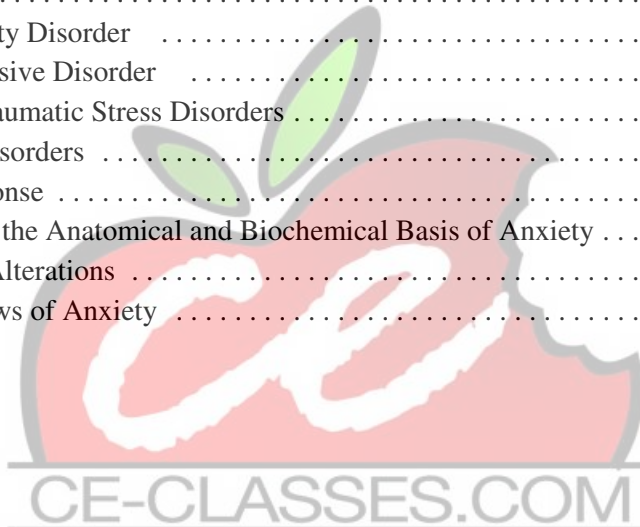


CHAPTER 4

ADULTS AND MENTAL HEALTH

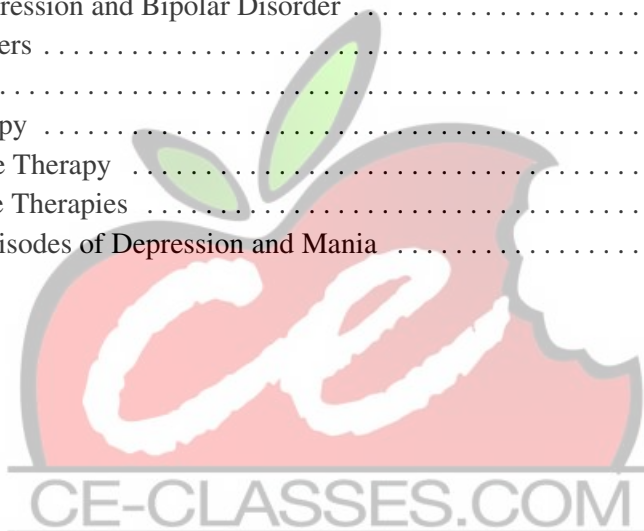
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ADULTS AND MENTAL HEALTH

Adulthood is a time for achieving productive vocations and for sustaining close relationships at home and in the community. These aspirations are readily attainable for adults who are mentally healthy. And they are within reach for adults who have mental disorders, thanks to major strides in diagnosis, treatment, and service delivery.

This chapter reviews the current state of knowledge about mental health in adults, along with selected mental disorders: anxiety disorders, mood disorders, and schizophrenia. These disorders are highlighted largely because of their prevalence in the population and the burden of illness associated with each. The chapter then turns to service delivery, describing the effective organization and range of services for adults with the most severe mental disorders. It also reviews an array of other services and supports designed to provide comprehensive care beyond the formal therapeutic setting.

Chapter Overview

Mental health in adulthood is characterized by the successful performance of mental function, enabling individuals to cope with adversity and to flourish in their education, vocation, and personal relationships. These are the areas of functioning most widely recognized by the mental health field. Yet, from the perspective of different cultures, these measures may define the concept of mental health too narrowly. As noted in Chapter 2, many groups, particularly ethnic and racial minority group members, also emphasize community, spiritual, and religious ties as necessary for mental health. The mental health profession is becoming more aware of the importance of reaching out to other cultures; an innovation termed “linguistically and culturally competent services” is

pertinent both to the field’s conception of mental health and to the diagnosis and treatment of mental disorders.

An assortment of traits or personal characteristics have been viewed as contributing to mental health, including self-esteem, optimism, and resilience (Alloy & Abramson, 1988; Seligman, 1991; Institute of Medicine [IOM], 1994; Beardslee & Vaillant, 1997). These and related traits are seen as sources of personal resilience needed to weather the storms of stressful life events.

Stressful life events in adulthood include the breakup of intimate romantic relationships, death of a family member or friend, economic hardship, role conflict, work overload, racism and discrimination, poor physical health, accidental injuries, and intentional assaults on physical safety (Holmes & Rahe, 1967; Lazarus & Folkman, 1984; Kreiger et al., 1993). Stressful life events in adulthood also may reflect past events. Severe trauma in childhood, including sexual and physical abuse, may persist as a stressor into adulthood, or may make the individual more vulnerable to ongoing stresses (Browne & Finkelhor, 1986). Although some kinds of stressful life events are encountered almost universally, certain demographic groups have greater exposure and/or vulnerability to their cumulative impact. These groups include women, younger adults, unmarried adults, African Americans, and individuals of lower socioeconomic status (Ulbrich et al., 1989; McLeod & Kessler, 1990; Turner et al., 1995; Miranda & Green, 1999).

