

Mindfulness - The Gateway to Transition



Study Guide

January 27, 2009

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Executive Summary

Mindfulness – The Gateway to Transition is a three month course designed to serve as a gateway to the instruction offered in the Character Based Dorm program as well as to facilitate an inmate's transition to freedom. Both aspects of the course have an end goal in not only reducing recidivism but empowering the inmates ability attain a meaningful life.

Mind Body Stress Reduction (MBSR) is a required precursor and relevant to both the inmates transition to freedom as well as a gateway to the Character Based Dorms. MBSR enables the inmate to contribute in a positive manner to the classroom, workplace and in relationships. This is done by improving on the inmate's ability and willingness to absorb information as well as work through difficult situations.

Difficult situations are often accompanied by feelings of discomfort which can become the foundation of unskillful habits: acting in (withdrawal, depression, anxiety, physical stress/disease/pain); acting out (violence, substance abuse, sexual promiscuity, and self-mutilation)

MBSR achieves this through an integration of meditation (mind) and yoga (body) exercises and activities designed to facilitate habit change. This is not only increases awareness of old triggers preceding destructive behaviors but also through a regular practice of new, stabilizing, self-calming behaviors.

MBSR as developed at the University of Massachusetts Medical Center is a proven program for both medical and therapeutic applications. The Mindful Gateway is a test program that ties the basic MBSR module to specific problems unique to prison inmates.

This program is the marriage of 10 years experience of the Gateless Gate Zen Center's teaching mediation and related programs in prison coupled with observation of inmate's transition to the free world.

The underlying theme of Mindfulness – The Gateway to Transition is the development of a transition plan that examines short and long term educational and employment strategies and opportunities. Also, included is an exposure to the dynamics associated with PTSD

and relationships. A segment necessitated by past behavioral patterns associated with dysfunctional family histories, criminal activities as well as incarceration.

The course of instruction is divided into a two month classroom period and a five day silent meditation retreat. The classroom phase is divided into eight blocks of instruction that are informational in nature. Each block of instruction is two hours in length with an additional 10 to 14 hours of experiential based homework designed for the student to apply to his/her own situation. The five day silent retreat provides an opportunity for the inmate to absorb and internalize the material and experiences over the previous two months.

Forward

This study guide was designed to serve three purposes: a workbook for a program called Mindfulness – A Gateway to Transition; second was to serve as a Gateway Program for character based dormitories; and finally as a standalone reference to assist ex-offenders as well as their families in the transition from incarceration to freedom.

This started out as a simple workbook to support a program built on a MBSR foundation to address some of the major issues facing prison inmates. The determination of issues to be covered came from two sources. First was a decade of observation of teaching meditation in prisons and monitoring problems encountered by ex-offenders when released. Second was an informal poll of 60 MBSR students in cycle 2 at Gadsden CI. The result was to focus primarily on Post Traumatic Stress Disorders and relationships, transition issues, and finally anger. The secondary focus was to be on employment and education.

The challenge was to put all the material into a meaningful context. The result was to devise a purpose driven transition plan that starts on the first day of the program. The first requirement at the orientation is to spell out on paper their plan A and turn it in. This enables the instructor to see what the commonalities are to the plans and build them into the program. Each of the students then builds a plan B that incorporates the material covered.

No attempt was made to originate new text or material. All the material relating to PTSD as well as PTSD and relationships came from well researched and documented papers that originated within the Department of Defense (DOD) or Veterans Administration (VA). The underlying premise in this selection was that trauma is trauma be its origination on the battlefield or on the streets and in the dysfunctional homes of the USA.

This is trauma that is exacerbated by prison sentences of several years in which a whole new paradigm of dysfunctional behaviors and survival skills are

superimposed on already unstable behaviors that are brought back to the home front upon their release from prison.

