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A comparative study of stress and depression in a psychoeducational setting

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A COMPARATIVE STUDY OF STRESS AND DEPRESSION IN A PSYCHOEDUCATIONAL SETTING

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CHAPTER 1

Introduction

Background of the Problem

The proposed thesis will attempt to measure and evaluate a class, Stress, Depression, and Anxiety, which is offered through Kaiser Hospital's Effective Living Classes. The course is funded by West Valley College, and uses the facilities at the Santa Clara Kaiser Hospital and has been taught by Peter Taylor, M.S.W., for the past ten years. The researcher has been assisting in teaching this class for over two years.

Many medical practitioners and investigators recognize that symptoms resulting from problems of everyday living contribute to the increased cost of health care. Potential clients sometimes resist a doctor's referral to psychiatry because of their preconceived stigma attached to the word "psychiatry" and because they do not accept the idea that their symptoms may have a psychological base. Participation in a psychoeducational program may therefore be an acceptable and effective alternative for many individuals, who might otherwise seek no help, or alternatives to their problems. This associated response between the stigma of mental illness and the "mystery" of the psychiatry department tends to become demystified through the openness and shared experiences of those class members who are either currently involved in therapy or have been in the past.

The Health Maintenance Organization (HMO) based psychoeducational project addresses two important problems: the overutilization of medical services and the common failure of individual counseling and other traditional approaches to attain results in the treatment of clients with problems in daily living.

The goal of the "More Effective Living" Series is to help people maximize personal health and well-being. It is estimated that as many as seven out of the ten leading causes of death in the United States might possibly be reduced through changes in lifestyle. The purpose of this class is to help one understand his symptoms, their causes, the interrelationships, and what can be done. Approaches include: exercise, dietary changes, cognitive and affective theory, relationship techniques, medication, sleep problems, and relaxation exercises. There are brief lectures, discussion, questionnaires, and homework assignments. Because the class requires the consumer's active participation and cooperation in helping himself, the client begins to gain some control over his problems and his life.

The researcher's operating paradigm will be the assumption that the information and skills learned in the Stress/Depression class will help alleviate the recognized symptoms of stress and depression, leading in improvement of the conditions and problems which brought the participant to the class. The researcher's theoretical framework can be applied to predict the events, relationships, and outcome of future classes.

Hypothesis

The basic hypothesis that the researcher wishes to test is

that the Heimler Scale of Social Functioning (HSSF) would reveal the Stress/Depression class population to be functioning at a higher and more satisfactory psychosocial level after six weeks of treatment in an educational class, as measured by HSSF, with a corresponding reduction in symptoms.

Much of the current research hypothesizes that the psychological state of a person and one's biological well-being share a symbiotic relationship. The class promotes holistic treatment of participants, encompassing the behavioral, psychological, social, and physical aspects, with special emphasis on one's daily habits and lifestyle. Stress management involves finding the right types and amounts of stress which are compatible with one's own individual personality, priorities, and lifestyle.

Operational Definitions

Stress is operationally defined as the nonspecific response of the body to any demand made upon it.[1] The stress-producing factors, technically called stressors, are different, yet they all elicit the same biological stress response. In addition to their specific actions, all agents to which we are exposed also produce a nonspecific increase in the need to perform adaptive functions and thereby to re-establish normalcy. For example, a great muscular effort, such as running up many flights of stairs makes increased demands upon our musculature and cardiovascular systems. The muscles will need supplemental energy, so the heart will beat faster and blood pressure will rise to dilate the vessels, thereby increasing the flow of blood to the muscles. So there is a demand by the body

for readjustment. The demand is non-specific; it requires adaptation to a problem to re-establish, or readjust to normalcy, or homeostasis.

The severity of the stressor is of less significance than the accumulation of stress. Responses to stress are controlled by the sympathetic nervous system, the network that helps prepare the body to meet emergencies by "fight or flight."

Selye has labeled the body's physiological response to stress as the General Adaptation Syndrome (GAS). He describes the syndrome as having three stages: 1) Alarm, 2) Resistance, 3) Exhaustion. After the initial alarm is triggered by introduction of a stressor, the body attempts to resist by utilizing its usual coping mechanisms to adapt. The stage of exhaustion follows long-term exposure to the same stressor; the body's adaptation energy has been exhausted. Eventually, the chronically stressed body begins to wear out from this accumulated stress, resulting in disease.

For example, transient hypertension may become permanent high blood pressure, a major contributor to cardiac and cerebral accidents. Chronic muscle tension can develop into a chronic back problem, or into tension headaches. Chronic stomach irritation can lead to ulcers, and chronically suppressed immune activities make the body vulnerable to infections such as colds. Other stress related disorders include arthritis, colitis, diarrhea, constipation, cardiac arrhythmia, sexual problems, circulatory problems, and even cancer.

Individuals differ in the way they respond to stress. When the body is repeatedly aroused, one or more functions may become permanently overactive as the response to stress becomes habituated. Damage to

bodily tissues may eventually result; the accumulation of stress will manifest itself in the body as physical or psychological problems.

At the turn of the century, the major reason for seeking medical assistance was to treat infectious diseases. Today, it is estimated that 75% to 90% of all visits to the doctor's office are for stress-related problems. The researcher sees the Stress/ Depression class as a means of teaching people to assume responsibility for their own health and well-being. Participants must examine their own habits and individual lifestyles. The class teaches them to recognize that they can, through their own efforts, remedy some physical ailments.

On the job stress is finally coming to the attention of big business. Employers are slowly recognizing that work-related stress is a major source of low morale, illness, poor work performance, and accidents. Studies are beginning to surface which indicate a 42% reduction in absenteeism after taking this type of stress management class. Many companies are initiating their own stress class for employees, as well as providing exercise programs.

Depression is operationally defined as physical symptoms which indicate that organic change is involved. These changes in body function may include nervous agitation or motionless apathy. The vegetative signs include: change in appetite (increase or decrease), a decreased or increased interest in sex, change in sleep patterns, and a loss of any kind of pleasure, known as Anhedonia. Feelings of hopelessness and helplessness are pervasive, resulting in a lack of energy. There is an inability to concentrate, and terrible slowing

of thought and action. These symptoms lead the depressed individual to withdraw and isolate himself. The condition is not temporary, but has lasted at least two weeks.

Individuals may be genetically susceptible to depression, meaning that certain circuits in the brain areas which promote pleasure and rewarding experiences are chemically fragile and somewhat easily upset. Psychological stress later in life reactivates early traumatic experiences that undermine confidence and self-esteem, such as the loss of or separation from a parent at a critical stage of development. This echo of early loss places unusual demands on the already vulnerable reward system. The class is introduced to the concept of better understanding of the biological defects underlying depression; prevention of depression may occur with drugs that correct imbalances in brain chemistry. During or after drug-induced recovery, psychotherapy can enhance psychological and social functioning and perhaps lessen the likelihood of relapse.

Patients referred to psychiatry are most often undergoing problems in living which might be treated just as effectively through the educational approach and techniques gained from this type of class. At one time, the classes were divided separately into one class for stress, and another separate class to treat the condition of depression. Anxiety is believed to be an underlying symptom in both conditions. Stress and depression were often seen to overlap, and some depressed people were attending the stress class, and some people who were suffering from stress were signing up for the depression class. In reality, both conditions can be

helped by applying many of the same techniques. The following are examples of techniques for treating both conditions: emphasizing the importance of incorporating daily routine and good habits into one's lifestyle, the awareness of sleep, diet, exercise, and proper nutrition, time management, creative problem solving, and cognitive and affective approaches. Some class members experience both conditions, stress and depression, simultaneously.

The instructor, Peter Taylor, L.C.S.W. for Santa Clara Kaiser Psychiatry, strives to acculturate the class to the therapeutic process, through the practice of lectures, and questions and answers each week. The six sessions serve the purpose of evaluating an individual's needs and determine whether another type of course (relaxation, assertiveness, etc.) might prove to be of further benefit. At the end of the six week assessment, participants whose scores have not reached the normal range, are urged to seek individual professional help.

For some patients, participation in a psychoeducational program alone may not be sufficient to produce improvement. Other patients would benefit from either counseling or the class, while others need the combined approach of both. Educational programs used in conjunction with therapy can be beneficial; and some individuals will improve in both psychosocial function and symptom reduction strictly with the help of the class.

A number of patients in psychiatry are also referred to the class. Mr. Taylor sees the class as a necessary means of transmitting pertinent information that would ordinarily have to be distributed on an

individual basis. Thus, the class is a source of information that saves time, cuts down on the number of psychiatric visits, and avoids the tediousness of repetition of information for those patients who are simultaneously in counseling. In addition, Kaiser physicians who do not find any medical reason for a patient's complaints conclude the problem may be stress related, and refer these patients to the class.

The researcher sees this as beneficial to both the client and Kaiser HMO. This process expedites the needs of the client, cuts down on the number of potential psychiatric visits, and is cost effective to both the consumer and Kaiser Hospital.

CHAPTER 2

Review of Literature

Introduction to the Review of the Literature

Because of the vast amount of literature on the subject of stress/depression, the researcher has chosen to review only those topics which are relevant to the class. Many different approaches are introduced, although the management of stress is unique to each individual. What may be beneficial to one person may not be helpful to another. The class provides the necessary tools; the choice is personal.

The content of the literature review will cover the concept of prevention, and the behavioral techniques included in the class: habits, sleep, diet, and exercise, as well as relaxation exercise, cognition, time management, action approach, and medication. The last two sections will discuss the value of self-help groups and cultural barriers to group representation.

Prevention

Prevention is a process of planned change. Prevention is an active, assertive process of creating conditions and/ or personal attributes that promote the well-being of people. Prevention equips people with practical concepts, strategies, tools and skills through which they can determine their own paths to achieve their own results and gauge their own progress.[2]

The working definition of prevention being proposed emphasizes the idea of actively creating conditions which would preclude the occurrence of the symptoms one wishes to avoid. Thus the emphasis is on promoting the well-being of people through positive action that changes the conditions under which the behaviors to be prevented are most likely to occur.

Any attempt either to promote interest in prevention or to implement specific strategies for prevention is an effort to bring about change. This includes change in the attitudes and behavior of individuals and change in the operational patterns of organizations and institutions.[3]

The National Institute of Mental Health regards prevention to be one of its major priorities in the field of mental health. The concept of prevention reduces unnecessary suffering and the associated costs for treatment, especially with vulnerable populations such as the elderly, children, and minorities.[4]

Descriptive risk factors including age, education, previous job history, and socioeconomic status might be identified, and potential modifiable risk factors might also be tentatively isolated. For example, some research "suggests that those unemployed persons who perceive themselves as having relatively low levels of social support also have the highest levels of depression."[5] With this available information, an administrator may begin to survey the changes needed to provide increased levels of social support to this identified high risk group.

Not all problems of individuals are equally susceptible to the impact of the material presented in the class at the same stage of

their lives.

> Just as it is important to understand a prevention program's effect on different types of people, so is it necessary to ascertain whether prevention efforts are differentially effective at different times in people's lives.[6]

Mental health practitioners committed to special populations also show a particular interest in prevention. Concern with child maltreatment (J. Garbarino, 1980), children in families experiencing divorce (R.D. Felner, et. al., 1980), women on public assistance (B. Tableman, et. al., 1982), and the elderly (M. Gatz, et. al., 1982) has stimulated practitioners and researchers to consider the possibility of prevention programs to reduce the problems encountered by these special populations.[7]

The goals of prevention encourage administrators and evaluators to analyze the projected achievement of the prevention concept, and help the staff develop a common conceptual framework for planning and program development.

Primary prevention focuses on interventions designed to reduce the incidence or rate of occurrence of new cases. The population of the Stress and Depression class have not all yet developed a particular disorder or health problem. Secondary prevention efforts are aimed at reducing the duration of a problem or disorder once it has occurred. A further distinction is often made identifying "tertiary prevention." Teritary prevention efforts are designed to reduce the disability associated with some already existing chronic problem or disorder.[8] The researcher believes the information and skills taught in the Stress class address all three concepts of prevention.

> Health promotion activities are designed to foster positive behaviors and good health practices. Health enhancement encompasses individual improvement and behavior change in relation to one's socioeconomic and existing physical environment. Health enhancement seeks to build adaptive strengths, coping resources, survival skills, and health in individuals, families, and social groups who must withstand the stress of living in our complex society. Health enhancement activities can seek to eliminate the sources of stress themselves.[9]

A second set of activities frequently called disease/disorder prevention is described by ADAMHA as

> A primary prevention approach, which encompasses services to prevent the occurrence of specific disorders, using strategies derived from analysis of risk factors for such disorders.[10]

Progress can be measured toward the program goal by measuring progress on the program objectives. An objective is a specific, desired outcome.

The class is designed to provide some skill, knowledge, or technique in the life of an individual who belongs to an identified vulnerable population. This may be an enhanced problem-solving skill or the capacity to manage stress more effectively. These outcomes are important, but proximinal; that is, they are changes invoked by design of the prevention project but not in themselves evidence of the class having a preventive effect.[11] Reduction of the symptoms of depression or anxiety, improved ratings on the Heimler Scale of Social Functioning, and improved health habits are all measurable outcomes of improvement.

The goal of prevention is to change the behavior of people in policy making, management, and service delivery positions, as well as other potential resource people who might become involved in carrying out an assertive prevention program.[12]

Habits

Daily habits and lifestyle are important in the reduction of stress and depression. Habits are secure, comfortable, and require little effort. Change requires effort and risk, and creates tension. Stress is not isolated within one's own mind and body. It is tied to daily habits of living which in turn are linked to the pace of social change around you. "Managing personal stress wisely depends upon taking deliberate steps to overcome the repetition compulsion, or the inner drive to be and to do that which is familiar."[13]

Self-care ameliorates the negative aspects of stress. The first class emphasizes the importance of accepting responsibility for one's own general health habits, as well as maintenance of a regular daily routine such as getting up and going to bed at the same time. It has been estimated that it takes an average of three weeks to either make or break a habit. A habit check list is administered in this first class. If a person is aged at least 45, and has two or less habits on the list, he will live to be 66. If he experiences six or more good habits, he is expected to live to be 77. This is a difference of 11 years of life, as well as an improved sense of well-being. Ninety percent of daily habits are related to longevity.