Anxiety disorders are the most prevalent mental disorders in adults (Regier et al., 1990). The anxiety disorders affect twice as many women as men. A broad category, anxiety disorders include panic disorder, phobias, obsessive-compulsive disorder, post-traumatic stress disorder, and generalized anxiety disorder,

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among others. Underlying this heterogeneous group of disorders is a state of heightened arousal or fear in relation to stressful events or feelings. The biological manifestations of anxiety, which are grounded in the “fight-or-flight” response, are unmistakable: they include surge in heart rate, sweating, and tensing of muscles. But this is certainly not the whole picture. Although the full array of biological causes and correlates of anxiety are not yet in our grasp, numerous effective treatments for anxiety disorders exist now. Treatment draws on an assortment of psychosocial and pharmacological approaches, administered alone or in combination.

Mood disorders take a monumental toll in human suffering, lost productivity, and suicide. Moreover, when unrecognized, they can result in unnecessary health care use. Mood disorders rank among the top 10 causes of *worldwide* disability (Murray & Lopez, 1996). Major depression and bipolar disorder are the most familiar mood disorders, but there are others including cyclothymia (alternating manic and depressive states that, while protracted, do not meet criteria for bipolar disorder) and dysthymia (a chronic, albeit symptomatically milder form of depression). The causes of mood disorders are not fully known. They may be triggered by stressful life events and enduring stressful social conditions (e.g., poverty and discrimination). With the exception of bipolar disorder, they too, like the anxiety disorders, are twice as common in women as men. One subtype of mood disorder, seasonal affective disorder, in which episodes of depression tend to occur in the late fall and winter, is seven times more common in women than in men (Blumenthal, 1988). Many psychosocial and genetic factors interact to dictate the appearance and persistence of mood disorders, according to the biopsychosocial model presented in Chapter 2.

Mood disorders, like anxiety disorders, can be treated with a host of effective pharmacological and psychosocial treatments. Either type of treatment is effective for about 50 to 70 percent of patients in outpatient settings (Depression Guideline Panel, 1993). Severe depression seems to resolve more quickly with pharmacotherapy (Depression Guideline Panel, 1993)

and may be helped further by multimodal therapy (the combination of pharmacotherapy and psychotherapy) (Thase et al., 1997b). Despite the efficacy of treatment, a surprising fraction of those with mood disorders go untreated (Katon et al., 1992; Narrow et al., 1993; Wells et al., 1994; Thase, 1996). The foremost barriers to treatment include cost, stigma, and problems in the organization of service systems that contribute to the underrecognition of these disorders.

Schizophrenia affects about 1 percent of the population, yet its severity and persistence reverberate throughout the mental health service system. Schizophrenia is marked by profound alterations in cognition and emotion. Symptoms frequently include hearing internal voices or experiencing other sensations not connected to an obvious source (hallucinations) and assigning unusual significance or meaning to normal events or holding false personal beliefs (delusions). The course of illness in schizophrenia is quite variable, with most people having periods of exacerbation and remission. Schizophrenia had once been thought to have a uniformly downhill course, but recent research dispels this view. Long-term followup studies show that many individuals with schizophrenia significantly improve and some recover (Ciompi, 1980; Harding et al., 1992). Although the causes of schizophrenia are not fully known, research points to the prominent role of genetic factors and to the impact of adverse environmental influences during early brain development (Tsuang et al., 1991; Weinberger & Lipska, 1995; Andreasen, 1997b). New pharmacological treatments are at least as effective as past pharmacological treatments with fewer troubling side effects.

Effective treatment of schizophrenia extends well beyond pharmacological therapy: it also includes psychosocial interventions, family interventions, and vocational and psychosocial rehabilitation. For those patients who are high service users, treatment should be coordinated by an interdisciplinary team that provides high-intensity, community-based services (Lehman & Steinwachs, 1998a). The prototype for this intensive case-management approach, which is useful for persons with other severe and persistent mental disorders as

well, is assertive community treatment, described more thoroughly later in this chapter. Among the services included in this approach is substance abuse treatment. Its inclusion stems from findings that about *half* of patients with serious mental disorders (including schizophrenia) develop alcohol or other drug abuse problems (Drake & Osher, 1997). Even though research generated a range of recommendations for effective treatment of schizophrenia, it is alarming that less than 50 percent of patients actually receive many of the recommended treatments and that the gap was more pronounced in African Americans (Lehman & Steinwachs, 1998b).