The resulting situation is comparable to veterans returning from tours of duty in Iraq and Afghanistan. I took the research and wisdom that evolved in the DOD and VA papers and made two simple substitutions. In place of such words as battlefield, Iraq, Afghanistan, deployment cycle and etc were changed to prison. Then words such as inmate, felon, ex-offender and significant other were substituted for soldier, veteran etc.

The segment on PTSD and relationships was lifted in its entirety and with the permission of the person sponsoring a workshop on the same subject in August of 2008 in the VA hospital located in Gainesville, Florida. We then went over the PowerPoint and did a like substitution. It is important to note that not all ex-offenders suffer from PTSD and this is for those that suffer from PTSD. However, there was no question about similar dynamics being at play regardless of the source of PTSD.

The last section on anger was taken from a web site operated by the American Psychological Association. The material dovetailed nicely with that of DOD, VA and MBSR. No changes were made in the attached article.

At first glance, it may seem unnecessary to put material that is readily available in the public domain into a workbook. However, incarcerated persons do not have access to the material in the public domain. A search of material made available to inmates in prison systems found no like presentation or preparation of transition plans for inmates as well as their families.

Most inmates getting out will not have families to support them in the journey. However, at some point they will have a family. The material is timeless as it speaks to universal behaviors that reach beyond family patterns but include the work place, general socialization and education.

The focus was on material in a bullet or outline format. In part, because it allows for the maximum latitude in its interpretation and implementation. Also, it is not as intimidating as long winded dissertations that become narrow in scope.

Whereas the scope of the material is universal in its application, not everyone will suffer from all features mentioned. It is up to the individual to identify what is useful and how to apply it.

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Mindfulness

Mindfulness can be defined as a state of continuous category formation. A mindful individual creates new approaches to events and situations. He or she is not bound by previously formed rigid attitudes; rather, the mindful person, situated in the present, explores a situation from several perspectives (p. 107).

Mindlessness

Mindlessness can be defined as a mental state in which an individual relies rigidly on categories and distinctions created in the past. Mindlessness involves acting on the basis of a formalized set of rules and attitudes. Each new event or situation is classified into a preexisting category. On the basis of **that** category, behavioral and attitudinal responses are prescribed.

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(Nkosi Johnson; a Zulu boy who died of Aids at the age of 12.

Homecoming after Prison: Tips for Reunion

Reunion is part of the prison experience and can be filled with joy and stress. The following tips can help you have the best possible reunion.

Tips for Ex-Offenders:

- Support good things your family has done.
- Take time to talk with your spouse and children.
- Make individual time for each child and your spouse.
- Go slowly when reestablishing your place in the family.
- Be prepared to make some adjustments.
- Romantic conversations can lead to more enjoyable sex.
- Make your savings last longer.
- Take time to listen and to talk with loved ones.
- Go easy on partying.

Tips for Spouses for Reunion:

- Avoid scheduling too many things.
- Go slowly in making adjustments.
- You and your significant other may need time for yourself.
- Remind your significant other that he or she is still needed in the family.
- Discuss splitting up family chores.
- Stick to your budget until you've had time to talk it through.
- Along with time for the family, make individual time to talk.
- Be patient with yourself and your partner.

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Tips for Reunion with Children:

- Go slowly. Adapt to the rules and routines already in place.
- Let the child set the pace for getting to know you again.
- Learn from how your spouse managed the children.
- Be available to your child, both with time and with your emotions.
- Delay making changes in rules and routines for a few weeks.
- Expect that the family will not be the same as before you left: everyone has changed.
- Focus on the successes with your children; limit your criticisms
- Encourage children to tell you about what happened during the separation.

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Homecoming after Prison: Dealing with Changes and Expectations

Some families must also deal with the trauma of having a parent seriously injured or killed. Families who have little or no contact with extended family and /or the community may be especially vulnerable to stress. In families with existing medical, emotional, or behavioral problems, a parent being away can be especially difficult.

