talk at all” (50d).

Given the growing intensity of an American way of life, Utah Youth Village conducted a small-scale literature review on the topic last year. In order to provide the information to our families, we depart from our survey of interview themes briefly, to consider patterns in the research literature related to this powerful challenge for homes: *families without time!*

In 2000, Harvard sociologist Robert Putnam published an exhaustive summary of statistics confirming a trend of family and community fragmentation noticeably worsening over the last 40 years. From dropping attendance in Rotary & Kiwanis meetings, to diminished voting and political participation, to decreasing rates of card-playing and bowling among friends, Putnam vividly details a substantial cultural shift that has occurred. This occurs what he calls a “dramatic change” in family connectedness over recent decades. This includes the following patterns, comparing measures of family time between 1981 and 1997:

- *Less talking together:* Household conversations dropped dramatically, with the average American family in 1997 spending close to no time per week “talking as a family” and only 45 minutes per week in “conversation with anyone in the family” as primary activities (Hofferth, 1999, University of Michigan).



- *Less eating together:* Family meal time declined by nearly an hour per week over the same period, with a 33% decrease over three decades in families who say they have dinner regularly. Currently, only one-third of U.S. families indicate they “usually have their evening meal together on a daily basis,” with 58%-66% also reporting that the TV is regularly on during dinner (RGA Communications, 1995/A.C. Nielsen Co).

Putnam points to national trends in family mealtime as particularly symptomatic: “Since the evening meal has been a communal experience in virtually all societies for a very long time, the fact that it has visibly diminished in the course of a single generation in our country is remarkable evidence of how rapidly our social connectedness has been changing” (p. 100).

In addition to talking and eating together, family time overall, simply “being together,” has also taken a hit. In a recent survey of 1,800 adults in the U.K., Vodafone (2006) found that during the week, “a quarter of all families spend an hour or less together without distractions (i.e., 8 minutes, 36 seconds, on average each day)” with statistics for the majority of families only twice as much (17 minutes, 24 seconds on average each day). Putnam elaborates:



Beyond mealtime, virtually all forms of family togetherness became less common over the last quarter of the twentieth century. Between 1976 and 1997, according to Roper polls of families with children 8-17, vacations together fell from 53 to 38%, watching TV together from 54 to 41%, attending religious services together from 38 to 31% and “just sitting and talking” together from 53 to 43%. It is hard to not read these figures as evidence of rapidly loosening family bonds (p. 101).

The Vodafone (2006) survey also found evidence that patterns do not simply reflect a lack of desire among families, with 70% of respondents who acknowledged not spending enough time with their families also insisting they *wanted to do something about it*.

If families want to make a change, then where does the primary problem lie? Vodafone’s survey indicated the main “disconnecter” was work obligations, blamed by 7/10 respondents for preventing more family time. Hofferth (1999) pointed to excessive recreation activities as playing a similar role, noting that youth time in structured sports doubled between 1981 and 1997, from 2 hours, 20 minutes per week, to 5 hours, 17 minutes per week. Doherty and Carlson (2002) argue that “soccer practice, violin lessons, and other extracurricular activities can serve to overwhelm children and distance them from their loved ones.”

In his analyses, Putnam also confirms the role of both over-scheduling and over-working. However, ultimately, he emphasizes a third cultural factor as the primary culprit for decreasing trends in family time and connectedness overall. Between 1965 and 1995, Putnam notes, Americans gained an average of six hours a week in added leisure time due to technological advances. Over this period, however, on average, they spent “almost all six of those additional hours watching TV” with statistics indicating approximately 40% of American free time in 1995 absorbed in watching television (pp. 222-223). Among Putnam’s own explanations for why American families were spending less time together, no factor accounted for more of the change than the growing reach of television.

Vodafone (2006) similarly notes 47% who say computer games and TV are the biggest reasons for not spending quality time with the family and “not having the chance to catch-up,” with 33-50% of all respondents saying their main way of communicating is not face-to-face (depending on the age bracket). According to recent surveys:

- The average American adult watches more than 4 hours of TV each day (totaling 28 hours per week or 2 months of nonstop TV-watching per year).
- U.S. kids are spending an average of 3 hours a day in front of the TV alone. When movie, video game and computer time is added in, total in-home screen time soars to an average of more than 4-6 hours a day (Centers for Disease Control and Prevention).
- The average U.S. home has the TV turned on daily for 6 hours, 47 minutes.

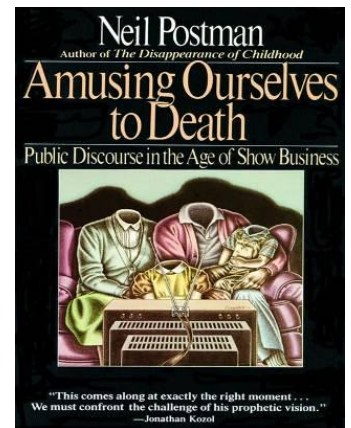
The significance of these figures comes into relief when compared with those for other activities such as talking with other family members, going to school and reading:

- Time per week that parents spend in meaningful conversation with their children: 3.5 minutes
 - ➔ Time per week that the average child watches television: 1,680 minutes
- Time per year the average American youth spends in school: 900 hours
 - ➔ Time per year the average American youth watches television: 1500 hours
- Number of movies rented in the U.S. daily: 6 million videos
 - ➔ Number of public library items checked out daily: 3 million books

As noted in Chapter 1, a recent study from researchers at the University of Michigan tracking the “major sources of influence in children’s lives” between 1950 and 2000 found that for the first time in history, media has become the top influence in most child’s lives—ahead of peers, school, family and church (Ako Kambon, personal communication January 22, 2010; see also <http://www.med.umich.edu/yourchild/topics/tv.htm>).

In a recent New York Times article about media use, the story of one family was detailed, including this excerpt of going on a vacation:

For spring break, the family rented a cottage in Carmel, Calif. Mrs. Campbell hoped everyone would unplug. But the day before they left, the iPad from Apple came out, and Mr. Campbell snapped one up. The next night, their first on vacation, “We didn’t go out to dinner,” Mrs. Campbell mourned. “We just sat there on our devices.” She rallied the troops the next day to the aquarium. Her husband joined them for a bit but then begged out to do e-mail on his phone. Later she found him playing video games.



The article went on to cite on Stanford researcher, Dr. Nass, raising a concern that “heavy technology use” can lead to decreased empathy by way of a basic decrease in human interaction, even when people are in the same room. He suggested, “The way we become more human is by paying attention to each other. . . It shows how much you care” and noted that interaction is crucial to the human condition: “We are at an inflection point. . . A significant fraction of people’s experiences are now fragmented” (Connelly, 2010). Pipher (1996) writes:

We are just beginning to grasp the implications for families of our electronic village. . . Family members may be in the same house, but they are no longer truly interacting. They may be in the same room, but instead of making their own story, they are watching another family’s story unfold. Or even more likely, family members are separated, having private experiences with different electronic equipment (p. 14).

Pipher elaborates, “The media forms our new community. The electronic village is our hometown. . . Parents and children are more likely to recognize Bill Cosby or Jerry Seinfeld than they are their next-door neighbors. All of us know Michael, Newt and Madonna. . . . We’re happy when Christie Brinkley marries on a mountaintop or when

Oprah loses weight. We follow the news of the stars' addictions, health problems, business deals and relationships. We know their dogs' and children's names. These relationships feel personal. But they aren't." She continues:
The new community is not a reciprocal neighborhood like earlier ones. David Letterman won't be helping out if our car battery dies on a winter morning. Donald Trump won't bring groceries over if Dad loses his job. Jane Fonda won't babysit in a pinch. Dan Rather won't coach a local basketball team. Tom Hanks won't scoop the snow off your driveway when you have the flu. These vicarious relationships create a new kind of loneliness—the loneliness of people whose relationships are with personae instead of persons (pp. 13-14).

In a broader context of citizen engagement and social participation, Putnam goes on to conclude that “compared to all other factors (education, generation, gender, region, size of home town, work obligations, marriage, children, religion, race, and more), dependence on TV for entertainment is the single most consistent predictor of [diminished] social participation.” He states, emphatically: “Nothing—not lower education, not full-time work, not long commutes in urban agglomerations, not poverty or financial distress—is more broadly associated with civic disengagement and social disconnection than is dependence on television for entertainment” (pp. 230-231).

Fighting back. In light of these challenges, one of the premiere researchers in the area of family time, Bill Doherty (family science professor at the University of Minnesota) is spearheading a multi-partisan, non-sectarian effort to “help parents reclaim family time” across the nation (Doherty & Carlson, 2002). After emphasizing that the “balance” of family time “has become gravely out of whack for many families of all social classes,” Doherty proposes that “retrieving family life requires a public, grass roots movement generated and sustained by families themselves” aimed at “raising awareness about finding balance in our over-scheduled lives.” In terms of ultimate goals, he envisions a nation-wide initiative to “counteract the erosion of family time and the overly-competitive world,” eventually “building a community where family time and family activities have high priority in a world that pulls families apart” and “where family life is an honored and celebrated priority” (see www.puttingfamilyfirst.org).

Doherty goes on to offer the following encouragement to families:

- ✓ Make family time and family activities a high priority in their decision making.
- ✓ Set conscious limits on the scheduling of outside activities in order to guard family time.
- ✓ Set limits on television, the Internet and other electronic media if these are dominating family life in the home.
- ✓ Seek out ways to participate together in activities that build and serve their communities.

While these ideas seem basic, a simple awareness of their importance may be all that is needed. When the Center for Disease Control interviewed parents on their views of children and television they learned that many families “did not see any reason for time limits, as long as chores and homework were done.” In order to facilitate these efforts, Doherty’s organization shares “innovative ways to address scheduling conflicts, strategies for reclaiming family time . . . and creating family rituals of connection, relaxation and fun” and a game plan for the “development of action steps to try within your own family” (see website above for further information).