Participants are encouraged to keep a week long assessment chart of sleep, diet, and exercise. (See Appendix H) This self-help intervention helps people feel more in control of their lives, and when people feel physically improved, they have more energy to devote to the other areas of stress in their lives.

Learning to live with stress requires self-appraisal, introspection, and a recognition of one's own manifestation of stress. Resistance to stress can be enhanced through high-level wellness, which can be achieved with proper sleep, diet, and exercise habits.

The class program expands upon the traditional content in health education, such as symptoms and risk factors, and includes self-assessment skills, and the development of emotional objectivity about oneself. The focus is on a process of increased responsibility in one's own health maintenance. Individuals are encouraged to process information as it relates to themselves, their values, and their life goals, according to their own strengths and potential.

John Knowles, of the Rockefeller Foundation, has stated that the next major advance in the health of the nation will come, not from increasing medical technology, but from what individuals can do for themselves.[14]

Sleep

Secondary sleep disorders are those in which chronic clinical problems are accompanied by specific or non-specific sleep disturbances. In this category is placed depression, schizophrenia, alcoholism, anorexia nervosa, hypothyroidism, and renal insufficiency.[15] Pathological insomnia may be a sign of depression.

Certain patterns in the sleep disturbances accompanying depression have been discovered. Most investigators agree that depressed persons have less total sleep time, less slow wave sleep, and more awakenings during the night than normal subjects.[16]

In their book, Insomnia, Gay Gaer Luce and Julius Segal describe what happens when a person falls asleep.

> At the threshold of sleep, body temperature goes down and what are known as "alpha rhythm" brain waves occur. At this point, after the alpha state is reached, many people experience a sudden jerking awake. This is technically known as the "Myclonic Jerk" and signals neural changes resulting from a sudden burst of activity in the brain. Typically, the sleeper jerks half awake, then quickly enters stage 1 of sleep. Muscles relax and the pulse slows. Sleepers awakened at this point often feel that they have not been asleep.
>
> If unawakened, the sleeper now enters stage 2. At this time if an EEG (electroencephalograph) were being made the tracings would show a burst of activity as the brain waves grow larger. The sleeper's eyes roll from side to side. If the eyes open, they do not see. At this point, although asleep about 10 minutes, a person if awakened might wonder if he or she had been sleeping or might believe no sleep had occurred. After about 30 minutes of sleep, stage 3 is reached, muscles are relaxed and breathing even.[17]

Stage 4, or delta sleep, is the deepest sleep of all. After about 20 minutes of delta sleep, the sleeper enters the REM period. Dreams occur during 85 percent of REM. The heartbeat is irregular and blood pressure fluctuates; the brain waves resemble those of a waking person. The first REM period lasts about 10 minutes, and the cycle begins again with the sleeper entering sleep stage 2. This cycle repeats itself about once every 90 minutes. Toward morning there is less delta sleep and more REM.

People who are deprived of REM sleep often become hostile, irritable, and anxious. Those deprived of delta sleep seem to become depressed and apathetic. When they return to a normal sleep cycle, their bodies make up the missed stages as soon as possible. Because sleeping pills may suppress these important phases of sleep, medical authorities are discouraging their use, especially over an extended time.

A direct relationship between amount of sleep reduction and level of Type A behavior fits D.C. Glass' hypothesis that the Type A person is both aggressively energetic and less able to cope with stress, and hence the well-documented increased frequency of coronary heart disease shown by Type A individuals.[18]

R. Hicks, et. al., advanced the hypothesis that an individual's normal habitual sleep duration might be implicated in the development of Type A behavior patterns.[19] Their findings indicate on the positive side, deprivation of REM sleep has been associated with increased levels of motivation, energy, and aggressiveness, while on the negative side, reductions of REM sleep have been associated with increased susceptibility to stressors and restrictions in the diversity of coping potential.[20] The REM period allows us to live a situation stressful to us, to discharge tension. Freud believed that dreams reduced tension, associated with problem solving, and coping procedures.

Drugs and alcohol greatly reduce REM sleep. REM deprived individuals are less fearful, less emotional, and more aggressive and competitive. Crimes involving assault are often drug or alcohol related. The rise in crime is related to the rise in drugs and alcohol usage. Recovering alcoholics have 95 percent REM in one night; this is known as the rebound effect.[21]

There is also some evidence of abbreviated REM latencies of shorter intervals between REM periods and of an intensification of the phasic components of REM during the most severe stages of depression.[22] Snyder, in noting his evidence, has suggested that a REM debt may be part of the causal developments leading to the psychotic phase of

the depression and preceding clinical improvement.

The American public spends approximately $25 million a year on over-the-counter (OTC) sleep aids, and additional millions are spent by the approximately 8.5 million Americans who take prescription sleeping pills. In 1977, about two million of these insomniacs took prescription sleep medications every night for two consecutive months or longer.[23]

The recent recall of OTC sleep aids containing methapyrilene and a previous FDA warning about the use of OTC sleep aids, coupled with an Institute of Medicine report on prescription sedatives and hypnotics, question the indiscriminate and widespread use of both OTC and prescription sleep medications.[24]

> In 1975, FDA's expert panel on sleep aids, daytime sedatives, and stimulants cautioned those with chronic sleep problems to seek medical help. It warned against using sleep aids containing bromides and scopolamine compounds, and found irrational: the use of passion flower extract and Vitamin B (thiamine hydrochloride) in sleep aids. Although most sleep aids containing these ingredients were reformulated after the panel's report, some remain on the market.
>
> More recently, OTC sleep aids containing the antihistamine methapyrilene, a carcinogen, were recalled down to the retail level in June, 1979. Manufacturers again reformulated their products, mostly with a chemically similar antihistamine, pyrilamine, which has not yet been tested for carcinogenicity. This action leaves thousands of users of OTC sleep aids wondering if they should continue to take these drugs, see their doctor for a prescription medication, or possibly look for other ways to relieve insomnia.[25]

The National Academy of Science's Institute of Medicine (IOM) has conducted a study of sedative-hypnotic drugs. This study was requested by the White House Office of Drug Policy and the National Institute on Drug Abuse. Of significance to insomniacs seeking

prescription drugs was the IOM report's advice to physicians to restrict use of sedative-hypnotic drugs to short-term treatment of insomnia. IOM found little evidence that sedative hypnotics in general continue to be effective when used nightly over long periods. Sleep laboratory research on sleeping pills shows that practically all lose their sleep promoting effectiveness after three to fourteen days of continuous use. Studies also show that many prescription drugs interfere with various stages of sleep. The barbituates suppress REM (rapid eye movement) sleep during which people dream. "In the last several years, this knowledge, together with the association of barbituates and drug abuse, has been responsible for a shift away from prescribing barbituates in favor of the benzodiasepines, most notably Dalmane."[26]

The single most common complaint in the Stress and Depression class is problems with sleep. Class participants are encouraged to examine their eating, drinking, exercise, and relaxation habits to see if these might be preventing good sleep. A more natural approach is advocated.

Factors that prevent people from getting a good night's sleep include poor sleep habits (such as irregular sleep routines), anxiety, depression, abuse of alcohol and drugs, illness, or physical ailments.[27] The amount of sleep needed depends on age, physical and mental health, and lifestyle. The average adult gets between seven and eight hours of sleep a night, so this is viewed as the norm.

Sleep experts have developed some simple rules for good sleep.

1. Go to bed and get up about the same time every day, weekends included. A regular routine keeps you in step with your biological rhythms.
2. Exercise regularly. (Some people, however, may find exercise too physically arousing if it's done too close to bedtime.)

3. Recognize that sleeping pills, alcohol, caffeine and cigarettes may induce sleeplessness. People who drink or smoke often remain awake in bed for a long time.
4. We all have the capacity to fall asleep. If we don't sleep for a night or two, no harm will come unless we try too hard. So don't try to force sleep. If you cannot sleep, get out of bed. Do something boring.
5. Find a quiet place. Noisy environments disturb sleep, even for deep sleepers.
6. Don't use the bedroom for reading, watching television, playing games. You will associate bed with activities that make the mind race. Bedrooms are only for sleep and sex.
7. Learn some kind of relaxation technique. Meditation is one, biofeedback another. You can relax by alternately tensing and relaxing your muscles.[28]

The Stress class addresses these alternatives to drugs as an effective, safe, long lasting solution to sleep difficulties. Class members report that once their sleep cycle is improved, they feel better equipped to cope with their problems.

Circadian Rhythms

Nearly every biological function exhibits 24-hour patterns of variations called circadian rhythms. For example, body temperature oscillates about a degree and a half Fahrenheit each day, reaching its peak in the early evening and its low point late in the night.

Patterns of sleep are regulated by these rhythms which are subject to alterations by stress and anxiety, as well as by external disturbances, which prevent sleep from occurring at its normal time. Shift work, environmental noise, travel (especially across time zones), illness, bereavement, or trauma are all examples of factors which might affect these rhythms.

Circadian rhythms are genetically programmed and internally driven by oscillators in the hypothalamus. The self-sustained nature

of these rhythms can be demonstrated by placing human subjects in constant conditions of isolation from all external time cues. In this situation, circadian rhythms persist.[29]

> Researchers have successfully treated subjects with chronic intractable sleep onset insomnia by "forcing" their sleep-wakefulness clock to run slower, i.e., having them go to bed later and later every night, in the direction they were already heading towards. After two or three weeks, patients had gone completely around the clock, until they returned to a normal bedtime, where the phase delay procedure was stopped. Results showed that the great majority of subjects were able to stay locked into their new (normal) sleep onset schedules. These experiments suggest one approach to coping with the very common problem of sleep onset insomnia, particularly if it is chronic.[30]

Vigorous activity at a set time of day is known to serve as a powerful time cue for synchronizing biological rhythms. The beneficial effects of exercising regularly are partly responsible due to the effects of the circadian clock.

Much research has been devoted to the role of body rhythms in the treatment and prevention of major affective disorders, depression, in particular.

> Studies can be interpreted to show that the timing of the circadian rhythm of REM sleep propensity in depressives is shifted abnormally early (phase-advanced) relative to their sleep period and to the external day-night cycle. The normal skewed temporal distribution of REM sleep (low at the beginning, high at the end of the night) is lost. The relative decrease of REM sleep at the end of the night and increase at the beginning are reflected in shorter REM latency (time from sleep onset to REM sleep onset) and occasional long first REM periods. In this connection it has been hypothesized that the phase position of the circadian rhythm in REM sleep propensity is shifted abnormally early in depressives.[31]

In summary, clinical studies indicate that the circadian rhythms occur abnormally early in depressives. These rhythms include at least three (body temperature, cortisol secretion and REM sleep

propensity) which appear to be controlled by the same driving oscillator.

In depression research, it has been discovered that one night of total sleep deprivation can induce transient remissions in endogenously depressed patients. When a typical endogenously depressed patient stays awake all night, he improves, sometimes rapidly and dramatically, between 1 and 5 A.M. It has also been determined that most switches into depression occur in the course of sleep. "The common feature of all of these observations is that sleep in the second half of the night sustains and augments depression, whereas wakefulness in the second half of the night ameliorates depression and may precipitate mania."[32]

There appears to be a sensitive phase of the circadian cycle beginning some time before dawn when sleep or wakefulness determines clinical state. Thus, if the advance phase-position of depressives' circadian rhythms is pathogenic, it may be due to a sleep-sensitive switch mechanism associated with a specific circadian phase to be advanced from the first hours of wakefulness into the last hours of sleep. Findings concerning the sleep-sensitive switch mechanism have important implications for treatment and prevention of affective disorders, as well as for coping with the impact of stress on bodily rhythms. Preliminary evidence indicates that the combination of sleep deprivation and antidepressant medication acts more rapidly than drugs alone. In the long-term treatment of patients with affective disorder, it seems logical that a certain regularity in sleep habits and activities could be a stabilizing factor.

L-Tryptophan

L-tryptophan is a natural amino acid which has proven effective in alleviating insomnia as well as reducing stress, anxiety, and depression. L-trytophan is used by the brain to manufacture serotonin, which is an amine transmitter that the nerves in the brain's emotional centers use to send messengers to each other.[33] With an inadequate amount of L-tryptophan in one's diet, brain serotonin levels fall, which may contribute to depression. Although L-tryptophan is found in many high protein foods, such as milk and turkey, the best way to obtain benefit is from L-tryptophan supplements, which are obtained over the counter. This amino acid is not addictive, and some class members report L-tryptophan as being very beneficial in promoting natural sleep, with no after effects.

Diet

The relationship between food and emotions is discussed as another self-help intervention in the prevention of stress, anxiety, and depression. What we eat can cause such strong psychological symptoms as depression, profound tiredness, listlessness, irritability, debilitating headaches, raging hyperactive outbursts, as well as forgetfulness, inattention, insomnia and severe anxiety. These reactions, though profound, often go unrecognized.[34]

Modern food processing has drastically changed the way we consume sugar. Examining product ingredients will demonstrate how difficult it is to find any type of prepared food that does not contain sugar. Between 1900 and 1970, world production of sugar grew from 8 million to 70 million tons. North Americans now average 24 percent of their

calories from sugar. Only 3 percent comes from the sugar in fruits and vegetables. Another 3 percent is from lactose in milk sugar in dairy products. Sugar that is added to our food accounts for 18 percent of all calories consumed, making sugar the leading food additive today. Nutrition labeling does very little to help promote an awareness of sugar content. The label shows only total carbohydrates and the percentage of sugar and starch in a product. Many different types of sugar may be listed on the label that are not familiar to most consumers, such as the words with an "ose" ending, such as fructose, lactose, or dextrose.[35]

As sugar enters the bloodstream, we may feel a rush of energy. Sugar in the blood signals the pancreas to pour out insulin to maintain the body's sugar level. This creates a temporary hypoglycemia, or low blood sugar. The result is that twenty minutes later, we may feel sluggish, tired, cranky, or depressed.