While most families and children manage successfully, it is important for parents to be aware of signs of stress and possibly serious problems. The responses of children to stress of separation are determined by their individual makeup and developmental age. The following are some common reactions:

- Infants (Birth – 12 months) may respond to disruptions in their schedule, physical environment or availability of caregivers with decreased appetite, weight loss, irritability and/or apathy.
- Toddlers (1-3 yrs.) may become sullen, tearful, throw temper tantrums or develop sleep problems.
- Preschoolers (3 – 6 yrs.) are more aware of the absence of a parent than younger children and their behavior may regress in areas such as toilet training, sleep, separation fears, physical complaints, or thumb sucking. They may personalize situations and express a fear that, “Daddy left because I was angry at him” or “Mommy stays away because she doesn’t love me.”
- School age children (6 – 12 yrs.) are more aware of the realities behind their parent leaving and the potential dangers. They may show irritable behavior, aggression or whininess. They also may become more regressed and fearful that their parents may be injured or die.

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- Teenagers (13 – 18 yrs.) may be rebellious, irritable or more challenging of authority. Parents need to be alert to high-risk behaviors such as problems with the law, sexual acting out, and drug/alcohol abuse.

A parent leaving home for a prison sentence increases the burden on all family members. The following suggestions can ease the stress:

- Talk as a family before incarceration, sharing information, feelings, worries and plans for the future. Let your child know that the family member is making a valuable contribution to their country and the world.
- Emphasize the need for the family to pull together during the parent's absence with everyone sharing in family responsibilities.
- Continue family traditions, structure and discipline. This is reassuring and stabilizing to children.
- Utilize available means (e.g. letters, email, phone) for the family member to communicate with the incarcerated parent.
- Share information with the children based upon their developmental level and ability to understand. No news is usually more stressful and difficult to deal with than bad news.
- Monitor children's exposure to TV coverage of events and political discussions.
- Encourage the open and honest expression of worries, feelings, and questions.
- Consider having children participate in a project associated with their parent's incarceration (e.g. letter writing project, keeping a journal or scrapbook).
- Don't make promises that you can't keep.
- Initiate and maintain a close relationship and communication with your child's teachers and school.
- Utilize extended family, community and spiritual resources and other natural supports that are available both within and outside.

Although a joyous occasion, when a family member returns home after a long absence, a period of adjustment will be necessary. Roles, responsibilities and routines must be re-established. The emotional readjustment will require time and

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patience. This can be a difficult time and all family members will need extra support. This is especially true if there has been a serious injury. If a parent or a child develops emotional Child, #66 Helping Teenagers with Stress, # 54 Children and Watching TV, and #67 Children and the News. **See also: *Your Child* (AACAP, 1998 Harper Collins) and *Your Adolescent* (AACAP, 1999 Harper Collins).**

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or behavioral problems or is having serious difficulties with the adjustment, they should be referred for evaluation by a qualified mental health professional.

While it is a difficult time for families, most children can and do adjust successfully to the separation and stress involved.

For additional information see *Facts for Families*: #4 The Depressed Child, #8 Children and Grief, #14 Children and Family Moves, #34 Children's Sleep Problems, #47 The Anxious

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Prison-Related Stress: What Families Need to Know

Ex-offenders frequently have serious reactions to their traumatic incarceration experiences. Sometimes the reactions continue after they return home. Ongoing reactions to incarceration related fears, horrors, or helplessness connected with posttraumatic stress and can include:

Nightmares or difficulty sleeping

Unwanted distressing memories or thoughts

Anxiety and panic

Irritability and anger

Emotional numbing or loss of interest in activities or people

Problem alcohol or drug use to cope with stress reactions

How Traumatic Stress Reactions Can Affect Families

Stress reactions in a returning ex-offender may interfere with the ability to trust and be emotionally close to others. As a result, families may feel emotionally cut off from the ex-offender. They may feel irritable and have difficulty with communication, making him/her hard to get along with. He or she may experience a loss of interest in family social activities. The ex-offender may lose interest in sex and feel distant from his or her spouse. Traumatized ex-offenders often feel that something terrible may happen “out of the blue” and can become preoccupied with trying to keep themselves and family members safe.