The social consequences of serious mental disorders—family disruption, loss of employment and housing—can be calamitous. Comprehensive treatment, which includes services that exist outside the formal treatment system, is crucial to ameliorate symptoms, assist recovery, and, to the extent that these efforts are successful, redress stigma. Consumer self-help programs, family self-help, advocacy, and services for housing and vocational assistance complement and supplement the formal treatment system. Many of these services are operated by consumers, that is, people who use mental health services themselves. The logic behind their leadership in delivery of these services is that consumers are thought to be capable of engaging others with mental disorders, serving as role models, and increasing the sensitivity of service systems to the needs of people with mental disorders (Mowbray et al., 1996).

Mental Health in Adulthood

What constitutes mental health during the adult years? A widely used standard of mental health is the *absence* of a defined mental disorder. This standard has its limitations (discussed later), yet remains useful for epidemiological purposes. Epidemiology studies investigate the prevalence of mental disorders within several time frames: current, the past 12 months, and across a lifetime. Two well-designed national epidemiologic surveys estimate that about 80 percent of the adult population of the United States do not have a mental disorder during a year and hence may be

considered “mentally healthy” (i.e., absence of a mental disorder) during any given year (Regier et al., 1993; Kessler et al., 1994). Thus, the popular notion that *everyone* is “dysfunctional” is far from the truth (Table 4-1). Yet, from time to time, many adults experience mental health problems.

Defining mental health by the absence of mental disorder does not convey the full picture of mental health. Among its limitations, this definition excludes adults with mental disorders who function well between episodes of illness. These people often are considered by themselves, and by coworkers, friends, and families, to be “mentally healthy” in spite of a history of mental illness and the risk of recurrence.

In addition to the mental health criteria cited earlier—that is, the successful performance of mental function, enabling individuals to cope with adversity and to flourish in their education, vocation, and personal relationships—a complementary approach defines the positive features of mental health in terms of attaining developmental milestones of adulthood, or in terms of displaying selected personality characteristics, traits, or attributes. Developmental theorist Erik Erikson viewed mental health in adulthood as achieving developmental tasks or milestones. According to Erikson’s formulation and his subsequent empirical research on adult men, adulthood was the time for overcoming what he termed “psychosocial crises,” the resolution of which led to satisfactory interpersonal and sexual relationships and to the pursuit of broader concerns for society and future generations (Erikson, 1963; Vaillant, 1977). However, these milestones, and the developmental theories that underpin them, have been criticized as reflecting the norms of European males rather than of women and other cultures.

Personality Traits

Mental health and mental illness can be seen as the product of various personality traits, behavior patterns, and other characteristics which have roots in the individual’s prior life experiences or biology.

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Table 4-1. Best estimate 1-year prevalence based on ECA and NCS, ages 18–54

	ECA Prevalence (%)	NCS Prevalence (%)	Best Estimate ** (%)
Any Anxiety Disorder	13.1	18.7	16.4
Simple Phobia	8.3	8.6	8.3
Social Phobia	2.0	7.4	2.0
Agoraphobia	4.9	3.7	4.9
GAD	(1.5)*	3.4	3.4
Panic Disorder	1.6	2.2	1.6
OCD	2.4	(0.9)*	2.4
PTSD	(1.9)*	3.6	3.6
<hr/>			
Any Mood Disorder	7.1	11.1	7.1
MD Episode	6.5	10.1	6.5
Unipolar MD	5.3	8.9	5.3
Dysthymia	1.6	2.5	1.6
Biopolar I	1.1	1.3	1.1
Biopolar II	0.6	0.2	0.6
<hr/>			
Schizophrenia	1.3	—	1.3
Nonaffective Psychosis	—	0.2	0.2
Somatization	0.2	—	0.2
ASP	2.1	—	2.1
Anorexia Nervosa	0.1	—	0.1
Severe Cognitive Impairment	1.2	—	1.2
<hr/>			
Any Disorder	19.5	23.4	21.0

*Numbers in parentheses indicate the prevalence of the disorder without any comorbidity. These rates were calculated using the NCS data for GAD and PTSD, and the ECA data for OCD. The rates were not used in calculating the any anxiety disorder and any disorder totals for the ECA and NCS columns. The unduplicated GAD and PTSD rates were added to the best estimate total for any anxiety disorder (3.3%) and any disorder (1.5%).