In the same direction, Pipher notes, “Most kids need more adult time and less money,” before sharing additional advice as a family therapist: “There are a variety of ways to protect time—limiting the activities of family members, having one day of the week be family day when no one schedules anything or having a regular mealtime when family members don’t answer the phone.” She proposes, specifically: “I recommend that families design time experiments to discover what works best for them. It’s good to try something for a month and then evaluate it. For example, some families really like game nights, others prefer going out for meals or hikes. Family meetings work beautifully in some, but not all, families.” Among other options that might work for different homes, she shares the following:

- ✓ *Family work.* One way to have more time is to work together. Rather than divide chores, everyone can help with the dishes, yard work, laundry and home repair. Children like communal work that's genuinely useful. They learn things with this work. And while they work, they can visit with adults. Many of my clients grew up on farms and they talk of working in the fields with their families. There is often pride and a sense of community in their descriptions of the plantings and the harvests. Their families' survival depended on their efforts.
- ✓ *Consistent schedules.* Routines protect time. As a girl, I loved to visit my grandparents. I knew that we would eat at five at night and all do dishes by seven. Then Grandfather would pull out the card table and we'd play dominoes or hearts. Before bed, Grandmother would serve lemonade and ginger cookies. The repetitive nature of those evenings was deeply comforting to me. Children like to be able to predict events. It gives them a sense of control.
- ✓ *Reigning in media.* One poll found that the average family spends seven to eight hours a day, or 40 percent of their private time, watching TV. It's amazing how much time families have if they turn off their televisions, radios, VCRs and computers. I recommend that families I see turn off these appliances for a month and keep a record of how their time is spent. Then after a month they can decide what role they want TV and other machines to play in their lives (pp. 231-233).

Laying aside all suggestions above, one potential family improvement has received more attention than any other. According to a national survey of more than 1,000 married men and women across the country commissioned by The Pfaltzgraff Co., "the daily ritual of gathering together at the dinner table is still venerated as the most important way to strengthen family ties" according to 33% of respondents (USA Today, 1998). Another study entitled, "the state of the 21st century family dinnertime," found family dinnertime similarly rated as the number one "quality-time activity" (Associated Press, 2001). Following a recent New York Times article on the matter, several citizens submitted editorials about "find[ing] the balance that allows for real quality family time — the intimacy of eating . . . laughing and talking together that comes with just being home together." One citizen said:

Be bold, families! Set boundaries on your workday. Make careful choices about the quality and number of activities your children engage in. Say no! And, say no to your own need to feel effective with endless committee work and board of director activities. Work, school and community involvement can all come together to enhance the family. But not if family is the last thing on the list. Create your vision of family life and make that your primary goal to achieve — and then build your life around that (Schulman, Herche & Edelman, 2006).

Another writer shared their family's solution, "When family dinners are not possible, we have found another solution: the family breakfast. For the past 10 years, every Sunday and sometimes Saturday, we make pancakes or waffles together from scratch. Weekend breakfasts are often more relaxing, and conducive to intimate family conversations, than late-night dinners . . . we linger together in our pajamas--a perfect way to begin the day (Schulman, et al., 2006).

In the wake of this renewed national attention to family mealtime, there is good news. After decades of decline in the simple ritual of family dinners, there is evidence that a change is happening. A nationwide survey by the National Center on Addiction and Substance Abuse at Columbia University found a recent rise in the number of children ages 12 to 17 who said they ate dinner with their families at least five times a week (from 47% in 1998 to 58% in 2005; Foderaro, 2006). As family mealtimes return to a place of high regard and esteem across the nation, a Californian journalist proposed that "Family value number one" in the U.S. should become "Don't share precious dinner hour with TV" (Crea, 1994). As evident here and elsewhere, families with a desire to buck the trends can clearly make changes! Even so, one commentator noted, "It really tells you something about our society when a

family sitting down to eat dinner together is newsworthy enough to be on the front page of The New York Times!” (Schulman, et al., 2006).

6. ‘I don’t want to force my own values on my kids’: Hesitancy to set guidelines and teach. While preserving family time is clearly important, what families do with this time seems to be even the bigger issue. In the final two sections, we consider two related hesitancies of parents regarding what to do when they are with their children. While on one hand, some parents are timid in offering their own guidance and counsel, others show the opposite inclination discussed earlier: hesitancy to limit their efforts to help a child. In these last two sections, we elaborate prior explorations by examining aspects of how these two patterns play out in terms of teaching itself.

An amusing story is told of a family having dinner together with their younger children. As the mother tried to encourage her young son to eat a balanced meal, she pointed to a small serving of green beans remaining on the plate that he adamantly disliked. When the mother picked up the fork to persuade him further, the boy had enough, exclaiming, “Look, Mom, don’t foul up a good friendship!” (Perry, 2003, p. 40).

It has become a popular idea among some families that a good parent is one who is, essentially, a ‘good friend’ to their children. As long as continual affection is communicated to a child, the belief is that they will basically turn out well. Rules or strict standards, from this vantage point, can be seen as an excessive imposition of a parents’ will on a child, with the more enlightened notion being to let a child choose for themselves, unfettered by parental directives. In this way, youth can choose what they believe, value and want, without undue parental interference.

One potentially problematic barrier for some families is thus a basic hesitancy to provide standards or structure to a child. Some, perhaps, view the insistence on standards, principles or guidelines within a family as a ‘religious’ thing, while others may simply fear the setting up of one’s own views becoming an imposition on their child. As a result, youth sometimes have little or no guidance from parents in crucial areas.

While attractive to many on the surface, this kind of “nondirective” parenting style has been associated with as many negative outcomes as the authoritarian one described in Chapter 5. It has consequently come to also be labeled an “indulgent” or “permissive” approach to parenting. As Baumrind (1991) writes, these parents are “nontraditional and lenient . . . allow considerable self-regulation, and avoid confrontation” (p. 62). According to one parenting organization, parents with an indulgent style “avoid punishment, [since] it . . . makes them feel uncomfortable. They need to be liked by their child and don’t want to risk the child’s rebellion and anger.” They summarize this approach with two phrases, “I don’t do punishment!” and “I don’t do rules!” (Frances, 2010).



A surprisingly high percentage of parents, 63% (87/138), were rated as fairly indulgent in their parenting style. These parents do not necessarily struggle with providing enough affection. More responsive than demanding, it is the accountability and structure that is lacking. One girl said, “At Alpine, we had to keep our rooms clean and bed made, but when I got home, I didn’t have to: it didn’t matter. It was like, ‘no one’s really going to stop me now’” (176d).

Among other things, this pattern can prompt situations where youth largely dictate the conditions within their own families. One mother whose daughter was currently doing well described other families she observed in her community as follows, “The funniest thing is . . . that kids run the household.” She continued, “Our own daughter

ran the household for a long time until we realized, ‘No! *We’re* running the household.’ Parents need to learn how to be the bosses of their own household . . . and realize they need to take charge in their own home” (114m).

In some cases, there can literally be *no structure* at home. In one divorced family, a father recounted how initially “rules were not in place with her mother; she allowed guys to come and sleep over.” He continued:

Their mother gave the children everything they wanted . . . “Here, take it.” She wanted to be loved and accepted, but forgot to be a parent. They understand that with me there are rules, that I don’t just allow anything. My daughter told me, “I know if I come with you, I have to follow the rules”. . . . So I came back with handwritten rules and made her sign it (26f).



In addition to male relationships, one area with major implications for adolescent girls was family policies towards alcohol. Of the girls struggling most after treatment, a solid 50% showed direct linkages to either drugs and alcohol or negative guy relationships. As reviewed in Chapter 1, these two variables play a particular role in youth well-being. One parent lamented the general impact of the lax cultural environment in this regard:

When your child is the *only* one around who has rules and limitations, as a parent that is really hard. . . . Her friends were clueless and not doing any of the Alpine patterns. They had never been trained to do it. They were resistant to following rules and expectations—e.g., “I am 18 and can do what I want to do” (142m).

While the surrounding cultural atmosphere can be disheartening, as noted previously, such challenges appear to be worse when a youth’s own home does not even provide a haven from societal trends and messages. Two parents admitted “letting things go” and “sweeping it under the rug” when new problems arise: “Well, it’s just a little pot, booze . . . every teenager does it.” One father described his daughter turning to them as parents when she needed help with things she was struggling with—i.e., “She is becoming sexually active, but talking about it.” He continued, however, “Last fall, she started smoking pot; we didn’t discourage it, but insisted she needed to be completely responsible about it” (132f).

Beyond their words, sometimes parents’ own behavior sends a similar message:

- Both my parents were drug abusers (54d).
- Her parents are heavy marijuana users (114staff).
- Her mother is abusive and an alcoholic (133staff).

Fifteen years ago, Pipher (1996) noted that “One in eight adults abuses alcohol, a phenomenon that wreaks havoc in families” (p. 10). Of 111 parents classified in terms of “drug/alcohol abuse or other addictions”:

- 18% of parents (20/111) were involved in drug use of some kind.
- 20% of parents (22/111) were involved in alcohol use that appears to be problematic.
- 27% of parents total (30/111) were using either drugs, serious alcohol, or both.



Whether in lived examples or spoken words, it seems clear that the issue of structure versus permissiveness goes beyond the simple existence of rules. It also involves the offering of teaching, guidance and some kind of a standard. In this area as well, some families reflect serious struggles.