Just as ex-offenders are often afraid to address what happened to them, family members also may avoid talking about the trauma or related

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problems. They may avoid talking because they want to spare the ex-offender further pain, or because they are afraid of his or her reaction. Family members may feel hurt, alienated, or discouraged because the ex-offender has not overcome the effects of the trauma and may become angry or feel distant from the ex-offender.

The Important Role of Families in Recovery

The primary source of support for the returning ex-offender is likely to be his or her family. Families can help the ex-offender avoid withdrawal from others. Families can provide companionship and a sense of belonging, which can help counter feelings of separateness and difference from other people. They can provide practical and emotional support for coping with life stressors.

If the ex-offender agrees, it is important for family members to participate in treatment. It is also important to talk about how the post-trauma stress is affecting the family and what the family can do about it. Adult family members should also let their loved ones know that they are willing to listen if the ex-offender would like to talk about incarceration experiences. Family members should talk with treatment providers about how they can help in the recovery effort.

What Happens in Treatment for PTSD

Treatment for PTSD focuses upon helping the ex-offender reduce fear and anxiety, gain control over traumatic stress reactions, make sense of traumatic experiences, and function better at work and in the family. A standard course of treatment may include:

- Assessment and development of an individual treatment plan.
- Education of ex-offenders and their families about posttraumatic stress and its effects.
- Training in relaxation methods, to help reduce physical arousal/tension.

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- Practical instruction in skills for coping with anger, stress, and ongoing problems.
- Discussion of feelings of anger or guilt, which are common among survivors of war trauma.
- Detailed discussion to help change distressing beliefs about self and others (e.g. self-blame).
- If appropriate, careful, repeated discussions of the trauma (exposure therapy) to help the ex-offender reduce the fear associated with trauma memories.
- Medication to reduce anxiety, depression, or insomnia.
- Group support from other ex-offenders, often felt to be the most valued treatment experience.

Mental health professionals in VA Medical Centers and community clinics and Readjustment Counseling Service have a long tradition of working with family members of ex-offenders with PTSD. Educational classes for families and couples counseling may be available. Family members can encourage the ex-offender to seek education and counseling, but should not try to force their loved one to get help. Family members should consider getting help for themselves, whether or not their loved one is getting treatment.

Self-Care Suggestions for Families

- Become educated about PTSD.
- Take time to listen to all family members and show them that you care.
- Spend time with other people. Coping is easier with support from caring others, including extended family, friends, church, or other community groups.
- Join or develop a support group.
- Take care of yourself. Family members frequently devote themselves totally to those they care for, and in the process, neglect their own needs. Watch your diet, exercise, and get plenty of rest. Take time to do things that feel good to you.

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- Try to maintain family routines, such as dinner together, church, or sports outings.

Additional Resources

For more information about PTSD and treatment, visit the National Center for PTSD website at www.ncptsd.org.

Matsakis, A. (1996). *Vietnam wives: Facing the challenges of life with ex-offenders suffering posttraumatic stress*. Baltimore, MD: Sidran, Mason, P. (1999) *Recovering from the war: A woman's guide to helping your Vietnam vet, your family, and yourself*. High Springs, Fl. Patience Press.

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Brain Lock Unlocked (OCD)

Using Plasticity to Stop Worries, Obsessions, Compulsions, and Bad Habits.

All of us have worries. We worry because we are intelligent beings. Intelligence predicts, that is its essence; the same intelligence that allows us to plan, hope, imagine, and hypothesize also allows us to worry and anticipate negative outcomes. But there are people who are “great worriers,” whose worrying is in a class of its own. Their suffering, though “all in the head,” goes far beyond what most people experience precisely ***because*** it is all in the head and is thus inescapable. Such people are so constantly traumatized by their own brains that they often consider suicide. In one case a desperate college student felt so trapped by his obsessive worries and compulsions that he put a gun in his mouth and pulled the trigger. The bullet passed into his frontal lobe, causing a frontal lobotomy, which was at the time a treatment for obsessive-compulsive disorder. He was found still alive, his disorder cured, and he returned to college.