**In developing best-estimate 1-year prevalence rates from the two studies, a conservative procedure was followed that had previously been used in an independent scientific analysis comparing these two data sets (Andrews, 1995). For any mood disorder and any anxiety disorder, the lower estimate of the two surveys was selected, which for these data was the ECA. The best estimate rates for the individual mood and anxiety disorders were then chosen from the ECA only, in order to maintain the relationships between the individual disorders. For other disorders that were not covered in both surveys, the available estimate was used.

Key to abbreviations: ECA, Epidemiologic Catchment Area; NCS, National Comorbidity Study; GAD, generalized anxiety disorder; OCD, obsessive-compulsive disorder; PTSD, post-traumatic stress disorder; MD, major depression; ASP, antisocial personality disorder.

Source: D. Regier, W. Narrow, & D. Rae, personal communication, 1999

Personality traits are thought to confer either beneficial or detrimental effects on mental health during adulthood. Here too, however, there may be insufficient attention to gender and culture. The culture-bound nature of much of behavior has limited widespread predictive validity of personality research (Mischel & Shoda, 1968). With this caveat in mind, a brief summary of healthy and maladaptive characteristics follows.

Self-Esteem

Self-esteem refers to an abiding set of beliefs about one's own worth, competence, and abilities to relate to others (Vaughan & Oldham, 1997). Self-esteem also has been conceptualized as buffering the individual from adverse life events. Emotional well-being is often associated with a slightly positive, yet realistic, outlook (Alloy & Abramson, 1988). The opposite outlook is

characterized by pessimism, demoralization, or minor symptoms of anxiety and depression. One seminal aspect of self-esteem has garnered much research attention: self-efficacy (Bandura, 1977). Self-efficacy is defined as confidence in one's own abilities to cope with adversity, either independently or by obtaining appropriate assistance from others. Self-efficacy is a major component of the construct known as resilience (i.e., the ability to withstand and overcome adversity). Other components of resilience include intelligence and problem solving, although resilience is also facilitated by having adequate social support (Beardslee & Vaillant, 1997).

Neuroticism

Neuroticism is a construct that refers to a broad pattern of psychological, emotional, and psychophysiologic reactivity (Eysenck & Eysenck, 1975). The opposite of neuroticism is stability or equanimity, which are major components of mental health. A high level of neuroticism is associated with a predisposition toward recognizing the dangerous, harmful, or defeating aspects of a situation and the tendency to respond with worry, anticipatory anxiety, emotionality, pessimism, and dissatisfaction. Neuroticism is associated with a greater risk of early-onset depressive and anxiety disorders (Clark et al., 1994). Neuroticism also may be linked to a particular cognitive attributional style in which life events are perceived to be large in impact and more difficult to change (Alloy et al., 1984). For example, this attributional style is embodied by pessimists who see every setback or failure as lasting forever, undermining everything, and being their fault (Seligman, 1991). Neuroticism also is associated with more rigid or distorted attitudes and beliefs about one's competence (Beck, 1976).

Avoidance

Avoidance describes an exaggerated predisposition to withdraw from novel situations and to avoid personal challenges as threats. This is the behavioral state that often accompanies the distress of someone who has a high level of neuroticism and low self-efficacy (Vaughan & Oldham, 1997). Closely related to the

characteristics of behavioral inhibition or introversion, the trait of avoidance appears to be partly inherited and is associated with shyness, anxiety, and depressive disorders in both childhood and adult life, as well as the subsequent development of substance abuse disorders (Vaughan & Oldham, 1997; Kagan et al., 1988). The people with low levels of harm avoidance are described as "healthy extroverts" and are characterized by confident, carefree, or outgoing behaviors.

Impulsivity

Impulsivity is a trait that is associated with poor modulation of emotions, especially anger, difficulty delaying gratification, and novelty seeking. There is some developmental continuity between high levels of impulsivity in childhood and several adult mental disorders, including attention deficit hyperactivity disorder, bipolar disorder, and substance abuse disorders (Svrakic et al., 1993; Rothbart & Ahadi, 1994). Impulsivity also is associated with physical abuse (both as victim and, subsequently, as perpetrator) and antisocial personality traits (Vaughan & Oldham, 1997).