When compared with residential treatment, in particular, the difficulty of maintaining an atmosphere of accountability at home was a common theme of interviews. Other parents admitted, “It is hard in a typical home to be that consistent” (101m) and “when there are working parents and she is home alone, it is difficult to retain that kind of control” (99f). One mother said, “She responded well to the accountability and the discipline at Alpine—which is critical,” before admitting:

I didn’t do well with these things at home, however. I would tell her, “You’re not going out unless your room is clean.” Then someone would call to ask her out and I would think, “Oh, I want to give her this chance,” so I would let her go . . . and she would promise it would be done the next day. I was so caught up in the emotional part of being a Mom and wanting her to be happy. . . . That’s the hard part at home—the discipline and consistency (67m).

As evident here, even for parents with more time and attention available, there can be strong inclinations to let go of basic structure, standards and rules after treatment. One girl whose father let up on accountability said her parents assumed it would not *be needed* after Alpine: “I asked my Dad, ‘Why did this change? Why weren’t you as supportive?’ He responded, ‘Well, you needed to be in the real world—and I figured if I was harsher . . . it would help.’” She, herself, admitted, “You are not really taught that this will continue when you go home. You think, ‘thank God, I’m going home and that won’t happen anymore.’” In contrast to both her and her parents’ prior expectations, she went on to emphasize the following:

Consequences need to stay in place. You can’t let the girls slide for anything. If anything is done wrong, she needs a consequence . . . even if it is a small consequence; it can be in proportion to the action, but still needs to be there. If curfew was 12, and I was back at 1, something should happen—maybe not grounding for a whole week—but consequences do need to stay in place. When you first get home, things are set in place similar to Alpine. We talked and established rules; we basically wrote out a contract thing. . . . There were consequences for bad things, and rewards for good ones—both are key for any person’s life, whether at Alpine or as a 5 year-old kid (158d).

One girl described struggling after returning to a home without structure. “To not have structure after two and a half years, I didn’t know what to do. . . . My parents tried to set up things, but it didn’t matter so much. At Alpine, if I didn’t do a certain thing, I would get negatives . . . and consequences. But at home, I don’t have [a system in place].” She continued, “I feel bad for my parents. If they had set up a plan--something like, ‘she will act out, so what should we do to motivate her to not want to act out and make sure she doesn’t fall behind?’” If they set up a plan “with my being a part of it, they would have had structure already there for me,” she added. “For instance, if I had a lot of things I wanted that were taken away and have to work back for them.” In contrast to these ideas, the girl related what happened upon her return:

I was given everything when I got home, because my parents were so happy for me to be home. I wish I had been told, “You need to go back to school, and get a job.” Instead, I got whatever I asked for; I didn’t have to do anything. I felt sometimes they were tiptoeing around me because they didn’t want me to fall back. But parents need to realize that I’m going to slip back a little bit, but they need to stay strong . . . and stick by the rules (7d).

In terms of qualitative patterns, many families who reported struggling with structure also reported girls not doing well long-term. This correlation was especially explicit in some home situations. The girl last quoted as encouraging parents to “stick by the rules,” went on to summarize what happened in her own family: “I came home with no structure and spiraled; I started to go back to feeling depressed, not wanting to get out of bed and not caring what parents wanted me to do. Nothing mattered. . . . There was so much freedom. I eventually went into another treatment center” (7d). Another girl started her interview saying, “Right after Alpine, our relationship was

not good They were bending the rules” (162d). After describing how positive effects seemed to “wear off” in her daughter, one mother admitted, “There was no one behind her saying . . . ‘we do this as a group’—there was none of that happening. So basically, she fell back, because there was no group thing to follow or . . . a great amount of structure” (83m). From parental attitude towards treatment to overall parenting style, the short and long-term impact of a more passive, indulgent family approach was born out statistically as well:

- Girls of parents identified as largely passive and uninvolved during treatment were 41% less likely to graduate from Alpine ($p=.001$) and 32% less likely to be doing well long-term ($p=.01$) when compared with girls from more proactive, balanced homes ($N=101$).
- Girls of parents identified as fairly permissive in their parenting style were 25% less likely to graduate from Alpine ($p=.04$) and 22% less likely to be doing well long-term ($p=.08^{**}$), when compared with girls of a parent reflecting a more balanced (“authoritative”) style ($N=115$).

Children and adolescents from *indulgent* homes are more likely to be involved in problem behavior and perform less well in school, but they have higher self-esteem, better social skills, and lower levels of depression. This includes poorer emotion regulation, higher likelihood of rebellion and defiance when desires are challenged, lower persistence to challenging tasks, and more overall antisocial behaviors (Darling, 1993).

Although girls of parents abusing either alcohol or illicit drugs were slightly less likely to graduate from Alpine (10-18% less) and to be doing well long-term (12-30% less), these correlations were not robust, with the strongest only mildly significant [X^2 of 7.5 ($p=.1^{**}$), Cramer’s V of .2 ($p=.1^{**}$)]. That a general correlation exists, however, seems clear. In one interview, a girl admitted that both her parents struggled with drug use. Reflecting on her depression diagnosis, she said, “I have my mood swings, but not that different from anyone else,” then added somewhat wistfully, “but *any* 15 year old girl living with drug abusers is going to have some issues” (54d).

Rather than competing with or diluting family love, such structure and direction may be re-framed as a *further expression* of caring and affection by parents—the kind that cannot bear to see a child go out in the world without appropriate guidance. Indeed, when families create an alternative atmosphere in their own home, this can be an important influence for youth resisting the larger culture. The power of simple teaching can be seen in additional vignettes from Alpine Academy. One mother, for instance, reported that “some of the conversations and interactions that the family teachers had with our daughter helped her to see things in a different way” (143m). Another girl said, “The thing that impacted me a lot was my conversation with Brad and Corrie before I graduated: They told me that beauty on the inside was more important than beauty on the outside . . . and reassured me that there were great things I can do for the world . . . and that there is someone out there in the world that loves me, but that I first have to have love for myself” (104d).

In a cultural landscape where a language of ‘values’ and ‘morality’ have been coopted by political agendas, Pipher offers a helpful clarification on why the terms hold a broader relevance than typically viewed:

These [terms] are emotionally loaded, under-analyzed words exploited by demagogues, mocked by some people and candy-coated by others. It’s almost impossible to use them without falling into one polarized pit or another. But morality is not the property of any one political party, race, religious group or segment of the population. And morality refers not only to sex and violence but also to the use of power, time and money. Broadly defined, morality is about making decent and wise choices about how to be in the universe. It implies purposeful action for the common good (p. 16).

From this perspective, the teaching of values and morals is a universal task of parenthood, despite political or religious orientation. In this regard, while spoken lessons are obviously important, the lessons from example itself

seemed to have made an equally lasting impression on girls. One mother said, “they modeled for my daughter what life can be” (25m), with a second parent saying likewise that Alpine helped their daughter in “seeing how life can be through a positive adult that she really respected and liked” (12mf). A third mother felt that seeing a positive model of family relationships at Alpine “will help her be able to choose a companion that will respect and love her.” She continued, “I loved the role-modeling. When girls are in a bad place, you pick the bad boys, because that’s how you feel about yourself. But as you can see a young married woman and child with a helpful, loving man. . . (you would never see Ben disrespecting his wife. . . . It was endearing to see the closeness of the family teachers). . . . My daughter said, ‘I want to find a man who treats me like that.’”

As reflected in these examples, Pipher notes, “Ideally, the education of the heart is done in families. Ideally, children learn from their families what to love and value.” She then qualifies, “Some parents have the impression that they shouldn’t impose their values on their children. But if parents don’t teach their children values, the culture will. Calvin Klein and RJ Reynolds teach values. . . . Our children are growing up in a consumption-oriented, electronic community that is teaching them very different values from those we say we value.” Revisiting the previous themes, she continues:

We must remember that all television is educational. It teaches values and behavior. Children are manipulated from the time they can sit in front of a television. . . . The average child is exposed to four hundred ads a day, which will add up to more than four million ads in a lifetime. . . . Children learn these things from ads: that they are the most important person in the universe, that impulses should not be denied, that pain should not be tolerated and that the cure for any kind of pain is a product. They learn a weird mix of dissatisfaction and entitlement. . . . The television, which Leonard Cohen called “that hopeless little screen,” teaches values as clearly as any church. We may try to protect our own children from such nonsense, but they live in a world with children who have been socialized into this value system. . . . [in a kind of] corporate colonialism (pp. 11, 14-15, 225).

In light of these trends, the issue seems to be not *whether* to have values taught to your children, but instead *what* values those end up being. From this vantage point, teaching becomes a literally inescapable aspect of parenting, since even the parent who says or does nothing, *teaches much*. In light of these consequences, the good news remains that parents can adjust their parenting style over time. Several parents spoke of learning how to revise their previous tendencies with structure:

- We learned to set boundaries a little as well, I think . . . and to expect more from her. We continued to support her and hold her accountable (31f).
- Alpine helped support our being consistent—we know that is part of our downfall: not being consistent. . . . In the scheme of everyone’s life, it is hard—especially in a divorced, remarried, blended family. In the midst of that all, it is hard to be consistent. You get worn down; you get beat up. But in the Alpine experience, I was reminded of how important it was to be consistent (94m).

Pipher notes, “Good parents are what Ellen Goodman called counterculture; they counter the culture with deeper, richer values.” Reflecting several themes above, one staff member reiterated, “Often these girls are severely neglected. The number one thing they need are parents who are consistent, who provide structure, and who will love them no matter what.”