There are many kinds of worriers and many types of anxiety-phobias, post-traumatic stress disorders, and panic attacks. But among the people who suffer most are those with obsessive-compulsive disorder, or OCD, who are terrified that some harm will come, or has come, to them or to those they love. Though they may have been fairly anxious as children, at some later point, often as young adults, they have an “attack” that takes their worrying to a new level. Once self-possessed adults, they now feel like anguished, terrified children. Ashamed that they’ve lost control, they often hide their worry from others, sometimes for years, before they seek help. In the worst cases they cannot awaken from these nightmares for months at a time or even years. Medications may quell their anxieties but often don’t eliminate the problem. OCD often worsens over time, gradually altering the structure of the brain. A patient with OCD may try to get relief by focusing on his worry-making sure he’s covered all the bases and left nothing to chance-but the more he thinks about his

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fear, however, the more he worries about it, because with OCD, worry begets worry.

There is often an emotional trigger for the first major attack. A person might remember that it is the anniversary of his mother's death, hear about a rival's car accident, feel an ache or lump in his body, read about a chemical in the food supply, or see an image of burned hands in a film. Then he begins to worry that he is approaching the age that his mother was when she died and, though not generally superstitious, now feels he is doomed to die that day; or that his rival's early death awaits him too; or that he has discovered the first symptoms of an untreatable disease; or that he has already been poisoned because he was not vigilant enough about what he ate.

We all experience such thoughts fleetingly. But people with OCD lock onto the worry and can't let it go. Their brains and minds march them through various dread scenarios, and though they try to resist thinking about them, they cannot. The threats feel so real, they think they must attend to them. Typical obsessions are fears of contracting a terminal illness, being contaminated by germs, being poisoned by chemicals, being threatened by electromagnetic radiation, or even being betrayed by one's own genes. Sometimes obsessionals get preoccupied with symmetry; they are bothered when pictures are not perfectly level or their teeth or not perfectly straight, or when objects are not kept in perfect order, and they can spend hours lining them up properly. Or they become superstitious about certain numbers and can set an alarm clock or volume control only on an even number. Sexual or aggressive thoughts—a fear they have hurt loved ones—might intrude into their minds, but where these thoughts come from they do not know. A typical obsessional thought might be “the thud that I heard while driving means I may have run somebody over.” If they are religious, blasphemous thoughts might arise, causing guilt and worry. Many people with OCD have obsessive doubts and are always second-guessing themselves: have they turned off the stove, locked the door, or hurt someone's feelings inadvertently?

The worries can be bizarre—and make no conceivable sense even to the worrier—but that doesn't make them any less tormenting. A loving mother and wife

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worries, “I am going to harm my baby,” or, “I will get up in my sleep and stab my husband with a butcher knife in the chest while he’s sleeping.” A husband has the obsessive thought that there are razor blades attached to his fingernails, so he cannot touch his children, make love to his wife, or pat his dog. His eyes see no blades, but his mind insists they are there, and he keeps asking his wife for reassurance that he hasn’t hurt her.

Often obsessives fear the future because of some mistake they may have made in the past. But it is not only mistakes that have happened that haunt them. Mistakes that they imagine they could make, should they let their guard down for a moment-which they, being human, eventually will-also generate a sense of dread that cannot be turned off. The agony of the obsessive worrier is that whenever something bad is remotely possible, it feels inevitable.

I have had several patients whose worries about their health were so intense that they felt as though they were on death row, each day awaiting their execution. But their drama does not end there. Even if they are told their health is fine, there may feel only the briefest flash of relief before they harshly diagnose themselves as “crazy” for all they have put themselves through-though, often, this “insight” is obsessional second-guessing in a new guise.