Sociopathy

This set of traits and behaviors refers to the predisposition to engage in dishonest, hurtful, unfaithful, and at times dangerous conduct to benefit one's own ends. The opposite of sociopathy may be referred to as character or scrupulosity. In its full form, sociopathy is referred to as antisocial personality disorder (DSM-IV). Sociopathy is characterized by a tendency and ability to disregard laws and rules, difficulties reciprocating within empathic and intimate relationships, less internalization of moral standards (i.e., a weaker conscience or superego), and an insensitivity to the needs and rights of others. People scoring high in sociopathy often have problems with aggressivity and are overrepresented among criminal populations. Although not invariably associated with criminality, sociopathy is associated with problematic, unethical, and morally questionable conduct in the workplace and within social systems. Marked sociopathy is much more common among men than

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women, although several other disorders (borderline and histrionic personality disorders and somatization disorder) are overrepresented among women within the same families (Widiger & Costa, 1994).

In summary, the various traits and behavioral patterns that epitomize strong mental health do not, of course, exist in a vacuum: they develop in a social context, and they underpin people's ability to handle psychological and social adversity and the exposure to stressful life events. Furthermore, as reviewed in Chapter 3, severe or repeated trauma during youth may have enduring effects on both neurobiological and psychological development, altering stress responsivity and adult behavior patterns. Perhaps the best documented evidence of such enduring effects has been shown in young adults who experienced severe sexual or physical abuse in childhood. These individuals experience a greatly increased risk of mood, anxiety, and personality disorders throughout adult life.

Stressful Life Events

The most common psychological and social stressors in adult life include the breakup of intimate romantic relationships, death of a family member or friend, economic hardships, racism and discrimination, poor physical health, and accidental and intentional assaults on physical safety (Holmes & Rahe, 1967; Lazarus & Folkman, 1984; Kreiger et al., 1993). Although some stressors are so powerful that they would evoke significant emotional distress in most otherwise mentally healthy people, the majority of stressful life events do not invariably trigger mental disorders. Rather, they are more likely to spawn mental disorders in people who are vulnerable biologically, socially, and/or psychologically (Lazarus & Folkman, 1984; Brown & Harris, 1989; Kendler et al., 1995). Understanding variability among individuals to a stressful life event is a major challenge to research. Groups at greater statistical risk include women, young and unmarried people, African Americans, and individuals with lower socioeconomic status (Ulbrich et al., 1989; McLeod & Kessler, 1990; Turner et al., 1995; Miranda & Green, 1999).

Divorce is a common example. Approximately one-half of all marriages now end in divorce, and about 30 to 40 percent of those undergoing divorce report a significant increase in symptoms of depression and anxiety (Brown & Harris, 1989). Vulnerability to depression and anxiety is greater among those with a personal history of mental disorders earlier in life and is lessened by strong social support. For many, divorce conveys additional economic adversities and the stress of single parenting. Single mothers face twice the risk of depression as do married mothers (Brown & Moran, 1997).

The death of a child or spouse during early or midadult life is much less common than divorce but generally is of greater potency in provoking emotional distress (Kim & Jacobs, 1995). Rates of diagnosable mental disorders during periods of grief are attenuated by the convention not to diagnose depression during the first 2 months of bereavement (Clayton & Darvish, 1979). In fact, people are generally unlikely to seek professional treatment during bereavement unless the severity of the emotional and behavioral disturbance is incapacitating.

A majority of Americans never will confront the stress of surviving a severe, life-threatening accident or physical assault (e.g., mugging, robbery, rape); however, some segments of the population, particularly urban youths and young adults, have exposure rates as high as 25 to 30 percent (Helzer et al., 1987; Breslau et al., 1991). Life-threatening trauma frequently provokes emotional and behavioral reactions that jeopardize mental health. In the most fully developed form, this syndrome is called post-traumatic stress disorder (DSM-IV), which is described later in this chapter. Women are twice as likely as men to develop post-traumatic stress disorder following exposure to life-threatening trauma (Breslau et al., 1998.)

More familiar to many Americans is the chronic strain that poor physical health and relationship problems place on day-to-day well-being. Relationship problems include unsatisfactory intimate relationships; conflicted relationships with parents, siblings, and children; and "falling-out" with coworkers, friends, and

neighbors. In mid-adult life, the stress of caretaking for elderly parents also becomes more common.

Relationship problems at least double the risk of developing a mental disorder, although they are less immediately threatening or potentially cataclysmic than divorce or the death of a spouse or child (Brown & Harris, 1989). Finally, cumulative adversity appears to be more potent than stressful events in isolation as a predictor of psychological distress and mental disorders (Turner & Lloyd, 1995).