Yeast is another common food that affects some people. It is present in baked goods, alcoholic beverages, vinegar, pickled or fermented foods, most cheeses, mushrooms, and dried fruits. Some people who complain of depression, irritability or fatigue are, in fact, intolerant of yeast.[36]

When chocolate is metabolized in the body, it creates the negative neurotransmitter phenylalanine, which has been implicated in many studies of depression, lethargy and anxiety. Strong cravings for chocolate are the result of this strong neurochemical imbalance.[37]

Dr. Berger states: "Vitamins are also linked to mood. Low levels of vitamins B_1, B_6, and C have been linked to depression or

sudden mood changes. A deficiency of vitamin B_{12} has been shown to cause forgetfulness among elderly patients."[38]

Each person's specific food sensitivities are unique; certain foods, when eaten, react with the white blood cells in our body, damaging hundreds of thousands of them. This results in a weakening of the immune system, often accompanied by a diminished sense of well-being.[39]

Dr. Theron Randolph, the physician recognized as the founder of modern understanding of food allergies, says we acquire and lose sensitivities, depending on how often we eat a given food.

Explains Dr. Randolph:

> Once, nature regulated this by making most foods available only in certain seasons, so we couldn't overdose. But mass industrial food production has made most foods available all year around.
>
> Once we identify and carefully remove the specific foods from the diets of those patients suffering from food intolerances, their moods improve, emotions level out, minds clear, and the tension, sleeplessness and stress that had poisoned their lives simply disappear.[40]

Good nutrition is important to today's modern world, but it is essential to those suffering the pain of stress and depression. Stressed and depressed people very often experience feelings of hopelessness and helplessness in their lives. Monitoring the effects of specific foods on one's emotional well-being is a way to gain some measure of control over their lives.

The National Institute of Health (NIH) has established a definite link between high cholesterol and heart disease and death in middle-aged men. Diet has been the subject of the greatest amount of

research, and is one of the easiest ways to control cholesterol. The NIH committee mainly advised a change in eating habits for millions of Americans whose cholesterol levels used to be considered normal by many physicians. Additionally, the NIH set a national goal of a 10 percent reduction in blood cholesterol level. Such a reduction could save 100,000 lives a year by reducing the deaths from heart disease, the nation's No. 1 killer, says the report.[41]

Weight reduction, exercise, kicking the smoking habit, and restricting salt and fats in the diet can dramatically improve blood pressure.

Exercise

The benefits of exercise are emphasized at the first class as the first self-help step that members can take for themselves. If suffering from depression, exercise will get you up and moving from your dull state; if stressed, exercise will have a calming effect on the body. Aerobic type exercise releases endorphins into the blood-stream. This is reported as a morphine-like substance, and is related to the "runner's high" that joggers get. Exercise also stimulates the secretion of neurochemicals called catecholamines into your brain.

Vigorous physical exertion provides a natural outlet when the body is in the "fight" or "flight" state of arousal. Following exercise, the body returns to its normal equilibrium. The kind of sedentary lifestyle which has developed since the industrial revolution has resulted in a lessening of exercise. Widespread physical inactivity

is a major contributor to coronary heart disease, obesity, joint and spinal disc disease, fatigue, muscular tension, and depression.[42]

Regular, vigorous exercise not only reduces stress, but allows for the release of toxic products. Exercise can reduce the effects of stress by strengthening the heart, lungs, and muscles, increasing energy and stamina, improving the absorption-utilization of food by replacing intramuscular fat with lean muscle. Physical activity has proven effective in reducing stress, relieving depression, and promoting more restful sleep.[43]

There are two categories of exercise: aerobic exercise and low intensity exercises. Aerobic exercise involves sustained, rhythmic activity of the large muscle groups, especially the legs, and includes running or jogging, swimming, bicycling, dancing, and very brisk walking. Aerobic exercise involves an increased demand for oxygen which is met by an increased heart and respiratory rate, and a relaxation of the small blood vessels to allow more oxygen carrying blood to reach the muscles.[44]

The goal of aerobic exercise is to strengthen the cardiovascular system and increase stamina, but any form of exercise carried out on a routine basis at least three times a week for a minimum of thirty minutes is beneficial and creates a feeling of well-being.

Medical researchers at Stanford and Harvard universities who have studied the habits and health of 17,000 middle-aged and older men reported the first scientific evidence that even modest exercise helps prolong life. The researchers concluded that sedentary life styles, even among former varsity athletes, lead to heart and

lung diseases that shorten lives.

> 'We have found a direct relationship between the level of physical activity and the length of life in the college men we studied,' said Dr. Ralph S. Paffenbarger, professor of epidemiology at Stanford, who is the principal author of the report.[45]

The study found that sedentary adults who were active in their youth are as likely as people who have never exercised to suffer high blood pressure and heart attacks. To achieve the benefits of exercise, physical activity must be maintained.

The group that participated in this study were 16,936 Harvard alumni who entered the university from 1916 to 1950. The study was conducted from 1960 to 1984. The research dealt with life styles and health habits. The group reported such data as stairs climbed, city blocks walked, and time and type or sports played each week, data that were coupled with other information about height, weight, smoking, blood pressure and family history of heart disease, and the total body of information translated into a complicated set of relative risks.

From studying those 640 men who died of cardiovascular disease, Paffenbarger and his colleagues reported that the adjusted death rates of the most sedentary group were almost twice as high as the most active group.

Relaxation Exercises

Some people have a chronic predisposition to develop a stress problem, due to a high arousal of the sympathetic nervous system. When startled, they often take longer than normal to return to their usual level of arousal. Anxious people require more practice than

normal people to learn to relax.[46] The goal of stress management is not merely stress reduction, but finding your own optimal stress levels according to your individual personality and lifestyle.

Employers are beginning to recognize that stress on the job is costing money in terms of productivity, accidents, absenteeism, low morale, illness, and poor work performance. Many companies recognize the importance of stress reduction, exercise, and relaxation classes at the workplace.

The use of prescription medication for hypertension can be greatly reduced as people learn to lower their own blood pressure. Self-regulation can be achieved from a specific state created in autogenic training.[47] Regular, brief sessions of passive concentration would gradually balance the physiology of the autonomic nervous system of the body by reducing other extraneous stimuli.

With continued practice, it should be possible to induce this state of relaxation in almost any environment without interference. The fundamental aim is to train certain mental processes to operate in such a way that finally a very brief passive concentration will accomplish the intended physiological change almost instantly, as the state of heaviness, warmth and relaxation occur.

The purpose of visualization is to discover by means of imagery the dynamics of the mind and to understand the symbolic discourse between body and mind. Where the mind focuses, the emotions and physiology are likely to follow. The research being done by Simonton and Simonton in the treatment of cancer shows dramatic examples of the healing effects of creative imagery of visualization.[48]

The Simonton's technique of combining visualization with radiation and chemotherapy in the treatment of cancer demonstrates that a person's belief system limits an individual's perception of reality and possibility. Through the relaxation process, patients are encouraged to create positive images of an enjoyable scene, to see themselves enjoying the activity in the scene. They then visualize their treatment and how it is working to shrink or remove the cancer.[49]

Research supports claims of lasting psychophysiological changes such as: lower arousal response to stress, less anxiety, better coping ability, more self-acceptance, improved learning ability with better retention and recall, and a calm, more philosophical attitude.[50]

Relaxation exercises relax the body and leave the mind free to identify what is needed in stressful situations, and supplies you with the calming energy to get it. The benefits of relaxation and stress reduction techniques can only be fully realized after they have been practiced regularly over a period of time. Regular practice is necessary to ensure one's ability to carry out instructions spontaneously when needed, and to develop the habit of relaxation at an unconscious level.[51]

You can learn to counteract your habitual reaction to stress. The relaxation response allows the body to recuperate, and keeps you from using up all of your adaptive energy by feeling overwhelmed by the stressors in your life. The relaxation response regulates your physical, mental, and emotional processes to a normal level.

Mind, body, and emotions are interrelated. An anxious person would benefit from progressive relaxation and breathing exercises to

calm the body. Chronic muscular tension occurs in people with particular attitudes which tend to tighten specific muscle groups. For example, a woman who believes that it is bad to express anger is likely to have chronic neck tension pain, or a man experiencing a lot of anxiety about the future, may develop chronic stomach problems.

Progressive relaxation of muscles reduces pulse rate and blood pressure, as well as decreases perspiration and respiration rates, and is incompatible with anxiety. Progressive relaxation provides a method for identifying particular problems with muscle groups.[52]

The stress class is advised that proper breathing habits are essential for good mental and physical health. Proper breathing works because the balance of oxygen and carbon dioxide is modified.

As relaxation is incompatible with tension, the potential advantages of relaxation are numerous. L. Burns has listed a number of the advantages, some of which are briefly summarized below:

1. Stress-related problems such as hypertension, tension headaches, and insomnia, may be eliminated.
2. Anxiety levels may be significantly reduced. There is evidence to show that individuals with high levels of anxiety will demonstrate the greatest positive physiological effect of relaxation training.
3. Preventive aspects of relaxation training are important, both in reducing the likelihood of the onset of stress-related disorders and in the control of anticipatory anxiety.
4. Research demonstrates that certain behaviors are likely to occur more frequently during periods of stress; there may

be an increase in the number of cigarettes smoked, in alcohol consumption, drug intake, compulsive overeating. Relaxation should help to diminish this dependent behavior.

5. Overall improvement in performance of vocational, social and physical skills may occur as a result of reduced levels of tension.
6. Fatigue, due to prolonged mental activity and/or physical exercise, may be overcome more rapidly by using relaxation skills.
7. Self-awareness of one's physiological state may be increased as a result of relaxation training; this enables the individual to use his relaxation skills at the onset of psychophysiological arousal.
8. Relaxation exercises can be an aid to recovery after certain illness and surgery. There is also evidence that it can raise the threshold of tolerance to pain.
9. During high levels of tension, cognitive distortions resulting in the adoption of untenable positions are more likely to arise. The relaxed person in difficult interpersonal situations will think more rationally and have an increased level of self-esteem.[53]

Relaxation is a self-control method. Substantial improvement will occur only if the individual realizes that relaxation is an active coping skill to be practiced and applied to daily life. The individual develops a feeling of having begun to assume responsibility for the management of his own life and his own health.

Although relaxation is an active process, the individual gains control over himself by letting go. Stressful situations generally result in tightening the reins of control. As H. Benson notes, an important component of the relaxation response is a passive "letting it happen" attitude of mind.[54]

Research evidence suggests that greater gains will be made when practiced for at least 30 minutes each day; during the intermediate and advanced stages, it should be practiced to 15/20 minutes. Thereafter, the skill should be maintained by practicing for 15/20 minutes two or three times each week although the number of sessions will depend on the individual and the stressors encountered in everyday life.

During relaxation, there is a lowering of tension level and a slowing down of bodily processes; these physical effects are frequently accompanied by a change in the direction of thought processes. There may be a feeling of calmness and a less critical or demanding attitude.

High levels of tension can lead to rigid control. The over-tense individual may have a pathological overawareness of anxiety-producing internal and external cues. Thus, he may engage in excessive monitoring of his physiological state. With perseverance, this problem can usually be overcome.

The individual learns to discriminate between the feelings of tension and relaxation in his muscles, and should monitor the appropriate feelings. Increased self-awareness enables him to utilize his skills in response to stressful life situations.

The goal of relaxation is to remove excessive stress which may be interfering with the optimal functioning of the individual. Some fluctuations may be due to the current physiological state of the body such as pre-menstrual tension and sleep deprivation.

Although the individual can gain benefit from practicing 20 minutes of relaxation daily, the ultimate goal is for him to use these skills to control tension in any area of his life. Just as an individual learns to become tense, so the process can be reversed and the relaxation skills become habitual. The aim is for internal cues of tension to automatically trigger a relaxation response.[55]

The instructor uses every opportunity to promote cognitive restructuring in accord with achieving the goal of self-facilitated relaxation. Group relaxation techniques appear to be a cost-effective way of teaching a heterogeneous population improved ways of coping with stress and encouraging individual responsibility for healthful behavior.

Relaxation training is not considered a substitute for individual therapy, but is seen as another tool for improving coping skills to improve health, and the individual ability to utilize body-mind interaction to deal more effectively with stress.

Cognitive Approach

Cognitive therapy pertains to mental activities that explain verbal and motor behavior, and includes imagery, perception, reasoning, reflection, and problem solving. The cognitive branch of stress research is based on Piaget's developmental psychology. Piaget described the interaction between a person and his environment as an

assimilation accommodation process whereby people assimilate the environment and accommodate their own structure to learn and survive.[56]

Stress involves many variables, rather than any one specific negative emotion, stimulus, or response. The response to stress comes from an individual interpretation and evaluation. Emotional and physiological responses are viewed as by-products of cognition.

Cognitive psychologists believe mental operation affects the physiological response level. Levels of consciousness, information, imagery, conceptualization and language, and memory are basic components of the cognitive process.[57] The individual continuously scans environmental stimuli to evaluate any threat to his survival.

The essential point of the cognitive approach is that in the critical progression of events which occur after the impact of stress on the person, cognitive functioning occurs which encompasses all neurological levels, autonomic regulation, feeling states, sensory processes, and the structure of memory and mental operation which form a basis for thought evaluation.

Coping strategies foster change and are seen as the link between the impact of the stressor and adaptation, and are seen in the form of 1) problem-solving, and 2) regulation of emotions revolving around the cognitive appraisal and subsequent emotional response.[58]

Initial direction of the coping response is comprised of the interaction between cognitive activity, emotions, and physiological response.

Mental operations are considered the dynamic components of thinking and reasoning and include:

1. Tools of symbolic logic: deduction, inference evaluation,

interpretation, and understanding the unstated assumptions with which people operate on perceived stimuli.

2. Levels of consciousness facilitating both sensory and motor systems and implied by the degree of alertness or changes in performance and brain activity. Generally, the more reflexive mental operations are preserved as consciousness decreases.[59]

Thatcher and John have identified six levels of information input and process that correlate with the extent of cortical activity and progressively higher levels of consciousness or awareness: 1) sensation, or reflex response; 2) perception; 3) reorganization of basic processes; 4) processing of multi-sensory perception as experience; 5) sequential or long time memory; 6) symbolic representation and critical thinkings.[60]

Neisser summarizes the process well when he defines cognition as the way in which sensory inputs are "transformed, reduced, stored, reconciled and used."[61] The cognitive phase of the primary appraisal determines the intensity and quality of emotional response to any transaction. There is growing recognition that affect and cognition are closely linked.[62]

> Current understanding of emotion suggests that 1) emotion occurs as a consequence of the person's evaluation of the environment; 2) emotion is a feeling state with physiologic parameters; 3) emotion is experienced initially in global form and later refined into specific basic emotion; 4) emotion may be classified according to type, duration, and intensity, characters that change over time and events.[63]

Following cognitive evaluation of a stressor, a person determines the degree of threat and resources available to meet the demand. The response is a translation of the emotion into a behavior. Over time and many reappraisals, an emotional response may become increasingly fixed and trait-like within the personality, and may play an

important role in determining the ultimate adaptation.