Soon after obsessive worries begin, OCD patients typically do something to diminish the worry, a compulsive act. If they feel they have been contaminated by germs, they wash themselves, when that doesn’t make the worry go away; they wash all their clothing, the floors, and then the walls. If a woman fears she will kill her baby, she wraps the butcher knife in cloth, packs it in a box, locks it in the basement, then locks the door to the basement. The UCLA psychiatrist Jeffrey M. Schwartz describes a man who feared being contaminated by the battery acid spilled in car accidents. Each night he lay in bed listening for sirens that would signal an accident nearby. When he heard them, he would get up, no matter what the hour, put on special running shoes, and drive until he found the site. After the police left, he would scrub the asphalt with a brush for hours, then skulk home and throw out the shoes he had worn.

Obsessive doubters often develop “checking compulsions.” If they doubt they’ve turned off the stove or locked the door, they go back to check and recheck often

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a hundred or more times. Because the doubt never goes away, it might take them hours to leave the house.

People who fear that a thud they heard while driving might be they ran someone over will drive around the block just to make sure there is no corpse in the road. If their obsessional fear is of a dread disease, they will scan and rescan their body for symptoms often make dozens of visits to the doctor. After a while these checking compulsions are ritualized. If they feel they have been dirtied, they must clean themselves in a precise order, putting on gloves to turn on the tap and scrubbing their bodies in a particular sequence; if they have blasphemous or sexual thoughts, they may invent a ritual way of praying a certain number of times. These rituals are probably related to the magical and superstitious beliefs most obsessionals have. If they have managed to avoid disaster, it is only because they checked themselves in a certain way, and their only hope is to keep checking in the same way each time.

Obsessive-compulsives, so often filled with doubt, may become terrified of making a mistake and start compulsively correcting themselves and others. one woman took hundreds of hours to write brief letters because she felt so unable to find words that didn't feel "mistaken," many a Ph.D. dissertation stalls-not because the author is a perfectionist, but because the doubting writers with OCD can't find words that don't "feel" totally wrong.

OCD has been very difficult to treat. Medication and behavior therapy are only partially helpful for many people. Jeffrey M. Schwartz has developed an effective, plasticity-based treatment that helps not only those with obsessive-compulsive disorder but also those of us with more everyday worries, when we start stewing about something and can't stop even though we know it's pointless. It can help us when we get mentally "sticky" and hold on to worries or when we become compulsive and driven by such "nasty habits" as compulsive nail biting, hair pulling, shopping, gambling, and eating. Even some forms of obsessive jealousy, substance abuse, compulsive sexual behaviors, and excessive concern about what others think about us, self-image, the body, and self-esteem can be helped.

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Schwartz developed new insights into OCD by comparing brain scans of people with OCD and those without it, then used these insights to develop his new form of therapy-the first time, to my knowledge, that such brain scans as the PET helped doctors both to understand a disorder and to develop psychotherapy for it. He then tested this new treatment by doing brain scans on his patients before and after their psychotherapy and showed that their brains normalized with treatment. This was another first-demonstration that a talking therapy could change the brain.

Normally, when we make a mistake, three things happen. First, we get a “mistake feeling,” that nagging sense that something is wrong. Second, we become anxious, and that anxiety drives us to correct the mistake. Third, when we have corrected the mistake, an automatic gearshift in our brain allows us to move on to the next thought or activity. Then both the “mistake feeling” and the anxiety disappear.

But the brain of the obsessive-compulsive does not move on or “turn the page.” Even though he has corrected his spelling mistake, washed the germs off his hands, or apologized for forgetting his friend’s birthday, he continues to obsess. His automatic gearshift does not work, and the mistake feeling and its pursuant anxiety build in intensity.

We now know, from brain scans, that three parts of the brain are involved in obsessions.

We detect mistakes with our orbital frontal cortex, part of the frontal lobe, on the underside of the brain, just behind our eyes. Scans show that the more obsessive a person is, the more activated the orbital frontal cortex is.