Past Trauma and Child Sexual Abuse

Severe trauma in childhood may have enduring effects into adulthood (Browne & Finkelhor, 1986). Past trauma includes sexual and physical abuse, and parental death, divorce, psychopathology, and substance abuse (reviewed in Turner & Lloyd, 1995).

Child sexual abuse is one of the most common stressors, with effects that persist into adulthood. It disproportionately affects females. Although definitions are still evolving, child sexual abuse is often defined as forcible touching of breasts or genitals or forcible intercourse (including anal, oral, or vaginal sex) before the age of 16 or 18 (Goodman et al., 1997). Epidemiology studies of adults in varying segments of the community have found that 15 to 33 percent of females and 13 to 16 percent of males were sexually abused in childhood (Polusny & Follette, 1995). A recent, large epidemiological study of adults in the general community found a lower prevalence (12.8 percent for females and 4.3 percent for males); however, the definition of sexual abuse was more restricted than in past studies (MacMillan et al., 1997). Sexual abuse in childhood has a mean age of onset estimated at 7 to 9 years of age (Polusny & Follette, 1995). In over 25 percent of cases of child sexual abuse, the offense was committed by a parent or parent substitute (Sedlak & Broadhurst, 1996).

The long-term consequences of past childhood sexual abuse are profound, yet vary in expression. They range from depression and anxiety to problems with social functioning and adult interpersonal relationships (Polusny & Follette, 1995). Post-traumatic stress disorder is a common sequela, found in 33 to 86

percent of adult survivors of child sexual abuse (Polusny & Follette, 1995). In a recent review, Weiss et al. (1999) found that sexual abuse was a specific risk factor for adult-onset depression and twice as many women as men reported a history of abuse. Other long-term effects include self-destructive behavior, social isolation, poor sexual adjustment, substance abuse, and increased risk of revictimization (Browne & Finkelhor, 1986; Briere, 1992).

Very few treatments specifically for adult survivors of childhood abuse have been studied in randomized controlled trials (IOM, 1998). Group therapy and Interpersonal Transaction group therapy were found to be more effective for female survivors than an experimental control condition that offered a less appropriate intervention (Alexander et al., 1989, 1991). In the practice setting, most psychosocial and pharmacological treatments are tailored to the primary diagnosis, which, as noted above, varies widely and may not attend to the special needs of those also reporting abuse history.

Domestic Violence

Domestic violence is a serious and startlingly common public health problem with mental health consequences for victims, who are overwhelmingly female, and for children who witness the violence. Domestic violence (also known as intimate partner violence) features a pattern of physical and sexual abuse, psychological abuse with verbal intimidation, and/or social isolation or deprivation. Estimates are that 8 to 17 percent of women are victimized annually in the United States (Wilt & Olsen, 1996). Pinpointing the prevalence is hindered by variations in the way domestic violence is defined and by problems in detection and underreporting. Women are often fearful that their reporting of domestic violence will precipitate retaliation by the batterer, a fear that is not unwarranted (Sisley et al., 1999).

Victims of domestic violence are at increased risk for mental health problems and disorders as well as physical injury and death. Domestic violence is considered one of the foremost causes of serious injury to women ages 15 to 44, accounting for about 30

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percent of all acute injuries to women seen in emergency departments (Wilt & Olsen, 1996). According to the U.S. Department of Justice, females were victims in about 75 percent of the almost 2,000 homicides between intimates in 1996 (cited in Sisley et al., 1999). The mental health consequences of domestic violence include depression, anxiety disorders (e.g., post-traumatic stress disorder), suicide, eating disorders, and substance abuse (IOM, 1998; Eisenstat & Bancroft, 1999). Children who witness domestic violence may suffer acute and long-term emotional disturbances, including nightmares, depression, learning difficulties, and aggressive behavior. Children also become at risk for subsequent use of violence against their dating partners and wives (el-Bayoumi et al., 1998; NRC, 1998; Sisley et al., 1999).

Mental health interventions for victims, children, and batterers are highly important. Individual counseling and peer support groups are the interventions most frequently used by battered women. However, there is a lack of carefully controlled, methodologically robust studies of interventions and their outcomes, according to a report by the Institute of Medicine and National Research Council (IOM, 1998). A research agenda for violence against women was developed (IOM, 1996) and has served as an impetus for an ongoing research program sponsored by the U.S. Departments of Justice and Health and Human Services. Clearly, there is an urgent need for development and rigorous evaluation of prevention programs to safeguard against intimate partner violence and its impact on children.