7. ‘But if I don’t force her, she won’t change!’ Hesitancy to stop pressuring. Whereas some parents struggle to feel comfortable sharing counsel and guidance with a child, others wrestle with the reverse: pressuring and attempting to control a child’s behaviors, a theme mentioned several times already. In addition to learning the importance of simply backing off sometimes, interviews confirmed the challenging lesson of adjusting structure and

accountability over time. One father spoke of the importance of “letting go and trusting her judgment, ‘Okay, sweetie, this is up to you now. We’ve done what we can.’” Daughters suggest that parents “show respect for what their girl has accomplished” and not always “watch her like a hawk.” Another girl said: parents are too strict, they will defy them. . . it is tricky, because some parents are relaxed and get into bad stuff. It is a hard balance between strict and relaxed (140d).

There is obviously a balance between allowance to fail and providing enough support. Referring to this kind of balance, another mother said, “We were hyper-vigilant in watching every move. . . . If you can, try to let go. If you have to, you can always pull the reins back in again. It’s kind of an ebb and flow. . . . make expectations really clear. . . . Find a way to reach a middle ground with your kid. If they’ve earned it, trust them to do things they want to do, even if you’re uncomfortable with it. It took us a year to learn that!” She continued, “She still tries to push the envelope a little bit . . . but that’s teenagers. It’s hard to distinguish between classic adolescence behavior and her actions—‘this is typical behavior.’ . . . it’s also hard to distinguish which is her and which is us” (157m).

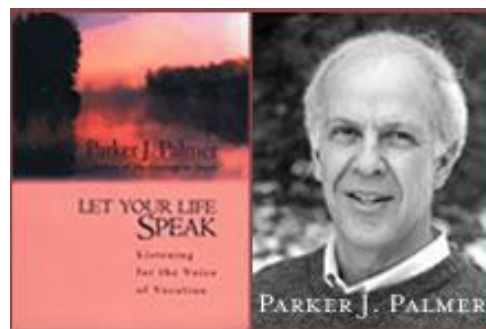
In the transition study, we observed that successful families ultimately avoided either extreme by settling on their own balance of freedom and structure and finding a structure that works for one’s family. Rather than being reactive, this balance requires a kind of “mindful parenting” attentive to the changing needs of an atmosphere moment-by-moment (Kabat-Zinn & Kabat-Zinn, 1998; McKay, Wood, & Brantley, 2007; McCurry & Hayes, 2009; Geoff Bell-Devaney, 2009; Greenland, 2010). In spite of good intentions, actually learning how to ‘be with’ a distressed individual in a way that avoids over- or under-involvement can be nuanced and difficult. The “Tidal Recovery Model” described in the prior chapter, includes this advice to caregivers:

1. Value the voice – the person's story is paramount.
2. Respect the language – allow people to use their own language.
3. Develop genuine curiosity – show interest in the person's story.
4. Become the apprentice – learn from the person you are helping.

Rather than telling individuals what to do, the researchers who created the model propose “the helper needs to be creatively curious, to learn what needs to be done to help the person,” all of which requires “giving the gift of time,” which they call “the midwife of change” (Barker & Buchanan-Barker, 2005).

What does this atmosphere really matter? Implications of healing relationships. For both youth and adults facing severe emotional problems, whether or not surrounding friends or family can overcome challenges above and find a general balance of intervention and space can have substantial implications for their capacity to endure and find relief. Historically, this has been illustrated by past examples of gentle, healing environments playing a major role in healing from severe emotional problems (e.g., Mosher, 1999; Borthwick et al., 2001). To conclude this chapter, two especially vivid examples of the consequences of such a relationship atmosphere and environment are shared. The first is an account taken from an interview with renowned author, Parker Palmer. Reflecting on his previous experience with depression, he said:

I had folks coming to me who wanted to be helpful, and, sadly, many of them weren't. These were the people who would say, 'Gosh, Parker, why are you sitting in here being depressed? It's a beautiful day outside. Go, you know, feel the sunshine and smell the flowers.' And that, of course, leaves a depressed person even *more depressed* because, while you know intellectually that it's sunny out and that the flowers are lovely and fragrant, you can't really feel any of that in your body, which is *dead* in a sensory way. And so you're left more depressed by this, "good advice" to get out and enjoy the day. And then other people would come and say something along the lines of, 'Gosh, Parker, why are you depressed? You're such a good person. You've helped so many people, you've written'...



Interviewer: "You're so successful."

Palmer: 'You're so successful, and you've written so well.' And that would leave me feeling more depressed because I would feel, 'I've just defrauded another person who, if they really knew what a schmuck I was, would cast me into the darkness where I already am.'



There was this one friend who came to me, after asking permission to do so, every afternoon about four o'clock, sat me down in a chair in the living room, took off my shoes and socks and massaged my feet. He hardly ever said anything. He was a Quaker elder. And yet out of his intuitive sense, from time to time would say a very brief word like, "I can feel your struggle today," or farther down the road, "I feel that you're a little stronger at this moment, and I'm glad for that." But beyond that, he would say hardly anything.

He would give no advice. He would simply report from time to time what he was sort of intuiting about my condition. Somehow he found the one place in my body, namely the soles of my feet, where I could experience some sort of connection to another human being. And the act of massaging just, you know, in a way that I really don't have words for, kept me connected with the human race. What he mainly did for me, of course, was to be willing to be present to me in my suffering.



He just *hung in* with me in this very quiet, very simple, very tactile way. And I've never really been able to find the words to fully express my gratitude for that, but I know it made a *huge* difference. And it became for me a metaphor of the kind of community we need to extend to people who are suffering in this way, which is a community that is neither invasive of the mystery nor evasive of the suffering but is willing to hold people in a space, a sacred space of relationship, where somehow this person who is on the dark side of the moon can get a little confidence that they can come around to the other side (Tippett, 2009).

As parents and other family members learn how to 'be with' a child in loving, attentive ways, their influence and impact can become similarly powerful. One final story from an Alpine interview illustrates vividly the impact of a family atmosphere where families 'get it right.' The mother describes bringing home her daughter from a hospital after doctors had essentially given up on her and what subsequently happened:

Back home, we went through a year of illegal stuff with her doing amphetamine, hospitals, living on the streets—a lot of stuff that went on there for 18 months. . . She got so bad that the state was going to commit her for life, to a long-term, mental illness state-run facility—where they put people where they are so bad they don't come out of. That's when we said, 'no, we are taking her home'—she had been in group homes and hospitals for years. . . . We took her home from the county lock-down hospitals.

It was a terrifying idea to bring her home. We didn't know if she would live, or anything. At the time, it was just terrifying. But I could see the state's solution was, "she's gone way over the edge . . . she's a crazy person beyond belief"—she *was* like a real crazy person. Her eyes were crazed, her mind, she was so unkempt. I grieved the death of my daughter for quite a long time. She was just gone and there wasn't much left. We took her guardianship; we took it all back from the county. They were ready to throw her aside; they felt they had done everything they could do. . . . When we brought her home, that's when the acceptance came. We had been through so many things trying to fix it—kind of like the county, "we've done everything we can do—she's not going to fit into normal society." We just accepted, 'this is just the way she is going to be' and brought her home. It caused a lot of disruption with our younger son. . . . We just keep pounding it into him, "that's just Anna." . . . It took a long-time, it was very gradual; I think we were all walking on egg-shells for awhile . . .

We had been through 3 years plus with her, when slowly things started to turn around with her. She requires a lot of extra attention and just a lot of understanding . . . She still has borderline personality disorder. She is doing much better—light years better. She has been holding a job—one for over a year and a second job for six months now. She has a singing career now. She still lives at home. She was suicidal for 3 years straight, but we haven't had any re-occurrence of that for some time. She's not the person she used to be . . . Doctors said that this girl's situation was one of the darkest situations and they couldn't believe she was doing better; they were totally shocked (59m).

When asked how her daughter had recovered and stopped her drug abuse, this mother emphasized, "She didn't get help in a drug rehab, she did it all on her own. She was heavily addicted to meth. . . . We didn't even know that she had made the decision to quit; she stopped the drugs on her own, how she got off the meth I will never know. She made decisions internally. What we did was accept her. What she did . . . a lot of her doing better came from inside of her, maybe from having the right environment." In spite of this mother's insistence, it is clear that the atmosphere of warm acceptance in this family's home was crucial to the daughter's progress:

I'd like to say that we did things, but we didn't do that much; we would just talk with her gently. . . . She just decided to stop doing drugs. You don't probe with questions—that sets her off. It gets to her and upsets her easily. We take whatever information we can get. She just said that she made these decisions; we don't know why or what influenced it. A lot of it goes to her. What we did was accept her. What she did . . . a lot of her doing better came from inside of her, maybe from having the right environment. . . . When she was surrounded by all these mentally ill people, you're not really cared for, you're kind of left to rot and die and you feel hopeless and helpless. That's kind of how she felt. When we brought her home, there was a change in the environment, [to more] loving . . . It was gradual, and it was all her. . . . The state was ready to commit her to life. She's gone from that to being a pretty productive member of society. She came out of it all on her own. She just needed the love and support of her family. . . . A lot of it is validation . . . when people try to fit her in a mode it devastates her and exacerbates everything that is wrong. I've adopted an attitude of 'that's just Anna'—you can't use logic, if you try, she'll bite you and hate you' It's just let her be her. . . . When someone is willing to understand her problem and have the flexibility to work with it and deal with it—and understand that she is very different, she tends to blossom. When you try to treat her like a normal person, she goes under (59m).

As reflected in this closing vignette, for families willing to keep trying and keep loving, there is legitimate optimism still to be had! While cultural forces depicted earlier are indeed, ominous, like other threatening atmospheric forces, they can surely be weathered by communities and homes willing to make preparations against the hurricane. If families still represent our best hope for a ‘shelter’ from the societal storm around us, then they arguably deserve our highest regard and most somber attention in bolstering and mobilizing them as “powerful institutions strong enough to withstand assaults” (Pipher, 1996). In the two closing chapters above, we have reviewed a number of ways parents and children might work together to do just this. For homes supporting a child (or adult) recovering from severe emotional problems, such preparations may be especially critical—even to the point of being both life-saving and life-changing.