Once the orbital frontal cortex has fired the “the mistake feeling,” it sends a signal to the cingulate gyrus, located in the deepest part of the cortex. The cingulate triggers the dreadful anxiety that something bad is going to happen unless we correct the mistake and sends signals to both the gut and the heart, causing the physical sensations we associate with dread.

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The ‘automatic gearshift,’ the caudate nucleus, sits deep in the center of the brain and allows our thoughts to flow from one to the next unless, as happens in OCD, the caudate becomes extremely “sticky.”

Brain scans of OCD patients show that all three brain areas are hyperactive. The orbital frontal cortex and the cingulated turn on and stay on as though locked in the “on position” together—one reason that Schwartz calls OCD “brain lock.” Because the caudate doesn’t “shift the gear” automatically, the orbital frontal cortex and the cingulated continue to fire off their signals, increasing the mistake feeling and the anxiety. Because the person has already corrected the mistake, these are, of course, false alarms. The malfunctioning caudate is probably overactive because it is stuck and is still being inundated with signals from the orbital frontal cortex.

The causes of severe OCD brain lock vary. In many cases it runs in families and may be generic, but it can also be caused by infections that swell the caudate. And, as we shall see, learning also plays a role in its development.

Schwartz set out to develop a treatment that would change the OCD circuit by unlocking the link between the orbital cortex and the cingulated and normalizing the functioning of the caudate. Schwartz wondered whether patients could shift the caudate “manually” by paying constant, effortful attention and actively focusing on something besides the worry, such as a new, pleasurable activity. This approach makes plastic sense because it “grows” a new brain circuit that gives pleasure and triggers dopamine release which, as we have seen, rewards the new activity and consolidates and forms new neuronal connections. This new circuit can eventually compete with the older one, and according to use it or lose it, the pathological networks will weaken. With this treatment we don’t so much “break” bad habits as replace bad behaviors with better ones.

Schwartz divides the therapy into a number of steps, of which two are key. The first step is for a person having an OCD attack to **relabel** what is happening to him, so that he realizes that what he is experiencing is not an attack of germs, AIDS, or battery acid but an episode of OCD. He should remember that brain lock

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occurs in the three parts of the brain. As a therapist, I encourage OCD patients to make the following summary for themselves: “Yes, I do have a real problem right now. But it is not germs, it is my OCD.” This relabeling allows them to get some distance from the content of the obsession and view it in somewhat the same way Buddhists view suffering in meditation: they observe its effects on them and so slightly separate themselves from it.

The OCD patient should also remind himself that the reason the attack doesn’t go away immediately is the faulty circuit. Some patients may find it helpful, in the midst of an attack, to look at the pictures of the abnormal OCD brain scan in Schwartz’s book *Brain Lock*, and compare it with the more normal brain scans that Schwartz’s patients developed with treatment, to remind themselves it is possible to change circuits.

Schwartz is teaching patients to distinguish between the universal form of OCD (worrisome thoughts and urges that intrude into consciousness) and the content of an obsession (i.e. the dangerous germs). The more patients focus on content, the worse their condition becomes.

For a long time therapists have focused on the content as well. The most common treatment for OCD is called “exposure and response prevention,” a form of behavior therapy that helps about half of OCD patients make some improvement, though most don’t get completely better. If a person fears germs, he is incrementally exposed to more of them, in an attempt to desensitize him. In practice this could mean making patients spend time in toilets. (The first time I heard of this treatment, the psychiatrist was asking a man to wear dirty underwear over his face.) Understandably, 30 percent of patients refused such treatments. Exposure to germs doesn’t aim to “shift” the gear to the next thought; it leads the patient to dwell more intensely on them—for a while, at least. The second part of the standard behavioral treatment is “response prevention,” preventing the patient from acting on his compulsion. Another form of therapy, Cognitive Therapy, is based on the premise that problematic mood and anxiety states are caused by cognitive distortions—inaccurate or exaggerated thoughts. Cognitive therapists have their OCD patients write down their fears and then list reasons they don’t make sense. But this procedure also