Pituitary cortical response to a stressor may require that the individual first recognize the threat and cognitively appraise the potential impact.[64] Stress lies in the perception of events, not in the events themselves. Stress is internal; it is the individual's response to life events. As individuals, stress response may reflect dissatisfaction with self, the inability to accept failure, a negative self-image, or a sense of alienation, a hopelessness and powerlessness.

Each individual's response to stressors is specific, depending upon the individual's constitutional makeup, or inner conditioning, previous experience with stress and learned behavior, and one's state of physical and mental health.

To seek relief from the negative aspect of stress it is necessary to gain insight into mistaken beliefs along with the recognition of the accompanying emotional consequences and physical ramifications. Class participants are asked to record in a depression diary each time they feel depressed. They are urged to try to identify a corresponding automatic negative thought they had just prior to feeling depressed. Because these thoughts have actually created their mood, restructuring of their thoughts will actually change their mood.

Cognitive therapy is the first form of psychotherapy in history that has been shown in clinical research studies to be more effective than antidepressant drug therapy in the treatment of serious depression.[65] Burns' conclusion is that depression involves a disturbance in

thinking; the depressed person thinks in negative ways about himself and his environment and projects those thoughts to future events.

Dr. Burns traces the origins of his work to Dr. Aaron Beck, one of the world's foremost authorities on mood disorders. Dr. Beck's thesis simply states: "when you are depressed or anxious, you are thinking in an illogical, negative manner, and you inadvertently act in a self-defeating way."[66]

David Burns, in his popular best seller, Feeling Good: The New Mood Therapy, states three principles of cognitive therapy. The first principle is that all moods are created by our "cognitions" or thoughts. You feel the way you do right now because of the thoughts you are thinking at this moment. Your emotional reaction is generated by your thoughts. Your thought creates an immediate emotional response. The second principle is that when feeling depressed, your thoughts are dominated by a pervasive negativity. You perceive yourself and the world in dark, gloomy terms. You believe things are as bad as you imagine them to be. His third principle states that research has documented that the negative thoughts which cause your emotional turmoil nearly always contain gross distortions.

Cognitive theory believes that it is a neurological fact that before you can experience any event, you must process it with your mind and give it meaning. You must understand what is happening to you before you can feel it. Depression is the result of distorted mental perception which results in an abnormal emotional response.

In his book, Feeling Good, Burns describes his pilot study comparing cognitive therapy with one of the most widely used and

effective antidepressant drugs on the market, Tofranil (imipramine hydrochloride). Over forty severely depressed patients were randomly assigned to two groups. One group received individual cognitive therapy sessions and no drugs, while the other group would be treated with Tofranil and no therapy. This provided the maximum opportunity to see how the treatments compared. Up to that time, no form of psychotherapy had been shown to be as effective for depression as treatment with an antidepressant drug.

Fifteen of nineteen patients treated with cognitive therapy had shown complete recovery after twelve weeks of active treatment. An additional two individuals had improved, but were still experiencing borderline to mild depression. Only one patient had dropped out of treatment, and one had not yet begun to improve at the end of this period. In contrast, only five of the twenty-five patients assigned to antidepressant drug therapy had shown complete recovery by the end of the twelve-week period. Eight of these patients dropped out of therapy as a result of the adverse side effects of the medication, and twelve others showed no improvement or only partial improvement.

Of particular importance was the discovery that the patients treated with cognitive therapy improved more rapidly than those successfully treated with drugs. Within the first week or two, there was a pronounced reduction in suicidal thoughts among the cognitive therapy group. Both groups continued to maintain the gains they had demonstrated by the end of twelve weeks of active treatment. Psychological tests, as well as the patients' own reports, confirmed

that the cognitive therapy group continued to feel better at a statistically significant rate. The relapse rate over the course of the year in the cognitive therapy group was less than half that observed in the group taking antidepressants.

These follow-up studies are important because the latest estimates from NIMH indicate that in the absence of effective treatment, depression becomes a chronic and relapsing disorder in 80 to 100% of patients who are afflicted with a first depression episode.[67]

David Burns lists ten definitions of cognitive distortions:

> All-Or-Nothing Thinking: You see things in black and white categories. If your performance falls short of perfect, you see yourself as a total failure.
>
> Overgeneralization: You see a single negative event as a never-ending pattern of defeat.
>
> Mental Filter: You pick out a single negative detail and dwell on it exclusively.
>
> Disqualifying the Positive: You reject positive experiences by insisting they 'don't count'.
>
> Jumping to Conclusions: You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.
>
> Magnification or Minimization: Exaggerating the importance of things, or inappropriately shrink things.
>
> Emotional Reasoning: You assume that your negative emotions necessarily reflect the way things really are.
>
> Should Statements: You try to motivate yourself with should statements; the consequence is guilt.
>
> Labeling and Mislabeling: This is an extreme form of overgeneralization. Mislabeling involves describing an event with language that is highly colored and emotionally loaded.
>
> Personalization: You see yourself as the cause of some negative external event which in fact you were not primarily responsible for.[68]

Feelings mirror the way we think. With cognitive distortions, feelings and actions will reinforce each other in a self-perpetuating vicious cycle. Writing down the class exercise forces one to develop more objectivity.

When one is depressed, his distorted thinking confuses feelings with facts. His feelings of hopelessness and despair are symptoms of depressive illness, not facts.

Time Management

Time is one of the most important, most discussed and most often misused resources available to human beings. As Lakein suggests, time is life![69] It is a unique resource that cannot be accumulated or saved. It is not how much time we have, but rather how we use that time that helps us decrease our stress levels. Understanding time and its mismanagement will help us learn how to better manage ourselves in relation to time. "Efficiency is doing things right, while effectiveness is doing the right things right."[70] Time cannot be saved; it can only be better utilized.

Mackenzie identified thirty-five time wasters related to management function. Some of the most important include the following:

1. Not having objectives, priorities, or daily plans.
2. Shifting priorities without sound rationale.
3. Leaving tasks unfinished.
4. Not setting time limits.
5. Daydreaming.
6. Attempting too much at once.

7. Experiencing personal disorganization.
8. Duplicating efforts.
9. Confusing lines of responsibility, communication, and authority.
10. Understaffing.
11. Overinvolvement in routine details.
12. Delegating ineffectively.
13. Making numerous mistakes.
14. Being unable to say no.
15. Not listening.[71]

"Separate those things that you have control over from those that you do not."[72] The second point of Weber's process of time management is concentration or systematically controlling those things that can be controlled. This involves planning, organizing, and implementing activities to control use of one's time.

Planning

Planning is the most important step in managing one's time. It includes setting priorities, scheduling, establishing a list of things to do.

The ABC approach, as devised by Lakein, consists of performing the following activites: 1) listing everything that needs to be done; 2) assigning an A to high-value items; 3) assigning a B to medium-value items; 4) assigning a C to low value items; and 5) doing all A items first, all B items second, and all C items third.

A time schedule should be devised for dealing with priorities. A written plan appears to be best for high achievers, perhaps because

high achievers cannot bear to deviate from what challenges them in writing. If a person's needs change, he must recognize the importance of remaining flexible.

Lakein suggests programming to succeed by planning whenever feeling overwhelmed, prioritizing, maintaining a positive attitude, doing something to reward yourself every day, resisting doing easy, but important tasks.[73]

Much of the stress research has been done in the work setting, because time pressured activity is highly stress inducing. When an individual is in a work situation that is incompatible with his personal philosophy, job dissatisfaction results and can be a major source of stress. When a worker's production is valued more for its quantity and production speed than its quality, personal values and the values of the work setting come into conflict.

Preoccupation with time in the work setting can carry over into one's personal life. Individuals may feel guilty when they do not spend leisure hours or free time productively. This robs leisure time of its ability to relax, refresh, and restore the individual.

Creative Problem-Solving

The purpose of the creative problem-solving exercise is to help find new solutions to old problems. The objective is to achieve new representations through the performance of mental operations. The process includes identification of the problem, collecting information, and determining a solution by writing down all the possible solutions, without censoring any ideas, getting as many ideas as possible, letting

one idea lead to another, and allowing yourself to push for more ideas, and to allow for the ridiculous. People's thoughts tend to become limited with stress and age.[74]

Action Approach

Stress that is not dealt with at the time can magnify itself; it is the accumulation of stress that becomes harmful. Setting goals helps to get you out of your dull state and moving. The class emphasizes the importance of setting reasonable and realistic goals that are both necessary, and also goals that give pleasure. When making a choice, weigh what you may gain against what you will give up.

In his book, Stress, Distress, and Growth, Walt Schafer offers five suggestions:

1. Living with the stress is a temporary solution, and not acceptable in the long run.
2. Withdraw from the stress (quit the job, or relationship.)
3. Relate to the stressor in a different way. (Change your perception.)
4. Accept the stressor.
5. Change the stressor, make the person or situation different.[75]

Even if a decision does not work out, taking action breeds the possibility of taking more action, whereas doing nothing increases the possibility that the next time there is a choice, you will again simply drift with the current.

Successful people who make risky decisions and make them stick typically ask themselves, "what's the worst thing that can happen?" All the years you have will go by anyway, and only by making good choices can you truly say you have lived those years.[76]

Goals make you feel in charge of your life, a sense of accomplishment when the job is done and increases self-esteem. Short

term goals provide immediate satisfaction, and long term goals create an outlet for self-expression, and give a permanent sense of direction to life.

Medication

The successful breakthrough in treating mental disorders with drugs came in the early 1950's with the development of anti-depressants and with the discovery of the existence of a variety of chemicals in the brain called neurotransmitters, which regulate pain, learning and memory, and the desire to eat, drink and sleep. Neurotransmitters also affect moods, feeling and behavior.[77]

Approximately 40 neurotransmitters have been identified, but according to Dr. Candace Pert of NIMH, co-discoverer of the endorphin neurotransmitters, "there might be 100 to 200 different kinds of neurojuices that help regulate emotions and other body processes."[78]

Dopamine, serotonin, and norepinephrine, are the three neurotransmitters that have been implicated in depression. Either too much or too little of them, or problems in regulating them as they journey through the brain may account for some types of depressive illnesses. The chemical neurotransmitters are concentrated in the limbic system, a primitive brain region which appears to be involved in mood regulation. One clue as to why such a large number of depressed individuals commit suicide has been traced to lowered activity of the neurotransmitter, serotonin. Significantly, low serotonin activity also has been linked to aggression and impulsiveness. Autopsies performed on the brains of suicide victims showed that those who committed violent suicide (gunshot and knife wounds) had lower

levels of serotonin functioning than those who committed nonviolent suicide (such as an overdose of sleeping pills). Dr. F. Goodwin, chief of NIMH, hypothesizes that such suicides result from an interaction of depression with a biochemical predisposition to aggression and impulsiveness.[79]

The lecture on the value of medication is given to the Stress Class to increase their awareness of the importance of antidepressants. Most class members express a desire to want to take control of their problems themselves, view the taking of drugs as a weakness, and express concern about addiction. These myths need to be dispelled. Drugs help many people to function day-to-day, keep them out of hospitals, and help them to keep their jobs and relationships intact. Antidepressants are not habit forming. Eighty-five percent of those people who are seriously depressed are in need of antidepressant medication. These are the people who are experiencing the vegetative signs of depression and whose scores fell below 30 on the Outlook Scale. Counseling alone will not benefit this group until they have been on medication.

Medication is necessary to restore the chemical imbalance in the brain. The basis for believing that there may be a chemical component in depression resides in the physical symptoms of depression which support the notion that organic change is involved in at least some depression. These changes in body function include, among others, agitation or motionless apathy. There is often a worsening of symptoms in the morning, change in sleep patterns, constipation, abnormalities in appetite, and an impaired concentration ability.

"A second argument for a physiologic cause for depression is that at least some forms of mood disorders run in families, suggesting a role for genetic factors. If there is an inherited abnormality that predisposes some individuals to depression, it is likely to be in the form of a disturbance in body chemistry, as is the case with so many genetic diseases."[80] Antidepressants compensate for the deficiency by raising the levels of chemical messengers, or by increasing the potency of the chemical messengers in the synapse region. Manic states, in which the patient is overwhelmed by an excessive level of activity of these chemical messengers, leads to hyperactive nerve function.

The most widely used class of the antidepressant drugs are the tricyclics, such as Imipramine and Amitriptyline. The tricyclics are prescribed for patients with endogenous symptoms, the vegetative signs of depression. According to Dr. W. Potter, a psycho-pharmacologist at the National Institute of Mental Health (NIMH), 80 percent of those on the correct dosage of tricyclic drugs eventually get better. Side effects include disturbed vision, sweating, dizziness, decreased or increased sexual desire, constipation, edema, and weight gain. Benefits far outweigh the side effects.

The second category of antidepressant medications is known as the M.A.O. Inhibitors (Monoamine Oxidose), such as Parnate, Marplan, and Nardil. These drugs interfere with the metabolic breakdown of amines which lead to an actual elevation of the levels of amine messengers in the emotional regions of the brain. As the brain becomes loaded with extra amounts of chemical transmitters, the presumed

chemical amine deficiency is corrected. The M.A.O. Inhibitors are especially effective in an atypical depression that is characterized by phobias and high levels of anxiety, chronic anger, hypochondriacal complaints, or impulsive self-destructive behavior, or obsessive-compulsive habits. If a patient shows no improvement after trying several different tricyclic drugs, it is a good idea to switch to a completely different type of antidepressant such as the M.A.O. Inhibitors. Because dangerous interactions between M.A.O. Inhibitors and tricyclic compounds can occur, it is imperative that you be drug-free for at least ten days between the use of these two different kinds of drugs.