Concluding observations

In the mental health crisis facing the U.S. currently, competing plans and proposals for what steps are needed have been raised. On one hand are those who generally believe that questions of etiology (origin/cause) and treatment for severe emotional problems have largely been settled by science and that, therefore, the important question at hand is how to better educate the public and help them more access dominant treatments options. On the other hand are those aware that fundamental debates on the cause and solutions of emotional problems continue en force, suggesting that a mass campaign of treatment and education might be somewhat premature.

If cutting-edge scientists and researchers across the nation are still debating basic issues in how to understand and intervene in emotional problems, then what should those who are affected by these problems be told? Better yet, what should they do? The assumption driving this book is that these individuals and families deserve to know both the critical questions being contested and the various answers being considered. Through each of the proceeding chapters, a series of these very questions have been reviewed—from issues involved in how to explain and think about the range of these emotional problems (Part I), to another set of issues involved in the range of possible interventions to bring relief and prompt recovery (Part II).

Among all the arguments raised by this book, there are a few more important than the rest. As illustrated throughout, particular ways of *thinking* lead to equally particular ways of *acting*. As we think about a challenge in a certain way, we are naturally led to favor certain solutions over others. Given this connection, it becomes especially crucial for families and individuals facing challenges like depression or addiction to think carefully about questions relevant to both explaining and treatment a problem. For many of these individuals, however, there is little awareness that fundamentally different ways of thinking about these questions even *exist!* For these individuals, therefore, a ‘biological explanation’ is a biological explanation, a ‘prognosis’ is a prognosis and an ‘effective treatment’ will obviously be effective for them too.

As explored in detail above, however, the essential argument of this book is that the situation is not quite so simple. In a world of large profits and competing discourses, writing down what someone told you to be ‘the truth’ doesn’t make it so—nor will it necessarily resolve your problem. In such a climate, in fact, taking such teachings at face value may complicate matters a bit. Simply put, with such an atmosphere, a ‘biological explanation’ is *not* only a biological explanation, nor is it necessarily ‘the biological explanation.’ Instead, it likely reflects one of *two* very different kinds of explanations about the body (see Ch. 2). Depending, in part, on the biological explanation adopted, resulting prognoses, diagnoses and prescriptions may all likewise be given and interpreted in fundamentally different ways.

As highlighted throughout these chapters, then there are intriguing treatment possibilities being raised by researchers in recent decades, constituting multiple ways of framing and interpreting both the problem and solution of ‘mental illness.’ At a most basic level, if it is true that brain patterns and genetic expressions can change, there is naturally greater hope for the possibilities of comprehensive and lasting recovery.

As long as the public remains unaware of different ways of thinking, however, they are left with no choice but to adopt the dominant way of thinking as ‘reality.’ In light of all the foregoing, a different kind of education becomes worth consideration. Rather than teaching American families that research has resolved all the fundamental answers to emotional problems, what about informing them of the crucial issues still being contested? Rather than directing educational efforts at convincing families of one (or another) way of thinking about problems or solutions, why not help them become more aware of the competing viewpoints at play? Instead of primarily aiming to persuade and

convince, this kind of education would have as its central goal, the facilitation of a more thoughtful public deliberation on these questions.

This has been the aim of this manuscript. Although my own views and positions are evident throughout, I have sought to fairly and comprehensively represent the different positions about biology, society, recovery and thinking/cognition itself, as I have come to know them. In this way, my hope has simply been to help families think a little more carefully about issues relevant to their own child's recovery from severe emotional problems. The eventual courses that Utah Youth Village will be creating over the common months will have a similar flavor and focus, each exploring different ways of thinking and intervening specific to one of the major emotional problems facing our youth. With the ADHD literature review already under way, we hope to launch the course later this summer. Subsequently, efforts will be focused on surveying the literature on anxiety and depression, turning to several other conditions in 2011. Although such discussions will generally be directed at helping parents with youth facing these problems, the issues explored in these classes will have obvious relevance to adult problems as well.

Researchers like me are not alone in advocating and working for this kind of an approach to education, of course. Across the nation, we are beginning to see growing instances of this style of teaching. In addition to courses highlighted above as presenting diverse options for depression (O'Connor, 1997; Nedley, 1997; Yapko, 1998; Gordon, 2008), there are many other similar resources becoming available across the range of conditions. On the sensitive issue of psychiatric treatment, as well, Dr. David Cohen at Florida International University recently received a government grant to create a free, online course to educate families and practitioners about the research regarding medical treatment for emotional problems. Dr. Cohen is an impeccable researcher whose work I have been able to hear first-hand, with an ethics and rigor to his work that any scientist would appreciate. Given the ongoing controversies regarding the integrity of research in this area, such efforts are clearly needed (to access the course, go to <http://www.criticalthinkrx.org/>).

Research controversies aside, on a number of levels, current societal conditions make things especially challenging for families. From the prevailing pace of life, to an omnipresent media, to the dominance of large corporate interests, families are facing conditions that make healthy atmospheres especially difficult to establish.

In spite of all this, however, a family who is persistent and determined in resisting the trends *can* establish an edifying and safe home atmosphere. With persistence and love, family members can work together to insist that their own home *not replicate* the dynamics of the larger culture around them. As parents, siblings, aunts, uncles, grandparents, friends and neighbors join forces on such a project, the combined power they represent is greater than any other force combining against them. Within such a community and such a family, children and adolescents facing serious emotional problems will be protected, nurtured and guided along his/her own journey—as long as it takes--to a lasting, and full recovery.

Citations

- Abbey, R. (Ed.) (2004). *Charles Taylor*. Cambridge, UK: Cambridge University Press.
- Addis, M. E. & Martell, C. R. (2004). *Overcoming depression one step at a time: The new behavioral activation approach to getting your life back*. Oakland, CA: New Harbinger Publications.
- Ahern, L., & Fisher, D. (2001). Recovery at your own PACE (Personal Assistance in Community Existence). *Journal of Psychosocial Nursing and Mental Health Services*, 39(4), 22-32.
- American Psychological Association, Task Force on the Sexualization of Girls. (2007). *Report of the APA Task Force on the Sexualization of Girls*. Washington, DC: American Psychological Association. Retrieved from www.apa.org/pi/wpo/sexualization.html. [First and third quotes are from the full report, second quote from the executive summary].
- Andreas, S. & Faulkner, C. (1994). *The new technology of achievement*. New York: Harper.
- Anthony, W. A., Cohen, M., Farkas, M., & Gagne, C. (2002). *Psychiatric rehabilitation*, 2nd edition. Boston, MA: Boston University Center for Psychiatric Rehabilitation.
- Arbib, M. A. & Amari, S. (Eds.). (2003). *The handbook of brain theory and neural networks*. (2nd ed). Boston: MIT Press.
- Arbinger Institute (2006). *The Anatomy of Peace: Resolving the Heart of Conflict*. San Francisco, CA: Berrett-Koehler Publishers, Inc.
- Armstrong, T. (2006). Canaries in the coalmine: Symptoms of child labeled 'ADHD' as biocultural feedback. In G. Lloyd, J. Stead, & D. Cohen, [Eds.] *Critical new perspectives on ADHD*. (pp. 34-44). New York: Routledge.
- Associated Press (2001, April). Survey reveals that family dinnertime rated top 'quality time activity.' *Dubuque Telegraph - Herald*.
- Australian Government Department of Health and Aging (2010). *National Mental Health Plan 2003-2008*. Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-plan03>
- Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology Science and Practice*, 10, 125-143.
- Barker, P. & Buchanan-Barker, P. (2005). *The tidal model: A guide for mental health professionals*. London: Brunner-Routledge.
- Barker, P. (2008). The tidal commitments: Extending the value base of mental health recovery. *Journal of Psychiatric and Mental Health Nursing*, 15, 93-100.
- Baumrind, D. (1967). Child care practices anteceding three patterns of preschool behavior. *Genetic Psychology Monographs*, 75(1), 43-88.
- Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance use. *Journal of Early Adolescence*, 11(1), 56-95.
- Baumrind, D. (1997). The discipline encounter: Contemporary issues. *Aggression and Violent Behavior* 2(4), 321-335.
- Berger, A. & Posner, M. I. (2000). Pathologies of brain attentional networks. *Neuroscience & Biobehavioral Reviews* 24, 1, 3-5.
- Bilic, B., & Georgaca, E. (2007). Representations of "mental illness" in Serbian newspapers: A critical discourse analysis. *Qualitative Research in Psychology*, 4(1-2), 167-186
- Bleuler, M. (1974). The long-term course of the schizophrenic psychoses. *Psychological Medicine*, 4, 244-254.
- Borthwick, B. Holman, C., Kennard, D., McFetridge, M. Messruther, K., & Wilkes, J. (2001). The relevance of moral treatment to contemporary mental health care. *Journal of Mental Health*, 10(4), 427-439.
- Bowers, L. (2000). *The social nature of mental illness*. Routledge
- Boydell, J., Van Os, J., Lambri, M., et al. (2003). Incidence of schizophrenia in south-east London between 1965 and 1997. *British Journal of Psychiatry*, 182, 45-49.