Interventions for Stressful Life Events

Stressful life events, even for those at the peak of mental health, erode quality of life and place people at risk for symptoms and signs of mental disorders. There is an ever-expanding list of formal and informal interventions to aid individuals coping with adversity. Sources of informal interventions include family and friends, education, community services, self-help groups, social support networks, religious and spiritual endeavors, complementary healers, and physical activities. As valuable as these activities may be for

promoting mental health, they have received less research attention than have interventions for mental disorders. Nevertheless, there are selected interventions to help people cope with stressors, such as bereavement programs and programs for caregivers (see Chapter 5) as well as couples therapy and physical activity.

Couples therapy is the umbrella term applied to interventions that aid couples in distress. The best studied interventions are behavioral couples therapy, cognitive-behavioral couples therapy, and emotion-focused couples therapy. A recent review article evaluated the body of evidence on the effectiveness of couples therapy and programs to prevent marital discord (Christensen & Heavey, 1999). The review found that about 65 percent of couples in therapy did improve, whereas 35 percent of control couples also improved. Couples therapy ameliorates relationship distress and appears to alleviate depression. The gains from couples therapy generally last through 6 months, but there are few long-term assessments (Christensen & Heavey, 1999). Similarly, interventions to prevent marital discord yield short-term improvements in marital adjustment and stability, but there is insufficient study of long-term outcomes. The prevention programs receiving the most study are the Couple Communication Program, Relationship Enhancement, and the Prevention and Relationship Enhancement Program (Christensen & Heavey, 1999). Greater research is needed to overcome gaps in knowledge and to extend findings to a broader array of programs, to diverse populations of couples, and to a wider set of outcomes, including effects on children.

Physical activities are a means to enhance somatic health as well as to deal with stress. A recent Surgeon General's Report on Physical Activity and Health evaluated the evidence for physical activities serving to enhance mental health (U.S. Department of Health and Human Services [DHHS], 1996). Aerobic physical activities, such as brisk walking and running, were found to improve mental health for people who report *symptoms* of anxiety and depression and for those who are diagnosed with some forms of depression. The mental health benefits of physical activity for individuals in relatively good physical and mental

health were not as evident, but the studies did not have sufficient rigor from which to draw unequivocal conclusions (DHHS, 1996).

Prevention of Mental Disorders

A promising development in prevention of a specific mental disorder in adults occurred with the publication of results from the San Francisco Depression Research Project (Munoz et al., 1995). This study investigated 150 primary care patients who did not meet diagnostic criteria for depression and who were being seen in a public clinic for other problems. They were randomized to either psychoeducation—an 8-week cognitive behavioral course to help them control and manage moods—or to a control condition. One year later, those who received psychoeducation were found to have developed significantly fewer depression symptoms than members of the control group. This trial is noteworthy in two major respects: it was a randomized controlled trial and its participants were low-income individuals, with high representation of all major minority groups. Low-income individuals are considered a high-risk population because of studies documenting their higher prevalence of mental disorders. This study demonstrated in a methodologically rigorous fashion that depression may be preventable in some cases. It serves as a model for extending the concept of prevention to many mental disorders. Prevention research is vitally important and needs to be enhanced.

Anxiety Disorders

The anxiety disorders are the most common, or frequently occurring, mental disorders. They encompass a group of conditions that share extreme or pathological anxiety as the principal disturbance of mood or emotional tone. Anxiety, which may be understood as the pathological counterpart of normal fear, is manifest by disturbances of mood, as well as of thinking, behavior, and physiological activity.

Types of Anxiety Disorders

The anxiety disorders include panic disorder (with and without a history of agoraphobia), agoraphobia (with

and without a history of panic disorder), generalized anxiety disorder, specific phobia, social phobia, obsessive-compulsive disorder, acute stress disorder, and post-traumatic stress disorder (DSM-IV). In addition, there are adjustment disorders with anxious features, anxiety disorders due to general medical conditions, substance-induced anxiety disorders, and the residual category of anxiety disorder not otherwise specified (DSM-IV).