The M.A.O. Inhibitor can in rare cases produce some serious toxic effects if they are not used properly. The most dangerous is the elevation in blood pressure that may occur if you eat certain foods or take certain drugs that are forbidden. The foods that need to be avoided contain a substance known as "tyramine," which might interfere with the brain's ability to regulate blood pressure properly; they include chocolate, cheese, soy sauce, avocadoes, raisins, yeast, alcohol, and bananas. Stimulants, caffeine and allergy pills should also be avoided.[81]

> Keeping persons on antidepressants long enough for the antidepressive effects to be felt often proves difficult. During the first two to four weeks, the patient feels the side effects of the drug, but has little relief from the depression. It may take as long as 6 weeks for the drug to work.[82]

Lithium is the recommended drug for patients suffering from manic depression or bipolar depression. Scientists suspect that genes play an important role in the incidence of this incapacitating

form of depression. A young people's disease, this depression most often strikes those in their mid-20's. Lithium brings down the euphoric highs of mania, and also works against the depressive phase.

One of the major problems in prescribing Lithium is getting patients to stay on the drug. Dr. Kay Jamison, director of the Affective Disorders Clinic at the University of California at Los Angeles, found in a study on Lithium compliance that 50 percent of the patients stopped taking the drug against medical advice. Their reason for stopping: they missed the euphoric feelings and sense of well-being experienced during mild manic states.

According to the National Institute of Mental Health:

> There is a narrow range between the therapeutic and toxic level. Periodic blood tests are needed to monitor the Lithium level. Because Lithium is excreted from the body almost entirely by the kidneys, any injury or weakening of the kidneys may allow Lithium to accumulate to dangerous levels in the body. Since little sodium also has been implicated in Lithium build-up, the use of diuretics and low-sodium diets can be especially harmful to the patient taking Lithium. Other side effects include nausea, lethargy, thirst, hand tremors, greatly increased urination, and possible weight gain.[83]

This extraordinary disease usually develops into a chronic pattern of uncontrollable highs and lows, so a physician will frequently recommend that you continue to take Lithium for the rest of your life. When taken for a prolonged period of time, its clinical effectiveness seems to increase.

Because of the general population's reluctance to take drugs, certain myths need to be dispelled to the population of the Stress/ Depression Class. Although these drugs eliminate depression, they

do not normally create abnormal mood elevations, and they will not make you feel abnormal or high. Most patients report that they feel much more like themselves after they have begun to respond to an antidepressant medication.

Adverse reactions are rare and can usually be safely and effectively managed when you and your doctor work together as a team. The antidepressants are far safer than the depression itself. The ultimate fear of severely depressed patients who go untreated is suicide.

The side effects are mild and can usually be made barely noticeable by adjusting the dose properly. Unlike sleeping pills, opiates, barbiturates, and minor tranquilizers, the addictive potential of antidepressants is quite low.

> Some doctors are now advocating long-term maintenance therapy to certain patients. A preventive effect can be achieved if you take a low dose of the antidepressants over a period of a year or more after you have recovered. That will minimize the probability of your depression returning. If you have had a significant problem with recurrences of depression over a period of years, this might be a wise step for you. At the lower doses used for maintenance, the side effects are usually negligible.[84]

Antidepressants can provide some needed leverage that can facilitate your efforts to help yourself. These drugs could speed up your personal effort to modify your attitudes and help change behavior patterns. An antidepressant may give you that little edge needed to begin to cope in a more productive manner, thus accelerating the natural healing process. The addition of the proper antidepressant to help your treatment program might make you more amenable to a rational self-help program and greatly speed up therapy.

There is a definite role for effective psychotherapy even in those individuals who benefit from drugs.

The barbiturates, like alcohol, are central-nervous system depressants, and often intensify depression, especially when used over a period of time. Amphetamines do not relieve depression. What they actually do is cause a transient increase in energy usually associated with a decrease in mental efficiency and judgement. As their effects wear off, they are often followed by episodes of severe depression, as the central nervous system attempts to rebound from the abnormal provocation and regain some kind of equilibrium. Antidepressants do not produce euphoria, and their effectiveness takes place slowly. If a person is not depressed, the antidepressant usually has no effect at all on mood or emotion.

> The depressed individual is usually unable to experience and express normal anger. Instead, according to psychoanalytic theory, the anger is turned 'inward against the self.' The anger rumbles around disguised as tension, agitation, intestinal distress, fear, anything but what it really is. As emotions are released, there is not only a lifting of spirits but also a progressive increase in the level of energy.[85]

Prevention requires a change in public attitudes, so that people who are depressed or stressed will know how and where to find professional help when they need it, and will do so without delay and embarrassment. In a more basic way, prevention involves creating educational programs of various types to strengthen our abilities to cope more effectively with life stresses.

To the extent that depression can be considered a health problem its prevention can be divided into three phases: tertiary, secondary, and primary.

Tertiary prevention involves steps that can be taken to prevent the person who has pulled out of a depression from slipping back into it again. One of the fundamental goals of therapy is to modify value systems and methods of coping with stress so as to eliminate patterns of behavior that set one up for depression. Procrastination and denial are good examples. To avoid becoming depressed again, such an individual must learn how to be more alert to issues as they arise and to deal more directly with them.

Primary prevention is concerned with two major goals: first, to increase the public's awareness of the best ways to cope with appropriate episodes of acute depression, and secondly, to teach the individual ways to avoid becoming caught in chronic depression, or in depressogenic environments.

Self-Help Groups

According to A. H. Katz and E. I. Bender, self-help groups are small groups structured for mutal aid in the accomplishment of a specific purpose. They are usually formed by people who have come together for mutual assistance in satisfying a common need, overcoming a common life-disrupting problem, or bringing about a desired personal change. The initiators and members of such groups perceive that their needs are not or cannot be met through existing social institutions.[86] To this description, A. Gartner and F. Riessman add features that they feel are critical to self-help groups. These include face-to-face interactions, spontaneous origins, personal participation, agreed upon and engaged actions, and initial conditions of powerlessness. They also see such a group as a reference point,

base for activity, and source of ego reinforcement.[87] D. Biegel defines self-help groups as voluntary associations of individuals with a common problem, stigma, or life situation.[88]

Self-help groups provide the format in which members can feel safe in ventilating their emotions, and where they can learn about themselves and others, and where they can be assured of a supportive atmosphere.

A. H. Katz and E. I. Bender note two explanatory factors in the recent increase in self-help groups, consumerism and professional acknowledgement. They feel the present generation of people in need are more likely to be educated and to feel that they have the power to develop alternative systems. Katz and Bender note that in both theory and practice, social services believe that it is necessary to involve clients in decisions about their treatment.[89]

Self-help groups frequently are organized around a chronic condition that affects members' lives. These groups promote a pattern of conduct and provide some control over members' behavior.

Some groups are generated by the effect of social change on normal life transitions. In such areas of child rearing, divorce, and death, societal standards and customs are becoming more varied. Individuals going through these transitions may not have familial and community resources to offer support and advice. Self-help groups form in response to these needs; the groups not only help members but also heighten societal awareness.[90]

Leon Levy lists nine helping activities that are offered by self-help groups: empathy, mutual affirmation, explanation, sharing, morale building, self-disclosure, positive reinforcement, personal

goal setting, and catharsis.[91] Leonard Borman notes five curative factors that are found in self-help groups: 1) universality, or recognition by group members that they are not alone in their problems; 2) acceptance of the problem rather than disapproval; 3) hope that the problem can be dealt with; 4) altruism or self-esteem through the experience of giving help; and 5) cognitive restructuring, which may involve a detailed belief system or simply new knowledge about the cause and effect of problems.[92]

In her discussion of the relation between community mental health services and mutual assistance groups, Laurieann Chutis notes that agencies and groups share broadly based goals and target populations.[93] Both types of organizations generally strive to increase the ability of individuals to cope and to both offer services to prevent problems or reduce their severity. Each tries to reach underserved populations. The services of groups and agencies are supportive and educational in nature.

The cooperation of agencies and groups increases the amount and variety of help that can be offered to clients. With this broader scope, individual service plans can be made more completely. More people can be reached.

According to Biegel and Naparstek,

> Government has expressed a growing interest in self-help groups as a way to maximize social service delivery. The government sees self-help groups as a way to reach underserved people, as demonstrated by the 1978 report of the President's Commission on Mental Health. Self-help groups often attract those individuals and groups unlikely to reach out for traditional therapeutic help from agencies.[94]

L. Chutis outlines three principles for mental health professionals working with such groups: 1) power and authority lie within the group, not the profession; 2) emphasis should be placed on the group's behavior, skills, and problem solving rather than weaknesses; and 3) in work with the groups, the diagnostic ability of the professional is not as important as his skills in community organization, group work, and communication.[95]

Members' commitment was of key importance. Self-help generally was seen as preventive, especially in stress alleviation, and maintenance functions.

Self-help is regarded as an adjunct to therapy. Self-help might be the first step in an individual's progress to needed therapy. Some saw self-help as important for people who had completed therapy; however, they felt that therapy on any level was beyond the capabilities of self-help groups, even those with professional advisors from agencies.

The Stress/Depression class serves only a partial function in the resolution of problems. It does not claim to resolve deep-seated issues which therapy might probe. The researcher wishes to emphasize that the Stress/Depression class is not a therapy group.

The recent increase in the number of medical self-help groups has been linked to the increase in stressful situations that have no all-purpose cure, but permit patients to maintain a modified life-style.[96] Medical treatment in the United States has been oriented toward acute illnesses, which have declined with the development of cures and vaccinations for most infectious diseases. In this time of rising health costs, alternative community support networks are being encouraged.

Epidemiological studies have established that the majority of people who report experiencing troublesome life events do seek help for their problems.[97] The key factors that differentiate those who do and do not seek help are age and race. Help seeking has been shown to decline consistently with age.[98]

> People who solicit help are usually looking for comfort, reassurance and advice. They tend initially to turn to family, and friends and contact relief agencies or professional service organizations only as a last resort. The sole use of professional services occurs much less frequently than either exclusive reliance on family and friends or help seeking from both the social network and professional sources.[99]

> It has been hypothesized that members of the social networks can affect help seeking in a number of ways: 1) by buffering the experience of stress, which obviates the need for help; 2) by precluding the necessity for professional assistance through the provision of instrumental and affective support; 3) by acting as screening and referral agents to professional services; and 4) by transmitting attitudes, values, and norms about help seeking.[100]

The social network appears to serve as a natural support system that counteracts the effects of stressful life events. The proportion of network members providing emotional support and the frequency of contact with network members were found to be inversely related to psychological distress among college students and residents of low-income housing.[101] Among women who experienced multiple life changes prior to and during their first pregnancy, only those with minimal social resources developed serious medical complications.[102]

In an epidemiological study of psychological well-being, G. Gurin, J. Veroff, and S. Feld found that the elderly composed the one subgroup of the general population most likely to adhere to the norms of self-reliance. In addition, they were a group that tended not to seek assistance for their problems.[103]

P. Antze sees highly specific cognitive restructuring unique to self-help groups as the prime mechanism of change.[104] Fundamental to this view is that each self-help group develops a belief system, and that change can best be understood in self-help groups through examining the value transformation, or the alteration of belief systems which take place through cognitive restructuring.

Self-help groups have the capacity to generate a sense of belongingness among the participants, a shared sense of similar sufferers that creates a feeling of cohesiveness. Cohesiveness has been well studied and is operationally defined as the attractiveness of the group to its participants. It provides the motivation for participants to remain in and work with the group.[105]

In some ways, the self-help group takes on characteristics of the family, and serves as a new reference group for the participants, as they gain support, acceptance. Another important aspect of groups is their capacity to induce powerful affective states in the participants. Members may act on feelings without displaying their typical controls.

The group provides the context for social comparative process, because the members are placed in a social situation that expects them to talk about personal matters and needs that brought them to the group. By comparing their attitudes and feelings, individuals compare and revise new possibilities for feelings, perceiving, and behaving.[106]

I. D. Yalom lists the following as change mechanisms: altruism, or the helping of others; group cohesiveness; universality; interpersonal learning (learning about the way one relates to others);

guidance; catharsis; identification (with a group member, or facilitator); family reenactment (relating learned behavior to family of origin); self-understanding; instillation of hope; existential factors, such as recognition that life's problems must be ultimately faced alone.[107]

Focusing on their impact upon their members L. H. Levy formulated the behaviorally oriented process operating in self-help groups to be the following: 1) both direct and vicarious social reinforcement for the development of desirable behaviors and the elimination or control of problematic behaviors; 2) training, indoctrination, and support in the use of various kinds of self-control behaviors; 3) modeling of methods of coping with stresses and changing behavior. This process can be seen to be operating in the self-disclosure and advice giving and sharing of coping techniques that are common to most self-help groups; 4) Providing members with an agenda of actions they can engage in to change their social environment.[108]

Cognitively oriented processes are concerned with the meaning of experiences, as well as with finding relief. They include the following seven processes:

> 1) Removing members' mystification over their experiences and increasing their expectancy for change and help by providing them with a rationale for their problems or distress and for the group's way of dealing with it; 2) provision of normative and instrumental information and advice; 3) expansion of the range of alternative perceptions of members' problems and circumstances and of the actions they might take to cope with their problems; 4) enhancement of members' discriminate abilities regarding the stimulus and event contingencies in their lives; 5) support for changes in attitudes toward oneself, one's own behavior, and society; 6) social comparison and consenual validation leading to a reduction or elimination of members' uncertainty and sense of isolation or uniqueness regarding their problems and experiences; 7) the emergence of an alternative or substitute culture and social structure within which members can

> develop new definitions of their personal identities and new norms upon which they can base their self-esteem.[109]

The group provides its members with an opportunity to build a new identity and increase their self-esteem, and provides a new base from which group members can face the world and their predicaments.

Cultural Barriers to Group Representation

Both Asian and Chicano populations show the lowest representation of any minority population in utilizing mental health facilities.[110] Perhaps the most important factor in client improvement is the selection of a therapist one can relate and feel comfortable with. Therapists must be constantly aware both of their own bias' and the cultural values of their target population. Ethnic minority group members receive less health care than the rest of the population; this is especially true of poor minorities.[111]

Although admissions to mental hospitals is higher for the lower socioeconomic groups, this same population shows an underrepresentation in outpatient treatment facilities. Demographic findings reveal minorities receive less mental health services than the majority. This has been confirmed by the studies of L. C. Kolb, V. W. Bernard, and B. P. Dohrenwend. This population's dropout rate after the initial visit is extremely high.[112] Of the 109 participants in the stress/depression class population, only 16 people belong to a race other than Caucasian. The researcher believes there was no difference in their participation.