- Brizendine, L. (2006). *The female brain*. Broadway Books: New York.
- Bruner, J. (1997). A narrative model of self-construction. In J. G. Snodgrass, & R. L. Thompson (Eds.), *The self across psychology: Self-recognition, self-awareness, and the self concept* (pp. 145-161). Academy of Sciences.
- Canadian Mental Health Association (2003). *Recovery rediscovered: Implications for the Ontario mental health system*. Ontario.
- Carr, N. (2010, June 5). The Saturday essay: Does the Internet Make You Dumber? *The Wall Street Journal*, W1 [author of "The Shallows: What the Internet Is Doing to Our Brains."]
- Chen, E. Y. H. & Berrios, G. E. (1998). The nature of delusions: A hierarchical, neural network approach. In D.J. Stein & J. Ludik (Eds). *Neural networks and psychopathology: connectionist models in practice and research* (pp. 167-188), Cambridge, UK: Cambridge University Press.
- Cheraskin, E., Ringsdorf, W. M., Jr., Brecher, A. (1974). *Psychodietetics. Food as the key to emotional health*. New York: Stein & Day Publishers.
- Ciampi, L., & Moller, C. (1976). *Lebensweg und alter der schizophrenie: Eine katamnestiche lonzenstudies bis ins senium*. Berlin, German: Verlig.
- Cockerham, W. C. (2005). *Sociology of mental disorder* (7th Edition). Prentice Hall
- Cohen, D. (Ed.) (1990). Challenging the therapeutic state: Critical perspectives on psychiatry and the mental health system. Special issue: *The Journal of Mind and Behavior*, 11(3-4).
- Cohen, D. (Ed.) (1994). Challenging the therapeutic state, part two: Further disquisitions on the mental health system. Special issue: *The Journal of Mind and Behavior*, 15(1), 1-98.
- Compton, M.T. (2007, October). Recovery: Patients, families, communities. Conference Report. *Medscape Psychiatry & Mental Health*, 11-14.
- Connelly, M. (2010, June 6). More Americans sense a downside to an online existence. *New York Times News Service*.
- Copeland, M. E. (1997). *Wellness recovery action plan*. Peach Press.
- Coyne, J. C., Wortman, C. B., & Lehman, D. R. (1988). The other side of support: Emotional overinvolvement and miscarried helping. In B. Gottlieb (Ed.), *Support from the social network* (pp. 305-330). Thousand Oaks, CA: Sage Publications.
- Clark, D. (2005). *Intrusive thoughts in clinical disorders: Theory, research and treatment*. New York. Guilford Press.
- CNN (2006, September 13). Skinny models banned from catwalk CNN. *CNN News (Reuters)*. Retrieved May 29, 2010 from <http://www.cnn.com/2006/WORLD/europe/09/13/spain.models/index.html>.
- Crea, J. (1994, October). Family Value No. 1: Don't share precious dinner hour with TV. *Orange County Register: Knight Ridder/Tribune News Service*.
- Curtis, A.B. (2001). *Depression is a choice: Winning the battle without drugs*. New York: Hyperion.
- Curtis, A.B. (2006). *Brainswitch out of depression: Break the cycle of despair*. Healthworks Clinic Press
- Darling, N. (1993). *Parenting style and its correlates*. Clearinghouse on Elementary and Early Childhood Education. Excerpt available on <http://www.athealth.com/Practitioner/ceduc/parentingstyles.html>
- Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, 65, 131–145.
- Davidson, L., O'Connell, M., Tondora, J., Styron, T. & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, 57, 640-645.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychiatric Rehabilitation Journal*, 11, 11–19.
- Deegan, P. E. (1997). Recovery and empowerment for people with psychiatric disabilities. *Journal of Social Work and Health Care*, 25, 11–24.
- DeGrandpre, R.J. (1999). *Ritalin nation: Rapid-fire culture and the transformation of human consciousness*. W.W. Norton & Company.
- De Rivera, J., & Sarbin, T. R. (Eds.). (1998). *Believed-in imaginings: The narrative construction of reality*. Washington, DC: American Psychological Association.
- Desisto, M., Harding, C., McCormick, R., Ashikaga, T., & Brooks, G. (1995). The Maine and Vermont 3-decade

- studies of serious mental illness 1 and 2. *British Journal of Psychiatry*, 167, 331-342.
- Dimeff, L. A., Koerner, K. (Eds.) & Linehan, M. (2007). *Dialectical Behavior Therapy in clinical practice: Applications across disorders and settings*. The Guilford Press.
- Doherty, W. J. & Carlson, B. (2002). *Putting family first: Successful strategies for reclaiming family life in a hurry-up world* 1st ed. New York: Holt Paperbacks.
- Elias, M. J., Tobias, S. E., Friedlander, B. S., & Goleman, D. (2000). *Emotionally intelligent parenting: How to raise a self-disciplined, responsible, socially skilled child*. Three Rivers Press.
- Fay, B. (1996). *Contemporary philosophy of social science: A multicultural approach*. Boston: Blackwell Publishing.
- Fisher, D. (2006). *Recovery from schizophrenia: From seclusion to empowerment*. Medscape, Clinical Update, Available from: <http://www.medscape.com/viewprogram/5097?src=hp12.infocus>
- Fisher, D. (2010a). *Believing you can recover is vital to recovery from mental illness*. National Empowerment Center Newsletter. Retrieved June 5, 2010 from: <http://www.power2u.org/articles/recovery/believing.html>
- Fisher, D. (2010b). *Healing and recovery are real*. National Empowerment Center. Retrieved June 5, 2010 from: <http://www.power2u.org/articles/recovery/healing.html>
- Fisher, D. & Ahern, L. (2010). *People can recover from mental illness*. National Empowerment Center. Retrieved June 5, 2010 from: http://www.power2u.org/articles/recovery/people_can.html
- Fisher, D., & Deegan, P. (1999). *Final report of research on recovery from mental illness*. Lawrence, MA: National Empowerment Center.
- Foderaro, L. W. (2006, April). Families with full plates, sitting down to dinner. *New York Times*.
- Frances (2010). *What Is Permissive Parenting Style Like?* Retrieved April 5, 2010 from: <http://www.all-about-motherhood.com/permissive-parenting-style.html>.
- Geoff Bell-Devaney, G. (2009). *A mindful approach to parenting: Insights on raising our children with wisdom, awareness, and acceptance*. Freedog Press.
- Goldapple, K., Segal, Z., Garson, C., Lau, M., Bieling, P., Kennedy, S., & Mayberg, H. (2004). Modulation of cortical-limbic pathways in major depression: Treatment-specific effects of cognitive behavior therapy. *Archives of General Psychiatry*, 61, 34-41.
- Gordon, J. S. (2008). *Unstuck: Your guide to the seven-stage journey out of depression*. New York: The Penguin Press.
- Gordon, R. A. (1992). *Anorexia and bulimia: Anatomy of a social epidemic*. Blackwell Publishers.
- Granger, D. A. (1994). Recovery from mental illness: A first person perspective of an emerging paradigm. In Ohio Department of Mental Health, *Recovery: The new force in mental health* (pp.1–13). Columbus, OH: Author.
- Greco L. A., & Hayes, S.C. (2008). *Acceptance & mindfulness treatments for children & adolescents: A practitioner's guide*. New Harbinger Publications.
- Greenland, S. K. (2010). *The mindful child: How to help your kid manage stress and become happier, kinder, and more compassionate*. Free Press.
- Greenspan, S. I. & Greenspan, J. (2009). *Overcoming ADHD: Helping your child become calm, engaged, and focused—without a pill*. Merloyd Lawrence Books.
- Gura, T. (2008). *Lying in weight: The hidden epidemic of eating disorders in adult women*. Harper Paperbacks
- Hammond, D. C. (2005). Neurofeedback treatment of depression and anxiety. *Journal of Adult Development*, 12(2-3), 131-137.
- Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Brier, A. (1987). The Vermont longitudinal study: Methodology, study sample, and overall status 32 years later. *American Journal of Psychiatry*, 144, 718-726.
- Harding, C. M., Strauss, J. S., & Zubin, J. (1992). Chronicity in schizophrenia: Revisited. *British Journal of Psychiatry*, 161, 27–37.
- Hariri, A. R., Bookheimer, S. Y. & Mazziotta, J. C. (2000). Modulating emotional responses: effects of a neocortical network on the limbic system. *Motivation, Emotion, Feeding, Drinking*, 11(1), 43-48.
- Harrow, M., Sands, J. R., Silverstein, M. L., & Goldberg, J. F. (1997). Course and outcome for schizophrenia versus other psychotic patients: A longitudinal study. *Schizophrenia Bulletin*, 23, 287–303.