Anxiety disorders not only are common in the United States, but they are ubiquitous across human cultures (Regier et al., 1993; Kessler et al., 1994; Weissman et al., 1997). In the United States, 1-year prevalence for all anxiety disorders among adults ages 18 to 54 exceeds 16 percent (Table 4-1), and there is significant overlap or comorbidity with mood and substance abuse disorders (Regier et al., 1990; Goldberg & Leerubier, 1995; Magee et al., 1996). The longitudinal course of these disorders is characterized by relatively early ages of onset, chronicity, relapsing or recurrent episodes of illness, and periods of disability (Keller & Hanks, 1994; Gorman & Coplan, 1996; Liebowitz, 1997; Marcus et al., 1997). Although few psychological autopsy studies of adult suicides have included a focus on comorbid conditions (Conwell & Brent, 1995), it is likely that the rate of comorbid anxiety in suicide is underestimated. Panic disorder and agoraphobia, particularly, are associated with increased risks of attempted suicide (Hornig & McNally, 1995; American Psychiatric Association, 1998).

Panic Attacks and Panic Disorder

A panic attack is a discrete period of intense fear or discomfort that is associated with numerous somatic and cognitive symptoms (DSM-IV). These symptoms include palpitations, sweating, trembling, shortness of breath, sensations of choking or smothering, chest pain, nausea or gastrointestinal distress, dizziness or lightheadedness, tingling sensations, and chills or blushing and “hot flashes.” The attack typically has an abrupt onset, building to maximum intensity within 10 to 15 minutes. Most people report a fear of dying, “going crazy,” or losing control of emotions or behavior. The experiences generally provoke a strong

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Conclusions

1. As individuals move into adulthood, developmental goals focus on productivity and intimacy including pursuit of education, work, leisure, creativity, and personal relationships. Good mental health enables individuals to cope with adversity while pursuing these goals.
2. Untreated, mental disorders can lead to lost productivity, unsuccessful relationships, and significant distress and dysfunction. Mental illness in adults can have a significant and continuing effect on children in their care.
3. Stressful life events or the manifestation of mental illness can disrupt the balance adults seek in life and result in distress and dysfunction. Severe or life-threatening trauma experienced either in childhood or adulthood can further provoke emotional and behavioral reactions that jeopardize mental health.
4. Research has improved our understanding of mental disorders in the adult stage of the life cycle. Anxiety, depression, and schizophrenia, particularly, present special problems in this age group. Anxiety and depression contribute to the high rates of suicide in this population. Schizophrenia is the most persistently disabling condition, especially for young adults, in spite of recovery of function by some individuals in mid to late life.
5. Research has contributed to our ability to recognize, diagnose, and treat each of these conditions effectively in terms of symptom control and behavior management. Medication and other therapies can be independent, combined, or sequenced depending on the individual's diagnosis and personal preference.
6. A new recovery perspective is supported by evidence on rehabilitation and treatment as well as by the personal experiences of consumers.
7. Certain common events of midlife (e.g., divorce or other stressful life events) create mental health problems (not necessarily disorders) that may be addressed through a range of interventions.
8. Care and treatment in the real world of practice do not conform to what research determines as best. For many reasons, at times care is inadequate but there are models for improving treatment.
9. Substance abuse is a major co-occurring problem for adults with mental disorders. Evidence supports combined treatment, although there are substantial gaps between what research recommends and what typically is available in communities.
10. Several special problems in care and treatment of adults have been recognized, beyond traditional mainstream mental health concerns, including racial and ethnic differences, lack of consumer involvement, and the consequences of disability and poverty.
11. Barriers of access exist in the organization and financing of services for adults. There are specific problems with Medicare, Medicaid, income supports, housing, and managed care.

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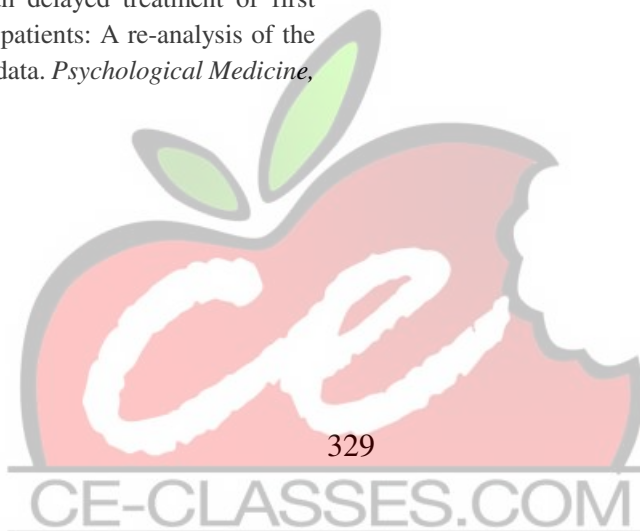
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