The poor economic status of the poverty community is assumed to be in a state of disorganization and that this disorganization manifests

itself in various forms of deficit. The differences in ethnicity and class have produced a "deficit hypothesis."[113] The dominant culture gives the impression that those unlike themselves are somehow inferior, deprived, or disadvantaged.[114]

Cultural barriers are often found in both the counselor's and the client's reciprocal racial attitudes, counselor's lack of knowledge of the client's background, language barriers of the poverty population, and the client's lack of familiarity with counseling procedures.[115] Kaiser Psychiatry appears to be lacking in sensitivity to the needs of minorities. Little or no attention is paid to different ethnic cultures. Of the therapists on staff, none are bilingual.

Different cultural groups of patients may have certain response sets in answering personality questionnaires, and may exhibit behaviors appropriate to their subcultures, but considered signs of psychopathology in another culture.[116]

Lower socioeconomic classes tend to view their problems in terms of somatic complaints rather than in relation to feelings, dreams, or past life experiences.[117]

The research findings of H. L. Kitano presents the view that Asian Americans have little psychopathological disturbance.[118] It is believed that Asian Americans are well adjusted, and this is reinforced by low official rates of psychiatric hospitals. The low utilization of mental health facilities may be due to low rate of psychopathology and/or to the cultural value inherent in the Asian culture which inhibit psychiatric self-referral.[119]

F. L. Hsu and H. L. Kitano indicate that Asians conform to the values of family, extended family, and community.[120] This is the

direct opposite of the Western society which encourage the traits of individualism and independence. There is much evidence which suggests that Chinese and Japanese cultures reinforce passive and conforming behaviors particularly in the presence of authority figures.[121]

The Japanese American population may be more vulnerable to stress. Those with a weak ethnic identity who have failed to integrate into either the Japanese or the larger social system will be the population which constitutes the high-risk group in terms of mental illness, suicide, crime, and delinquency.[122]

> Mexican Americans receive relatively less mental health care than the general population; they actually need more. Investigators such as M. Karno and R. Edgerton, and E. Torrey point out that the California Mexican-American population is subject to a number of 'high stress indicators' which are correlated with mental breakdown (or some form of self-destructive behavior, such as alcoholism, drug addiction, or suicide) and subsequent need for treatment. The indicators include a) poor communication skills in English; b) the poverty cycle--limited education, lower income, depressed social status, deteriorated housing, and minimal political influence; c) the survival of traits from a rural agrarian culture which are relatively ineffectual in an urban technological society; d) the necessity of seasonal migration (for some); and e) the very stressful problem of acculturation to a society which appears prejudicial, hostile and rejecting.[123]

The findings of J. Iwaki indicate the mental health centers should:

1) request cultural preference for a therapist at the intake interview and honor the client's preference.
2) make available a staff with sex and ethnic characteristics which match the client population.
3) be aware of the population they serve, particularly if they are of minority status.
4) be knowledgeable of the current literature and research with relation to cultural aspects, which will aid in effective minority counseling.
5) be sensitive to the needs of the client, his environment, and his community.[124]

It is the researcher's intent to bring this information on Iwaki's recommendation to the attention of Kaiser psychiatry, along with the low figures of cultural representation in the Stress/ Depression class with the hope that the needs of clients of diversified cultural backgrounds will be better served.

If the concept of self-care health education programs and participation by patients in the care extended to them by medical providers is accepted and integrated into total health care, greater efficiency and savings could result, not to mention greater satisfaction among health plan members and an increased appropriateness in response to their needs when they suffer from the related symptoms of stress or depression.

The concept of prevention depends on compliance. The preliminary exposure to a psychoeducational class may assist a patient to be more receptive to individual counseling. The researcher believes this is an area that might be substantiated by continuing research.

CHAPTER 3

Methodology

Method

The type of research design that was implemented was experimental. This experimental design was a comparative study, with no true control group, or nontreatment group. The group acted as its own control, and may be classified as an approximation to a field experiment. Therefore, the results of this study only show whether there is improvement for those people taking the class.

The class which the research evaluated was entitled, Stress, Depression, and Anxiety, which is offered through Kaiser Hospital's Effective Living Classes. The purpose of the class is to recognize one's symptoms, their causes, and to gain knowledge of what can be done to alleviate these conditions. The class members play an active role in helping themselves, which is beneficial to gaining some control over problems.

Independent Variable

The factor which was manipulated was the content or techniques for the Stress/Depression class.

Dependent Variable

The change in the state of well-being of the participants of the class was measured by the Heimler Scale of Social Functioning (HSSF), Symptom, and Habit Checklists.

Intervening Variables

There is a confounding factor present which may lead one to think that a manipulation has an effect, when it does not. The effect may be attributed to something else. In this case, because the participants in the class get better, as evidenced by an improvement in their score, it is because of the class, or are there other reasons?

How to control for this confounding factor? The researcher has given some thought to this question, and prepared the following questions which were asked at the conclusion of each six week class.

1. Has your condition improved during the class? YES NO
2. Is this improvement due to:
   a) problem resolved itself without the benefit of the class.
   b) I was in counseling and this was the main source of help.
   c) I received another form of help outside the class.
   d) The class was the main source of help.

The majority of participants checked areas b) and d). (Many indicating both areas to be helpful)

Sample

The sample consists of participants in each of seven stress classes. The total number of participants was 109, all of whom volunteered to take part in this study. All class members had an equal opportunity to participate and were recruited by invitational letter at the first session of each class (See Appendix C). The researcher compared scores at the beginning and end of each class to compare participants' level of functioning after the treatment (the class).

Holmes Scale

The Social Readjustment Rating Scale (SRRS) was developed in 1967 by Holmes and his colleagues. The SRRS is a self-rating questionnaire made up of forty-three life changes to which a person may have been exposed. It is designated to estimate the amount of stress in a person's life over a given period of time (See Appendix E).

Each life change event is given a number designating its severity in terms of Live Change Units (LCUs). For example, death of a spouse is assigned 100, divorce 73, and personal illness or injury, 53 LCUs. By simply adding up the number of LCUs, the severity of stress a person has experienced over a given period can be assessed.

Indices for the Holmes Scale are as follows:

At 150 points	25% chance of serious health change within two years.
Between 150-300	50% chance of serious health change within two years.
Above 300	80% chance of serious health change within two years.[125]

As might be expected, aversive events carry the highest number of LCUs, but many of the less heavily weighted items are positive in nature. For example, outstanding personal achievement is assigned twenty-eight; a vacation, 13, and even Christmas rates 12. It is not the type of life change that is of key importance; it is the adjustive demand that life change places on the individual. As these adjustive demands increase in number and severity, there is a corresponding increase in life stress.

The Holmes Scale is included simply as a way of measuring the demands that are presently being made on the individual's coping resources, and to bring attention to the importance of reducing change when one is under excessive stress. Generally speaking, LCUs are external events that would not register any internal change within the individual in a 6 week class period. Therefore, the researcher's intent is strictly to bring this information on the relationship between change and stress to the awareness of the class, and will not be used as a measurement in evaluating the class. The average score across the 7 sessions was 191.5, which indicates this was a population which, on the average, has a 50% chance of having a major illness within the next two years. This score was used as an indication that this was a population of stressed people.

Data Definition

The principal instrument for data collection was the Heimler Scale of Social Functioning (HSSF) which is a self-appraisal inventory designed to provide a measurement of an individual's level of psychosocial functioning. The HSSF relies upon the subject to make his own evaluation of the success (or lack of success) which he is experiencing in various important life activity areas. It measures psychosocial functioning as an ongoing process of the individual's external and internal perceptions rather than providing a cataloging on the subject according to certain diagnostic and/or defensive categories (See Appendix D). The researcher chose to include a letter granting permission to use the HSSF tests, rather than the test itself.

The scale can be self-administered in five to eight minutes and scored in five minutes. The HSSF was developed in England by Eugene Heimler, a psychiatric social worker. From his observations of people, both as a professional mental health worker and earlier as an internee in the Nazi extermination camps, Heimler developed the concept that an individual's ability to function is directly related to the degree and the balance of satisfactions and frustrations he is experiencing in life.[126]

The first subtest of the HSSF is the measurement of Satisfaction subjectively experienced in five life areas: work, finances, friends, family, and personal. Fifteen or more Yes answers is desirable; a score below 15 indicates a problem area.

The second subtest of the HSSF is the measurement of Frustration in the following five areas: activity, somatization, persecution, depression, and escape routes. Seven or less Yes answers is desirable; a lower number of Frustrations indicates a better score. A high number in the Frustration area is an indication of psychological problems.

The third subtest of the HSSF is the Perhaps category. Eight Yes answers in this area would be acceptable; a higher number would be an indication of anxiety. Anxiety is a condition which underlies depression and stress.

The fourth subtest of the HSSF is the Outlook Scale. The average person could expect to score 80 on the Outlook Scale. A score below 60 indicates a need for counseling; a score in the 40's would be an indication the person may need medication. The Outlook Scale gives

continuity to the past and present, and the questions are a representation of how much meaning is present in an individual's life.[127] The class emphasizes putting one's energy into an area that is amenable to change; to pick an area that feels possible to change and move forward.

Symptom Check

Participants were asked to check which symptoms applied to their present condition. The researcher sees the symptoms as the body's physiological response to stress (See Appendix F). The body attempts to resist stress by utilizing its usual coping mechanisms to adapt. A state of exhaustion follows long-term exposure to the same stressor; the body's adaptation energy has been exhausted. The body is no longer able to return to a state of homeostasis, as the response to stress becomes habituated. The severity of the stressor is of less significance than the accumulation of stress. Eventually, the chronically stressed body begins to wear out from this accumulated stress, resulting in disease (See Appendix F).

Habit Check

Daily habits and lifestyle are important in the management and reduction of stress and depression. The researcher believes we become secure and comfortable with our habits, as they require little effort. Because stress is related to one's daily habits of living, the class emphasizes the importance of accepting responsibility for one's own general health habits. A Habit Check List requires self-appraisal and a recognition of one's own manifestation of stress (See Appendix A).

Possible Limitations

The researcher feels the refusal to participate in the study may indicate a significant difference in the well being of the participants. Those participating in the sample may be at an overall higher level of functioning, and may be in a better psychological state to have participated. This might possibly have affected the study by not reflecting the general condition of the entire class as a whole. They may also have given the answers they think the investigator wanted to hear (biased toward wanting to please the investigator). The following steps were taken to avoid this from happening: 1) the researcher repeatedly emphasized that all data were confidential; 2) the participants were told that their comments and opinions were very important to the study and that they should be truthful in their answers; and 3) the researcher emphasized that all answers are important to the study, including a "no" answer.

Data Collection and Recording

The class participants' level of functioning (through the use of rating scales) and their symptomatic improvement were recorded at the beginning and ending session of each six week class.

The following methods were utilized:

1. A self-rating of daily social functioning as measured by compiling the subtests of the HSSF at the first and last class of each six week session.
2. A few short questions were administered at the conclusion of each of the seven sessions (refer to confounding factor under intervening variable). This determined if the participants

skills and knowledge were increased as a direct result of pertinent class information.

3. A pre and post test of individual symptoms was recorded at the beginning and ending class of each session.
4. The Habit Check List was administered to emphasize the importance of daily living, and is related to longevity. The average person in the class added one good habit to his lifestyle (See Appendix A).

CHAPTER 4

Results

The data were analyzed to determine if the techniques and interventions which occurred during the course of a six week class produced any significant change. The statistical test conducted was the paired t-test. Paired t-tests were computed for all subtests of the Heimler Scale (HSSF), Habits, and Symptoms Scales. Rather than use the total HSSF score, it is more specific to deal with subtests of the Heimler because they give more concrete information about sub-elements of stress.

The class results showed significant differences between pre- and post-tests in all categories, except Perhaps. The class appeared to have minimal impact on Perhaps and Outlook within the sessions. Table 1 shows the results.

Table 1

Pre-Test

	SAT	FRS	Perhaps	Outlook	Habits	Sx
Total	1384	954	1280	6357.5	436	1151
Mean	12.70	8.83	11.85	59.41	4.07	10.76
Std Dev	4.57	4.65	5.51	22.11	1.56	5.81
Var	20.91	21.62	30.35	492.37	2.44	33.66
N	109	108	108	107	107	109

Post-Test

	SAT	FRS	Perhaps	Outlook	Habits	Sx
Total	1698	575	1170	7577	504	703
Mean	15.58	5.32	10.83	70.81	4.71	6.57
Std Dev	4.81	4.55	6.01	20.72	1.50	5.35
Var	23.1	20.7	36.1	429.37	2.26	28.6
N	109	108	108	107	107	107

Paired t-test--Tests Main Difference Between the Scores Using The Individual Differences Mean and The Standard Deviation

	SAT	FRS	Perhaps	Outlook	Habits	Symptom
Deg of Freedom	108	107	107	106	106	107
Critical Value	1.99	1.99	1.99	1.99	1.99	1.99
Calculated t	-7.00	8.58	1.93	-7.5	-5.50	8.6
@ 95% Conf	Sig	Sig	Not Sig	Sig	Sig	Sig

Each subtest present $\bar{x}$ pretest and $\bar{x}$ post test.

CHAPTER 5

Conclusions

The findings of this study, which measured and evaluated one of Kaiser Hospital's Effective Living Classes, Stress, Depression, and Anxiety, revealed significant differences.

Six tests were analyzed, Satisfaction, Frustration, Perhaps, and Outlook on the HSSF Scale, Habits, and Symptoms Scale. Five of these six tests demonstrated significant differences using the paired t-test. The only area not found to be significant was the Perhaps category. The researcher did not expect change to occur in this area, because, although the Perhaps could change to Satisfaction, it would be offset by Frustrations moving into the Positive area. For this reason, the researcher considers the Perhaps category not to be of any great importance.

Conclusions and Recommendations

1. Clients who seek psychiatric assistance are often experiencing problems in daily living and these problems might be treated just as effectively through their participation in a psychoeducational class.
2. For some clients, participation in a psychoeducational program alone may not be sufficient to produce improvement.
3. Some clients need either counseling or a program of self-help classes, whereas, others need a combined approach.