- Hess, J. Z. (2009). "Prozac saved my life" vs. "Prozac ruined my life": Investigating the adoption, constitution and maintenance of distinct interpretations associated with depression and its medical treatment. University of Illinois, Urbana-Champaign. Available for download at <http://www.ideals.illinois.edu/handle/2142/11307>.
- Hess, J. Z. & Lacasse, J. (In press). What does it mean for an intervention to "work"?: Making sense of conflicting treatment outcomes for youth facing emotional problems. *Families in Society: The Journal of Contemporary Social Services*.
- Hess, J.Z., Moore, M.C., Brahm, D., Judd, Y, Petroske, R. E., & Klok, H. (2008). *Narrating eating disorders: Investigating online accounts of anorexia and bulimia*. Unpublished research report.
- Hetherington, J. A, & Stoppard, J. M. (2002). The theme of disconnection in adolescent girls' understanding of depression. *Journal of Adolescence*, 25(6), 619-629.
- Hevern, V. W. (2004). *Introduction and general overview. Narrative psychology: Internet and resource guide*. Retrieved March 22, 2004 from the Le Moyne College Web site: <http://web.lemoyne.edu/~hevern/narpsych.html>
- Hofferth, S. L. (1999). *Changes in American children's time, 1981-1997*. University of Michigan's Institute for Social Research
- Hollon, S. D. (1995). *Depression and the behavioral high-risk paradigm*. In G. A. Miller (Ed.), *The behavioral high-risk paradigm in psychopathology* (pp. 289-302). New York: Springer-Verlag.
- Honore, C. (2004). *In praise of slowness: How a worldwide movement is challenging the cult of speed*. New York: Harper Collins.
- Horwitz, A. V. (2003). *Creating mental illness*. University Of Chicago Press
- Hyman, S. et al., (2006). Mental disorders. In D. T. Jamison, et al. (Eds.) *Disease Control Priorities in Developing Countries, 2nd ed.* New York: Oxford University Press.
- Jablensky, A., Sartorius N., Ernberg, G., et al. (1992). Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organization ten-country study. *Psychological Medicine Monograph Supplement*, 20, 1-97. Cambridge, UK: Cambridge University Press.
- Jacobson, N., & Greenley, D. (2001, April). What is recovery? A conceptual model and explication. *Psychiatric Services*, 52(4), 482–5.
- Jones, R. L. (1996, November). More parents finding ways to restore family dinner hour. *Knight Ridder/Tribune News Service*.
- Kabat-Zinn, J., et al. (1992). Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. *American Journal of Psychiatry*, 149, 936-943.
- Kabat-Zinn, J. (1993, September). The art of conscious living. *VHL Family Forum*, 1(3), Retrieved June 15, 2010 from: <http://www.vhl.org/newsletter/vhl1993/93cazinn.php>
- Kabat-Zinn, J. (2005a). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness. The program of the stress reduction clinic at the University of Massachusetts Medical Center*. Bantam Dell: New York.
- Kabat-Zinn, J. (2005b). *Wherever you go, there you are*. New York: Hyperion.
- Kabat-Zinn, J. (2006). *Mindfulness for Beginners*. Audio Renaissance CD. Louisville, CO: Sounds True Producers.
- Kabat-Zinn, M., & Kabat-Zinn, J. (1998). *Everyday blessings: The inner work of mindful parenting*. Hyperion
- Karp, D.A. (1997). *Speaking of sadness: Depression, disconnection, and the meanings of illness*. London: Oxford University.
- Kerns, K. A., Esso, K., & Thompson, J. (1999). Investigation of a direct intervention for improving attention in young children with ADHD. *Developmental Neuropsychology*, 16, 273–295.
- Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.
- Klingberg, T., Forssberg, H., & Westerberg, H. (2002). Training of working memory in children with ADHD. *Journal of Clinical and Experimental Neuropsychology*, 24, 781–791.
- Kristeller, J. L., Baer R. A., & Quillian-Wolever, R. (2006). Mindfulness-based approaches to eating disorders. In Baer, R. (Ed.) *Mindfulness and acceptance-based interventions: Conceptualization, application, and empirical support*. San Diego, CA: Elsevier.

- Lacasee, J. R. & Leo, J. (2005). Serotonin and depression: A disconnect between the advertisements and the scientific literature. *PLoS Med* 2(12), e392.
- Lakhan, S. E. & Viereira, K. F. (2008). Nutritional therapies for mental disorders. *Nutrition Journal*, 7(2), 1-8.
- Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin*, 8, 605–609.
- Leyse-Wallace, R. (2008). *Linking nutrition to mental health: A scientific exploration*. Bloomington, IN: iUniverse, Inc.
- Lloyd, G., Stead, J., & Cohen, D. (Eds.) (2006). *Critical new perspectives on ADHD*. New York: Routledge.
- Logan, A. C. (2006). *The brain diet: The connection between nutrition, mental health, and intelligence*. Nashville, TN: Cumberland House Publishing.
- Long, A. E. (1994). Reflections on recovery. In Ohio Department of Mental Health, *Recovery: The new force in mental health* (pp.1–16). Columbus, OH: Author.
- Ludik, J. & Stein, D. J. (1998). Neural-network modeling of cognitive disinhibition and neurotransmitter dysfunction in obsessive-compulsive disorder. In D.J. Stein & J. Ludik (Eds). *Neural networks and psychopathology: connectionist models in practice and research* (pp. 231-247), Cambridge, UK: Cambridge University Press.
- Lutz, A., Brefczynski-Lewis J., Johnstone, T., & Davidson, R. J. (2008). Regulation of the neural circuitry of emotion by compassion meditation: Effects of meditative expertise. *PLoS ONE* 3(3): e1897.
- Maccoby, E. E., & Martin, J. A. (1983). Socialization in the context of the family: Parent–child interaction. In P. H. Mussen (Ed.) & E. M. Hetherington (Vol. Ed.), *Handbook of child psychology: Vol. 4. Socialization, personality, and social development* (4th ed., pp. 1-101). New York: Wiley.
- Maisel, R., Epston, D. & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York: Norton & Company.
- Marcus, G. (2004). *The birth of the mind*. New York: Perseus.
- Marlatt, G. A., & Donovan, D. M. (Eds.). (2007). *Relapse prevention, second edition: Maintenance strategies in the treatment of addictive behaviors, 2nd edition*. The Guilford Press.
- Martin, J. & Sugarman, J. (2001). Interpreting human kinds: Beginnings of a hermeneutic psychology. *Theory & Psychology*, 11(2), 193-207.
- McCurry, C., & Hayes, S. C. (2009). *Parenting your anxious child with mindfulness and acceptance: A powerful new approach to overcoming fear, panic, and worry using acceptance and commitment therapy*. New Harbinger Publications.
- McKay, M., Wood, J. C. & Brantley, J. (2007). *Dialectical behavior therapy skills workbook: Practical DBT exercises for learning mindfulness, interpersonal effectiveness, emotion regulation, & distress tolerance*. (New Harbinger Self-Help Workbook). New Harbinger Publications.
- McKnight, J. (1995). *The careless society: Community and its counterfeits*. New York: Basic Books, HarperCollins Publishers, Inc.
- McLean, A. (2003). Recovering consumers and a broken mental health system in the United States: Ongoing challenges for consumers/survivors and the New Freedom Commission on Mental Health. Part II: Impact of managed care and continuing international challenges. *Journal of Psychosocial Rehabilitation*, 8, 58-70.
- McManamy, J. (2008). *Mindfulness - The ultimate mood stabilizer*. Retrieved on June 18, 2010 from <http://www.mcmanweb.com/mindfulness1.html>
- Meany, M. J. (1998, September). *Variations in maternal care and the development of individual differences in neural systems mediating behavioral and endocrine responses to stress*. Address presented at the annual meeting of the Society for Psychophysiological Research, Denver, CO.
- Medscape (2005). Empowerment model of recovery from severe mental illness: An expert interview with Daniel B. Fisher, MD, PhD. *Medscape Psychiatry & Mental Health* 10(1).
- Merzenich, M. M., & deCharms, R. (1996). *Neural representations, experience and change*. In R. Llinas, & P. S. Churchland (Eds.). *The mind-brain continuum: Sensory processes*. Cambridge, Mass: MIT Press, pp. 62-81.

- Miller, G. A. & Keller, J. (2000). Psychology and neuroscience: Making peace. *Current Directions in Psychological Science*, 9(6), 212-215.
- Miller, J. J., Fletcher, K., & Kabat-Zinn, J. (1998). Three-year follow-up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. *Journal International Journal of Yoga Therapy*, 8(1), 45-53.
- Miller, N. B., Cowan, P. A., Cowan, C. P., & Hetherington, E. M. (1993). Externalizing in preschoolers and early adolescents: A cross-study replication of a family model. *Developmental Psychology*, 29(1), 3-18.
- Morrissey, J. P. (2000). *Social factors in mental health and illness*, Volume 11 (Research in Community and Mental Health). JAI Press.
- Mosher L. R. (1999). Soteria and other alternatives to acute psychiatric hospitalization: a personal and professional review. *Journal of Nervous Mental Disorders*, 187, 142-149.
- Mulligan, K. (2003, January 3). Recovery movement gains influence in mental health programs. *Psychiatric News: American Psychiatric Association*, 38(1), 10.
- Mulligan, K. (2001, June 1). Psychiatrist turns illness into empowerment tool. *Psychiatric News*, 36, 11.
- National Health Service website (2010). *London Development Centre*. Retrieved June 5, 2010 from <http://www.londondevelopmentcentre.org/page.php?s=1&p=2462>.
- National Institute of Mental Health (2009). *The numbers count: Mental disorders in America*. Retrieved April 8, 2009 from: <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>.
- Nedley, N. (2005). *Depression: The way out*. Ardmore, Oklahoma: Nedley Publishing.
- Niederdeppe, J., Farrelly, M. C., & Haviland, M. L. (2004). Confirming “truth”: More evidence of a successful tobacco countermarketing campaign in Florida. *American Journal of Public Health*, 94(2), 255–257.
- Null, G. (2008). *The food-mood connection: Nutritional and environment approaches to mental health and physical wellbeing*. New York: Seven Stories Press
- Office of the Surgeon General and various United States Government agencies (1999). *Mental Health: A report of the Surgeon General. Section 10: Overview of recovery*. Retrieved from: <http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec10.html>.
- O'Connor, R. (1997). *Undoing depression: What therapy doesn't teach you and medication can't give you*. New York: Berkley Books.
- O'Hagan, M. (2004). Recovery in New Zealand: Lessons for Australia? *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, 3(1).
- Olesen, P. J., Westerberg, H., & Klingberg, T. (2004). Increased prefrontal and parietal activity after training of working memory. *Nature Neuroscience*, 7(1), 75–79.
- Ornish, D. (1995). *Dr. Dean Ornish's program for reversing heart disease: The only system scientifically proven to reverse heart disease*. Ivy Books
- Ornish, D., et al. (2008). *Changes in prostate gene expression in men undergoing an intensive nutrition and lifestyle intervention*. Proceedings of the National Academy of Sciences, 105, 8369-8374.
- Osterhout, L, Poliakov, A., Inouea, K., McLaughlina, J., Valentinea, G., Pitkanena, I., Frenck-Mestred, C., & Hirschensohnc, J. (2008). Second-language learning and changes in the brain. *Journal of Neurolinguistics*, 21, 6, 509-521.
- Ottowitz, W. E., Tondo, L., Dougherty, D. D. & Savage, C. R. (2002). The neural network basis for abnormalities of attention and executive function in major depressive disorder: Implications for application of the medical disease model to psychiatric disorders. *Harvard Review of Psychiatry*, 10, 2, 86-99.
- Peck, M. S. (1978/2003). *The road less traveled, 25th anniversary edition: A new psychology of love, traditional values and spiritual growth*. New York: Touchstone.
- Perry, L. T. (2003). The importance of the family. *Ensign*, 40.
- Peterson, C., Maier, S. F., Seligman, M. E. P. (1995). *Learned helplessness: A theory for the age of personal control*. New

- York: Oxford University Press.
- Phillips, E. L., Phillips, E. A., Fixsen, D. L., & Wolf, M. M. (1974). *The Teaching Family handbook*. The Bureau of Child Research, University of Kansas. Lawrence, Kansas.
- Pipher, M. (1994). *Reviving ophelia: Saving the selves of adolescent girls*. New York: Ballantine Books.
- Pipher, M. (1996). *The shelter of each other: Rebuilding our families*. New York: Ballantine Books.
- Posner, M. I., Sheese, B. E., Odludaša, Y., & Tangb, Y. (2006). Analyzing and shaping human attentional networks. Special issue: Brain and attention. *Neural Networks*, 19(9), 1422-1429.
- Pratt, C., Gill, K. J., Barrett, N. M., Hull, K. K., & Roberts, M. M. (2002). *Psychiatric Rehabilitation*. Academic Press.
- Prochnik, G. (2010). *In pursuit of silence: Listening for meaning in a world of noise*. Doubleday.
- Putnam, R. (2000). *Bowling alone: The collapse and revival of American community*. New York: Simon and Schuster.
- Repper, J. & Perkins, R. (2006). *Social inclusion and recovery: A model for mental health practice*. Bailliere Tindall, UK.
- Ridge, D. & Ziebland, S. (2006). "The old me could never have done that": How people give meaning to recovery following depression. *Qualitative Health Research*, 16(8), 1038-1053.
- RGA Communications (1995). *The 1995 Kentucky Fried Chicken family dinner survey*.
- Rorty, M., Yager, J., & Rossotto, E. (1993). Why and how do women recover from bulimia nervosa? The subjective appraisals of forty women recovered for a year or more. *International Journal of Eating Disorders*, 14(3), 249-260.
- Rosen, G., Fee, E., Morman, E. T. (1993). *A history of public health*. Baltimore, Maryland: John Hopkins University Press.
- Rosenzweig, M. R., & Bennett, E. L. (1996). Psychobiology of plasticity: Effects of training and experience on brain and behavior. *Behavioral Brain Research*, 78(1), 57-65.
- Rueda, M. R., Fan, J., McCandliss, B., Halparin, J. D., Gruber, D. B., Pappert, L., et al. (2004). Development of attentional networks in childhood. *Neuropsychologia*, 42, 1029–1040.
- Schmidt, M. A., & Bland, J. (2006). *Brain-building nutrition: How dietary fats and oils affect mental, physical, and emotional intelligence*. Bombay, India: Frog Books.
- Schulman, C., Herche, R. & Edelman. (2006, April). Ah, the Family Dinner. Remember? (5 Letters to the Editor). *New York Times*.
- Schwandt, T. A. (1996). Farewell to criteriology. *Qualitative Inquiry*, 2, 58-72.
- Schwartz, J. M. (1997). *Brain lock: Freeing yourself from obsessive-compulsive behavior*. Harper Perennial: New York.
- Schwartz, J. M. & Begley, S. (2002). *The mind and the brain: Neuroplasticity and the power of mental force*. New York: Harper.
- Scottish Recovery Network (2009) Accessible at <http://www.scottishrecovery.net/>
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2001). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: The Guilford Press.
- Sharkey-Orgnero, M. I. (1999). Anorexia nervosa: A qualitative analysis of parents' perspectives on recovery. *Eating Disorders: The Journal of Treatment and Prevention*, 7(2), 123–141.
- Shepherd, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality*. Sainsbury Centre for Mental Health
- Siegle, G. J. (1999). A neural network model of attention biases in depression. *Progress in Brain Research*, 121, 407-432.
- Siegel, M. (2002). The effectiveness of state-level tobacco control interventions: a review of program implementation and behavioral outcomes. *Annual Review of Public Health*, 23:45-71.
- Slife, B. D., & Williams, R. N. (1995). *What's behind the research? Discovering hidden assumptions in the behavioral sciences*. Thousand Oaks, CA: Sage.
- Sohlberg, M. M., McLaughlin, K. A., Pavese, A., Heidrich, A., & Posner, M. I. (2000). Evaluation of attention process therapy training in persons with acquired brain injury. *Journal of Clinical and Experimental Neuropsychology*, 22, 656–676.

- Stein, D. J., & Ludik, J. (Eds). (1998). *Neural networks and psychopathology: connectionist models in practice and research*. Cambridge, UK: Cambridge University Press.
- Stolzer, J. M. (2007). The ADHD epidemic in America. *Ethical Human Psychology and Psychiatry*, 9(2), 109-116(8).
- Taylor C. (2002). Gadamer on the human sciences. In R. J. Dostal (Ed.), *The Cambridge Companion to Gadamer* (pp. 126-142). New York: Cambridge University Press.
- Teicher, M. H, Andersena, S. L., Polcarib, A., Andersona, C. M., Navaltae, C. P. & Kima, D. M. (2003). The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience & Biobehavioral Reviews* 27, 1-2, 33-44.
- Tierney, S. (2005). The treatment of adolescent anorexia nervosa: A qualitative study of the views of parents. *Eating Disorders: The Journal of Treatment & Prevention*, 13(4), 369–379.
- Tippett, K. (2009, February 26). *The soul of depression: Transcript of radio program*. Speaking of Faith. Retrieved on October 5, 2009 at <http://speakingoffaith.publicradio.org/programs/2009/depression/transcript.shtml>.
- Torrey, E. T. (2003). *Treatment Advocacy Center statement*. Newswire.
- Twenge, J. M. (2000). The age of anxiety? Birth cohort change in anxiety and neuroticism, 1952-1993. *Journal of Personality and Social Psychology*, 79, 6, 1007-1021
- USA Today (1998, April). Dining together strengthens ties. *USA Today*.
- USA Today (2010, January 12). Study: Students more stressed now than during Depression? *USA Today*. Retrieved June 7, 2010 from: http://www.usatoday.com/news/education/2010-01-12-students-depression-anxiety_N.htm
- United States Department of Health and Human Services/SAMHSA Center for Mental Health Services (2004). *National consensus statement on mental health recovery*
- Valenstein, E. S. (1998). *Blaming the brain*. London: The Free Press.
- Vinogradov, S., Poole, J. H., & Willis-Shore, J. (1998). ‘Produced by either God or Satan’: Neural network approaches to delusional thinking. In D.J. Stein & J. Ludik (Eds). *Neural networks and psychopathology: connectionist models in practice and research* (pp. 189-239), Cambridge, UK: Cambridge University Press.
- Vodafone corporation (2006, November). *New research reveals clock ticking for quality family time*. Vodafone UK press releases. Retrieved April 18, 2009 from <http://www.vodafone.com>.
- Wall, J. T., Xu, J., Wang, X. (2002). Human brain plasticity: an emerging view of the multiple substrates and mechanisms that cause cortical changes and related sensory dysfunctions after injuries of sensory inputs from the body. *Brain Research Reviews*, 39(2-3).
- Wallerstein, J. S., Lewis, J. M., & Blakeslee, S. (2000). *The unexpected legacy of divorce: The 25 year landmark study*. New York: Hyperion.
- Warner, C.T. (2001). *Bonds that make us free: Healing our relationships, Coming to ourselves*. Salt Lake City, UT: Shadow Mountain.
- Weiss, L. H., & Schwarz, J. C. (1996). The relationship between parenting types and older adolescents’ personality, academic achievement, adjustment, and substance use. *Child Development*, 67(5), 2101-2114.
- White House, President's New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America*.
- Whitney, J., Murray, J., Gavan, K., Todd, G., Whitaker, W., & Treasure, J. (2005). Experience of caring for someone with anorexia nervosa: Qualitative study. *British Journal of Psychiatry*, 187(5), 444-449.
- Widiger, T. & Samuel, D. (2005). Diagnostic categories or dimensions? A question for the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. *Journal of Abnormal Psychology*, 114, 494-504.
- Widiger, T. A. & Trull, T. T. (2007). Plate tectonics in the classification of personality disorder: Shifting to a diagnostic model. *American Psychologist*, 62(2), 71-83.
- Williams, M., Segal, J., Teasdale, Z. & Kabat-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: The Guilford Press.
- Williams, R. N. (1992). The human context of agency. *American Psychologist*, 47(6), 752-760.

- World Health Organization (1979). Schizophrenia: WHO study shows that patients fare better in developing countries. *WHO Chronicle*, 33, 428.
- World Health Organization (2004). *The World Health Report 2004, Table 3: Burden of disease in DALYs by cause, sex, and mortality stratum in WHO regions, estimates for 2002*. Geneva: World Health Organization.
- Yapko, M. D. (1998). *Breaking the patterns of depression*. New York: Doubleday.
- Zuckerman, M. (1999). *Vulnerability to psychopathology: A biopsychosocial model*. Washington: American Psychological Association.