4. Education programs used as adjunctive aids to counseling can represent an added dimension to counseling techniques and be cost-effective in an HMO program.
5. A class is one way to serve large groups efficiently, as well as reduce the need for expensive one to one contact.
6. The class content needs to cover both physical and psychological symptoms, because many patients exhibit a constellation of stress-related symptoms.
7. For some members, there will be an improvement in both psychosocial functioning and a corresponding reduction in physical stress-related symptoms.
8. By exploring their own habits and individual lifestyles, people can assume more responsibility for their own health and well-being.
9. The conditions of both stress and depression can be helped by applying many of the same techniques, and the class can be a suitable model for health care.
10. In addition to classes, counseling services need to be available, as some clients will require both a class and individual help. Improvement should be greater when this is provided.
11. Instructors from the medical setting itself function better than outside speakers because of their knowledge of the system and its goals. In addition, they may answer questions that clients have about counseling or scheduling, and may remove some of the "fear of the unknown."
12. A number of clients will go to psychiatry after completing a class; a number of patients in psychiatry may be referred

to classes.

13. Some clients could benefit from either classes or counseling, but resist a doctor's referral to psychiatry because of the stigma they believe it carries, and because they do not accept the idea that there may be a psychological base for their symptoms.
14. Sharing and group support in an educational setting has good potential for helping clients who are either stressed or depressed.

Recommendations for the Use of Findings

If the concept of self-care and participation by clients in the care given them by medical providers is accepted and integrated into total health care, greater efficiency and savings could result, not to mention greater satisfaction among health plan members and an increased appropriateness in response to the clients' needs. The researcher thinks this information would be of interest to Kaiser Hospital, and may generate interest in more self-help classes. As the funding agency and sponsor of the class, West Valley College (Community Development) would be interested in the researcher's conclusions as a basis for other related classes to be offered in the future.

Although minorities receive less mental health services than the majority population, admissions to mental hospitals is higher for lower socioeconomic and minority groups. This identified at risk population could be better served in outpatient treatment facilities, as a preventive measure to hospitalization.

Those active in policy making and administration need to analyze the concept of prevention and help the staff develop a common conceptual framework for planning and program development. The concept of prevention is cost-effective, as well as reducing needless suffering of vulnerable populations.

APPENDIX A

Habit Check List

	(Circle One)	
1. I eat three meals a day (No snacks).	YES	NO
2. I eat breakfast every day.	YES	NO
3. I exercise moderately (at least 2-3 times/ week).	YES	NO
4. I sleep 7-8 hours/night.	YES	NO
5. I do not smoke.	YES	NO
6. My weight is correct for my height/age.	YES	NO
7. I do not drink alcohol. (or do so with moderation)	YES	NO

TOTALS

Scoring:

At age 45, 2 or less YES: Live to age 66

6 or more YES: Live to age 77

APPENDIX B

Release Form

I have been provided with a letter of intent which describes the research study being conducted in the class, "Stress, Depression, and Anxiety," which is part of the Effective Living Classes sponsored jointly by Kaiser Hospital and West Valley College. I understand the procedures to be followed, and that all information provided to Connie Putz will be treated in strict confidence and that in any discussion of this study, no information or quotes which can identify me will be used without my express consent. I understand I may terminate my participation in this study at any time.

_____ _____

Signature Date

Thank you for your time.

APPENDIX C

Letter of Intent

Dear "COPING WITH STRESS/DEPRESSION" member,

I would like to extend to you an invitation to be a participant in a research project which I am conducting for my thesis paper as a graduate student of Social Work at San Jose State University. I plan to measure and evaluate the class, "COPING WITH STRESS/DEPRESSION", which is a part of the Effective Living Classes which are jointly sponsored by Kaiser Hospital and West Valley College.

Participants' satisfaction with the course, their own function (through the use of rating scales) and their symptomatic improvement will be evaluated over a 6 week period. As a prospective participant, your responses will be recorded at the beginning and end of each 6 week class. A three month followup study will be conducted.

For the purposes of anonymonity and confidentiality, each participant will be assigned a number which will identify his/her responses. The goal of the More Effective Living Series is to help people maximize personal health and well-being. It is estimated that as many as seven out of the ten leading causes of death in the U.S. could be reduced through changes in lifestyle. The purpose of my study will be to document these significant changes. The class is designed to help one understand his symptoms, their causes, their interrelationships and what can be done. Approaches include: exercise, dietary changes, cognitive and affective theory, relationship techniques, medication, sleep problems, and relaxation exercises. There are brief lectures, discussion, questionaires, and homework assignments. Participation in the study is voluntary, and if you decline to participate, it will in no way reflect in the workshop.

The expected outcome should reflect a heightened sensitivity to participants needs resulting in a more beneficial and appropriate program for all.

Thank you very much for your cooperation and contribution to this important project. Please feel free to call me, as I will be happy to answer any questions or give you additional information.

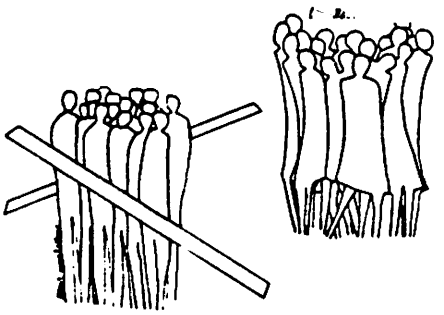
Sincerely,

Connie Putz

Connie Putz
Student Teacher
227-9080

APPENDIX D

Letter of Permission



The Heimler Foundation

25th July 1984

Ms C. Putz
388 Avenida Del Roble
San Jose
California 95123
U.S.A.

Dear Ms Putz,

Thank you for your letter of 27th June.

There are three conditions on which you may use the Heimler Scale of Social Functioning.

1. You may put details of your research project to Betty Ross at:-

   1358 Tourney Drive
   San Jose
   California 95131
   (408) 272 2143

2. On completion of your research you send a copy of the work to the Heimler Foundation in London.

3. We may take extracts of your research and include them in our research library so that they may be shared with other students.

Yours sincerely,

BRIGITTE SCHULZE
Senior Lecturer in the Heimler Method

APPENDIX E

THE SOCIAL READJUSTMENT RATING SCALE (THOMAS HOLMES)

If any of these events have happened to you in the past 12 months, circle the figure in the Mean Value Column:

	Life Event	Mean Value	
1.	Death of spouse	100	
2.	Divorce	73	
3.	Marital separation	65	
4.	Jail Term	63	
5.	Death of close family member	63	
6.	Major personal injury or illness	53	
7.	Marriage	50	
8.	Fired at work	47	
9.	Marital reconciliation	45	
10.	Retirement	45	
11.	Change in health of family member	44	
12.	Pregnancy	40	
13.	Sex difficulties	39	
14.	Gain of new family member	39	
15.	Business readjustments	39	
16.	Change in financial state	38	
17.	Death of close friend	37	
18.	Change to different line of work	36	
19.	Change in number of arguments with spouse	35	
20.	Mortgage over $10,000	31	
21.	Foreclosure of mortgage or loan	30	
22.	Change in responsibilities at work	29	
23.	Son or daughter leaving home	29	
24.	Trouble with in-laws	29	
25.	Outstanding personal achievement	28	
26.	Wife begin or stop work	26	
27.	Begin or end school	26	
28.	Change in living conditions	25	
29.	Revision of personal habits	24	
30.	Trouble with boss	23	
31.	Change in work hours or conditions	20	
32.	Change in residence	20	
33.	Change in schools	20	
34.	Change in recreation	19	
35.	Change in church activities	19	
36.	Change in social activities	18	
37.	Mortgage or loan less than $10,000	17	
38.	Change in sleeping habits	16	
39.	Change in number of family get-togethers	15	
40.	Change in eating habits	13	
41.	Vacation	13	
42.	Christmas	12	
43.	Minor violations of the law	11	
		TOTAL	

Enter all the values circled in the column on the right and add the total.

APPENDIX F

Symptom Checklist

HOW TO COPE WITH STRESS, ANXIETY AND DEPRESSION

RESEARCH QUESTIONNAIRE

The purpose of this form is to measure the success of the class. Participants are asked to complete the form in the first session and again in the last session, and to hand the forms to the instructor. Participation is voluntary: If you do not wish to participate, do not hand in the form at the end of the session. All information is confidential. The form does not become part of your medical chart.

TODAY'S DATE _____

NAME _____

TELEPHONE # _____

ADDRESS _____

_____

Check items below that apply to your present condition:

_____ Always tired
_____ Headaches
_____ Stomach/bowel trouble
_____ Weight change
_____ Dizziness
_____ Chronic pain
_____ Sleep problems
_____ Rapid heart beat
_____ Excessive sweating
_____ Difficulty breathing
_____ Numbness/tingling
_____ Eating problem
_____ Memory loss
_____ Tense/irritable
_____ Unusual thoughts
_____ Thoughts of suicide
_____ Fear of losing control
_____ Thoughts of hurting others
_____ Feeling worthless
_____ Nightmares

_____ Always worried
_____ Ready to explode
_____ Trouble concentrating
_____ Strange experiences
_____ Depression
_____ Fear things I shouldn't
_____ Conflict within family
_____ Can't make friends
_____ Can't keep friends
_____ Feel apart from people
_____ Sexual problems
_____ Marital problems
_____ Relationship problems with live-in partner
_____ Work problems
_____ Unable to work well
_____ Drink excessively
_____ Excessive use of drug
_____ Panic attacks
_____ Not able to exercise

APPENDIX G

Class Agenda

HOW TO COPE WITH STRESS
AGENDA

SESSION I:

Enrollment procedures
Participants complete questionnaire
Lecture - Interpretation of Questionnaire
Break
Lecture - Principal Causes of Stress/Depression
Question period
Homework Assignment - Week Long Assessment of Sleep, Diet, Exercise, etc.

SESSION II:

Review of homework
Relaxation tape (bring tape recorders)
Break
Discussion - Relaxation exercises
Homework Assignment - The Cognitive Approach to Stress/Depression/Mood
Diary; Relaxation exercises

SESSION III:

Review homework
Lecture - Sleep
Relaxation tape
Break
Lecture - The Time Management Approach to Stress/Depression
Homework Assignment - Time Management

SESSION IV:

Review homework
Lecture - Creative Problem Solving
Relaxation exercise
Break
Lecture - The Action Approach to Stress/Depression
Homework Assignment - Creative Problem Solving Action Approach

SESSION V:

Review homework
Lecture - Medication
Relaxation exercise
Break
Lecture - The Affective Approach to Stress/Depression
Homework Assignment - The Affective Approach

SESSION VI:

Participants complete questionnaire
Review homework
Review - Interpretation of Questionnaire
Break
Lecture - Reading List
Question and Answer Session
Participants complete Evaluation Form ("More Effective Living")

APPENDIX H

PRINCIPAL CAUSES OF STRESS/ANXIETY/DEPRESSION WITH EXAMPLES

PSYCHOLOGICAL (FEELINGS/THOUGHTS ABOUT YOURSELF) - Telling yourself you are a failure, or listening to others who tell you you are a failure.

SOCIOLOGICAL (ENVIRONMENTAL/SOCIAL SITUATIONS) - Experiencing an event, such as loss of a job, or death of someone close to you. Experiencing too many stressful events.

HEREDITARY - Having a mother who suffered from stress/depression and a grandmother before her who suffered the same.

PHYSICAL (PERSONAL HEALTH) - Not exercising enough or not eating properly. Having a physical problem, the side effect of which is stress/depression. NOTE: The side effects of some medications can be depression.

CLIMATOLOGICAL/METEOROLOGICAL (INFLUENCE OF CLIMATE OR WEATHER ON MOOD) - Being under stress/depressed because it is January and it is a cold, long, wet month.

CHEMICAL IMBALANCE - Your body lacks certain chemicals which affect your mood.

TREATMENTS/TECHNIQUES

EXERCISE - Exercising vigorously/briskly for at least thirty (30) minutes three times per week. (i.e. briskly walking, jogging, playing tennis, swimming -- NOTE: Activity at work does not count.)

PROPER NUTRITION - Eating regular meals. Eating balanced meals. Eating breakfast, if possible. Avoiding foods you may be allergic to. Avoiding excessive caffeine, sugar and alcohol.

KEEPING A REGULAR DAILY ROUTINE -.Getting up at the same time. Going to bed at the same time.

TALKING/EXPRESSING FEELINGS VERBALLY - Having someone you can really talk to about your feelings.

BEING AWARE OF THOUGHTS - Noticing how you tend to put yourself down and changing the habit.

TAKING ACTION IN REGARDS TO SPECIFIC PROBLEM AREA (CAUSE OF STRESS/DEPRESSION) - Dealing with the parts of your life that cause you stress/depression.

TAKING MEDICATION - When you just can't function, obtaining a prescription and taking it.

WEEK LONG ASSESSMENT OF SLEEP, DIET, EXERCISE, RELAXATION AND MOOD

COMPLETE AS MANY DAYS AS POSSIBLE DURING THE WEEK. IF YOU MISS A DAY, LEAVE THE COLUMN BLANK.

DAY 1 DATE:	DAY 2 DATE:	DAY 3 DATE:	DAY 4 DATE:	DAY 5 DATE:	DAY 6 DATE:	DAY 7 DATE:
12 midnight ____	12 midnight ____	12 midnight ____	12 midnight ____	12 midnight ____	12 midnight ____	12 midnight ____
1 ____	1 ____	1 ____	1 ____	1 ____	1 ____	1 ____
2 ____	2 ____	2 ____	2 ____	2 ____	2 ____	2 ____
3 ____	3 ____	3 ____	3 ____	3 ____	3 ____	3 ____
4 ____	4 ____	4 ____	4 ____	4 ____	4 ____	4 ____
5 ____	5 ____	5 ____	5 ____	5 ____	5 ____	5 ____
6 A.M. ____	6 A.M. ____	6 A.M. ____	6 A.M. ____	6 A.M. ____	6 A.M. ____	6 A.M. ____
7 ____	7 ____	7 ____	7 ____	7 ____	7 ____	7 ____
8 ____	8 ____	8 ____	8 ____	8 ____	8 ____	8 ____
9 ____	9 ____	9 ____	9 ____	9 ____	9 ____	9 ____
10 ____	10 ____	10 ____	10 ____	10 ____	10 ____	10 ____
11 ____	11 ____	11 ____	11 ____	11 ____	11 ____	11 ____
12 noon ____	12 noon ____	12 noon ____	12 noon ____	12 noon ____	12 noon ____	12 noon ____
1 ____	1 ____	1 ____	1 ____	1 ____	1 ____	1 ____
2 ____	2 ____	2 ____	2 ____	2 ____	2 ____	2 ____
3 ____	3 ____	3 ____	3 ____	3 ____	3 ____	3 ____
4 ____	4 ____	4 ____	4 ____	4 ____	4 ____	4 ____
5 ____	5 ____	5 ____	5 ____	5 ____	5 ____	5 ____
6 P.M. ____	6 P.M. ____	6 P.M. ____	6 P.M. ____	6 P.M. ____	6 P.M. ____	6 P.M. ____
7 ____	7 ____	7 ____	7 ____	7 ____	7 ____	7 ____
8 ____	8 ____	8 ____	8 ____	8 ____	8 ____	8 ____
9 ____	9 ____	9 ____	9 ____	9 ____	9 ____	9 ____
10 ____	10 ____	10 ____	10 ____	10 ____	10 ____	10 ____
11 ____	11 ____	11 ____	11 ____	11 ____	11 ____	11 ____
HOURS OF SLEEP: Total ____	Total ____	Total ____	Total ____	Total ____	Total ____	Total ____

DIRECTIONS:

SLEEP: Mark IN at the time when you go to bed (every night).
Mark OUT at the time when you got out of bed (every morning).
Mark A for any time you awakened during the night or laid in bed without sleeping.
For each night, calculate the total hours you slept. Put the total for the night in the column of the day when you woke up.

DIET: Mark M whenever you eat a meal and N whenever you snack.
Mark C whenever you had caffeine. (This includes coffee, tea, cola drinks, no-doz, some pain relievers and chocolate in any form.
Mark D whenever you have a drink of alcohol.
Mark S whenever you have any food with a large amount of sugar. (i.e. ice cream, candy, soft drinks, cookies, most breakfast cereals, honey, sugar in coffee, etc.)

EXERCISE: Mark E when you exercised 20 minutes or longer (including walking).

RELAXATION: Mark R whenever you have relaxed for 20 minutes or longer (i.e. relaxation exercise, music, reading, T.V.).

MOOD: Put a circle around every hour when you felt depressed. Put a square around every hour when you felt agitated.

APPENDIX J

RELAXATION EXERCISES

A. SET THE STAGE:

1. Find a time and place where you can be alone.
2. Sit in a comfortable position in a chair.
3. Rest both feet on the floor.
4. Deliberately relax every part of your body.
5. Close your eyes.

B. VARIOUS EXERCISES TO TRY:

1. BREATHING:
   a. Pay attention to your breathing.
   b. Notice the way you breathe in and out.
   c. Do nothing else.
2. THOUGHT MONITOR:
   a. Pay attention to your thoughts, but do not let them worry you.
   b. Let a thought enter your mind, think about it, and let it go. Don't worry about it. Tell yourself you can worry about it later.
   c. See what the next thought is. Let that one pass by and think about the next one.
   d. Observe the stream of thoughts. Don't worry about any of them.
   e. Note if one thought keeps returning. Don't try to control it.
3. BODY AWARENESS:
   a. Let your mind slowly explore every part of your body - your feet, your legs, your stomach, your chest, your arms, your hands, your shoulders, your neck, your head.
   b. Note if you experience tension, aches, pain.
   c. Make a conscious note of every area where you have some physcial sensation.
4. VISUALIZATION:
   a. Picture a scene where you can feel very relaxed and let yourself be a part of it. (It may be somewhere you have previously visited or somewhere you imagine you would like to go.)
   b. Imagine you are alone there and just enjoy it. (It may be by the ocean or a stream or in the mountains.)
   c. Pick something that comes easily to your mind.
5. POSITIVE SELF IMAGE:
   a. Imagine yourself as a very relaxed person. You feel good about yourself; you like yourself. People see you as competent.
   b. Picture a scene where you normally have a problem and imagine yourself handling it in a relaxed way.
   c. Note the way you handle yourself.

C. PRACTICE:

1. Do one of these exercises at least twice a day for about five to ten minutes.
2. The best time to do the exercises is early morning or late evening.
3. At some point, try each exercise. Each has its own value.

APPENDIX K

THE COGNITIVE APPROACH TO STRESS/ANXIETY/DEPRESSION

1. People have both feelings and thoughts.

   Examples of feelings are: depression, anxiety, guilt, shame, inadequacy

   Examples of thoughts are: "things never work out", "I am a failure"

2. Negative feelings are usually the results of negative thoughts.

   Example: You tell yourself you are a failure - as a result, you feel depressed.

   You imagine a waterfall - you feel peaceful.

3. It is easier to control thoughts than to control feelings.

4. Many of our thoughts are habitual, automatic; we keep telling ourselves the same thing.

5. Therefore, one way to control feelings is to change our habitual way of thinking. (This is called the "cognitive approach".)

6. This is accomplished by keeping a record of your feelings and automatic thoughts. As well as writing down your automatic thoughts, write down other thoughts you could have had.

INSTRUCTIONS:

When you notice you are suffering from stress/anxiety/depression, note the time and the event and make a note in the diary.

Attached is a sample page of how a diary might appear.

As you complete the diary:

a. Note how automatic thoughts generate certain feelings.

b. Learn to recognize your automatic thoughts.

c. See how much energy you spend on these feelings.

d. Take note of your characteristic ways of feeling. (People are not always aware of this.)

e. It requires real effort to let go of your automatic thoughts.

f. The key is to catch yourself when it is happening.

g. Keep it simple.

h. Be gentle to yourself; be a friend.

MOOD DIARY (SAMPLE)

EVERY TIME YOU ARE UNDER A LOT OF STRESS/DEPRESSED, MAKE AN ENTRY.

DAY/TIME	EVENT	FEELING	AUTOMATIC THOUGHT	ALTERNATE THOUGHT
EXAMPLE I Thurs. 6:45 P.M.	Went to class; parking lot was full	angry surprised anxious irritated	I will be late. I will miss a lot. Things are not going the way I want them to. I should have known.	The longer walk will do me good. Fortunately, I know other places to park.
EXAMPLE II Wed. 8:00 P. M.	Went to first aerobic dance class.	inferior inadequate	Why did I think I could do it? I am not athletic. Others are better. It's hopeless. I can't do anything right.	It doesn't matter. Be patient; it takes time. I'm new. No need to be perfect. Goal is exercise.
EXAMPLE III Sat. 8:00 P. M.	Husband said to me, "I wish I was <u>everything</u> to you!"	guilt frustration blame self-reproach	I wish I had shown him more affection. I could have done better.	He was not coming down on himself. He loves me. He wants me to have the best.

MOOD DIARY

EVERY TIME YOU ARE UNDER A LOT OF STRESS/DEPRESSED, MAKE AN ENTRY.

DAY/TIME	EVENT	FEELING	AUTOMATIC THOUGHT	ALTERNATE THOUGHT

APPENDIX M

THE TIME MANAGEMENT APPROACH

1. LISTING: Make a list of the jobs you have to do.

2. SETTING PRIORITIES: By the side of each item, write a number indicating the item's priority.

3. ALLOCATING TIME: Set a time within which each item can be completed. (Notice that many items take just as long as you give them.)

4. ELIMINATING ITEMS: Look at the list and eliminate items whenever you can.

5. PLANNING YOUR DAY: Use the list to plan your work. Keep going back to your plan and make the plan work for you.

6. DEALING WITH INTERRUPTIONS: Don't be distracted from you plan. After each interruption, go back to your plan. If the interruption requires a change in your plan, make the change but keep working the plan.

7. SETTING LIMITS: Set limits on your time.
   a. If someone asks, "Do you have a minute?" say, "Yes, I have three!" This raises people's awareness of time.
   b. In a meeting, have an agenda and a time limit for each item.
   c. Whenever you find yourself at the point of diminishing returns (people are starting to repeat themselves), end the meeting or change the subject.
   d. Handle an item only once.
   e. Recognize your limited energy resources.....KNOW WHEN TO QUIT!

8. RECOGNIZING TYPES OF TIME:
   a. Decision Time: "I'll decide next week".....then set a time.
   b. Think Time: Have a time each day to just plain think.
   c. Relax Time: Have a time to take it easy.
   d. Protected Time: Have a time when you are left alone to do your work.

9. SOME KEY IDEAS:
   a. Avoid procrastination.....DO IT NOW.
   b. Divide and conquer.....if it's a big job, break it down into small parts and start with one part.
   c. Action vs. reaction.....many people spend their lives reacting. This time, take the initiative and act.
   d. Effectiveness.....doing the right thing at the right time, not doing everything as it comes to your attention.
   e. Trade-offs.....say, "I'll do that for you, if you'll do this for me."
   f. Help others use their time effectively.....give clear directions, set deadlines.

10. ASK YOURSELF LOADED QUESTIONS:
   a. If you could do only one thing today, what would it be?
   b. What am I avoiding?
   c. What is the value of this item?
   d. How much time will this take?

APPENDIX N

Creative Problem-Solving

The purpose of the exercise is to help you find new solutions to old problems.

STEP 1:

Write down the problem (be specific).

i.e. How can I get my son to put out the garbage without being asked.

STEP 2:

Write down all the possible solutions.

Use the following rules:

a. Write down everything that comes to mind.

b. Let one idea lead to another.

c. Don't censor any ideas.

d. Keep pushing for any ideas.

e. Allow yourself to be ridiculous.

f. Take a break.

g. Push for a few more ideas.

h. Get as many ideas as possible.

i. Have fun.

STEP 3:

Take a long break and let the ideas float in your mind.

STEP 4:

Go back to the list and pick the solution that strikes you first.

STEP 5:

Try it.

APPENDIX O

THE ACTION APPROACH TO STRESS/ANXIETY/DEPRESSION

When you are under stress/anxiety/depression, you do not want to do anything. When you do do things, you don't do them well. You also jump from one task to another.

You need to monitor/check what you do and set goals.

Goals should be realistic and reasonable.

The more you do that gives you pleasure, the better you should feel about yourself.

Therefore, set goals that both have to be done and that will give you pleasure. Bear in mind three things that tend to reduce pleasure:

1. Doing things you do not want to do.
   e.g. Doing things you feel you "should" do or "ought to" do.
2. Doing things that you feel you "ought not" to do.
   e.g. Feeling that you are doing something that someone else would say you shouldn't be doing.
3. Doing something you normally enjoy but not being able to focus on the pleasurable sensations.
   e.g. Can't enjoy listening to music you usually like or can't enjoy spending time with your children because your mind is preoccupied.

Take a few minutes and set some goals for yourself either for the day or the week. Have as many pleasurable goals as necessary ones.

GOALS FOR DAY/WEEK OF _____

		Accomplished (YES/NO)
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____

EXAMPLES:

1. Go to the movies on Friday.
2. Get my hair done Saturday.
3. Help Joey (son) with homework Tuesday.
4. Register for aerobic dance class before end of week.
5. Clean house Saturday morning.

APPENDIX P

THE AFFECTIVE APPROACH (EXPRESSING YOUR FEELINGS)

Sometimes people have symptoms such as stress, anxiety or depression because they have not learned to express their feelings.

This can happen in two ways:

a. People are aware of their feelings and don't express them.

   Example: There is a death of someone close to you and you do not let yourself cry and talk about the loss.

b. People, through habit and upbringing, have learned to suppress their feelings and just don't know what they are.

   Example: A wife is angry at her husband but because she was brought up to suppress anger (told it was wrong) treats her husband with sweetness and obedience.

To help you get in touch with your feelings and express them, the following may help:

1. When you are in a situation which troubles you, ask yourself, "What am I feeling?"
2. Ask yourself at regular intervals (for instance, at the beginning of each hour), "How am I feeling?"
3. Begin thinking and using "feeling" words, such as happy, sad, excited, anxious, joyful, etc.
4. When you talk to people, include references to your feelings. (For example: When your husband talks about his worries at work, tell him you feel close to him.)
5. Notice "feeling" situations. (For example: a father playing with his children in the local park).
6. When you are with a close friend, tell the friend what the friendship means to you.
7. When you have a particular worry, share it with someone.
8. Touch people when you talk to them.
9. Accept your feelings as a part of you; as much as your thoughts. Don't say, "I should not feel like this."
10. Pay attention to the sound of your voice. Notice when you like the sound, and when it sounds resonant rather than restricted. A good sound is probably a sign you are expressing your feelings.
11. Laugh more.
12. Play music which has an emotional impact on you and let yourself experience the feelings. (For example: movie theme music such as Doctor Zhivago.)
13. Keep a diary. Write down each day, exactly as the words come to you, on what kind of a day it was. Use feeling words.
14. Review important events in your life and check how you felt about them at the time and now.
15. Recognize that you may have both good and bad feelings about a situation or a person.

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[18]Robert Hicks and J. M. Sawrey, "REM Sleep Deprivation and Stress Susceptibility in Rats," Psychological Record, 28 (1978), p. 187.

[19]Robert Hicks, et al., "Type A Behavior and Normal Habitual Sleep Duration," Bulletin of the Psychonomic Society, 14 (1979), pp. 185-186.

[20]Hicks and Sawrey, pp. 187-191.

[21]Robert Hicks, et al., "Reduction in Sleep Duration and Type A Behavior," Bulletin of the Psychonomic Society, 16, No. 2 (1980), pp. 109-110.

[22]Frederick Snyder, "Sleep Disturbance in Relation to Acute Psychosis," A. Kales, ed. Sleep-Physiology and Pathology (Philadelphia: Lippincott, 1969), pp. 170-182.

[23]Willis, p. 1.

[24]Willis, p. 1.

[25]Willis, p. 1.

[26]Willis, p. 2.

[27]William Dement, "Do You Have Trouble Sleeping?" Parade Magazine, September 16, 1984, p. 12.

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[29]T. Wehr and F. Goodwin, "Biological Rhythms in Psychiatry," S. Arieti and H. K. H., eds. American Handbook of Psychiatry, Vol. 7 (New York: Basic Books, 1980), p. 1.

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