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immerses the patient in the content of his OCD. As Schwartz says, “To teach a patient to say, ‘my hands are not dirty,’ is just to repeat something she already knows...cognitive distortion is just not an intrinsic part of the disease; a patient basically knows that failing to count the cans in the pantry today won’t really cause her mother to die a horrible death tonight. The problem is, she doesn’t feel that way.” Psychoanalysts too have focused on the content of the symptoms, many of which deal with troubling sexual and aggressive ideas. They have found that obsessive thought, such as “I will hurt my child,” might express a suppressed anger at the child, and that this insight might, in mild cases, be enough to make an obsession go away. But this often does not work with moderate or severe OCD. And while Schwartz believes that the origins of many obsessions relate to the kind of conflicts about sex, aggression, and guilt that Freud emphasized, these conflicts explain only the content, not the form of the disorder.

After a patient has acknowledged that the worry is a symptom of OCD, the next crucial step is to refocus on a positive, wholesome, ideally pleasure-giving activity the moment he becomes aware he is having an OCD attack. The activity could be gardening, helping someone, working on a hobby, playing a musical instrument, listening to music, working out, or shooting baskets. An activity that involves another person helps keep the patient focused. If OCD strikes while the patient is driving a car, he should be ready with an activity like a book on tape or a CDE. It is essential to do something, to “shift” the gear manually.

This may seem like an obvious course of action, and may sound simple, but it is not for people with OCD. Schwartz assures his patients that though their “manual transmission” is sticky, with hard work it can be shifted using their cerebral cortex, one effortful thought or action at a time.

Of course, the gearshift is a machine metaphor, and the brain is not a machine: it is plastic and living. Each time patients try to shift gears, they begin fixing their “transmission” by growing new circuits and altering the caudate. By refocusing, the patient is learning not to get sucked in by the content of an obsession but to work around it. I suggest to my patients that they think of the use-it-or-lose-it principle. Each moment they spend thinking of the symptom-believing that

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germs are threatening them-they deepen the obsessive circuit. By bypassing it, they are on the road to losing it. By bypassing it, they are on the road to losing it. with obsessions and compulsions, ***the more you do it, the more you want to do it; the less you do it, the less you want to do it.***

Schwartz has found it essential to understand that ***it is not what you feel while applying the technique that counts, it is what you do.*** “The struggle is not to make the feeling go away; the struggle ***is not to give in to the feeling***”-by acting out a compulsion, or thinking about the obsession. The technique won’t give immediate relief because lasting neuroplastic change takes time, but it does lay the groundwork for change by exercising the brain in a new way. so at first one will still feel both the urge to enact the compulsion, and the tension and anxiety that come from resisting it. the goal is to “change the channel” to some new activity for fifteen to thirty minutes when one has an OCD symptom. (If one can’t resist that long, and time spent resisting is beneficial, even if it is only for a minute.

That resistance, that effort, is what appears to lay down new circuits.) One can see that Schwartz’s technique with OCD has parallels with Tabuy’s CI approach to strokes. By forcing the patients to “change the channel” and refocus on a new activity, Schwartz is imposing a constraint like Taub’s mitt. By getting his patients to concentrate on the new behavior intensively, in thirty-minute segments, he is giving them massed practice.

In chapter 3, “Redesigning the Brain,” we learned two key laws of plasticity that also underlie this treatment. The first is that Neurons that fire together wire together. By doing something pleasurable in place of the compulsion, patients form a new circuit that is gradually reinforced instead of the compulsion. The second law is that Neurons that fire apart wire apart. By not acting on the compulsions, patients weaken the link between the compulsion and the idea it will ease their anxiety. This delinking is crucial because, as we’ve seen, while acting on a compulsion eases anxiety in the short term, it worsens OCD in the long term.

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Schwartz has had good results with severe cases. Eighty percent of his patients get better when they use his method in combination with medication—typically an antidepressant such as Anafranil or a Prozac-type drug. The medication functions like training wheels on a bike, to ease anxiety or to lower it enough for patients to benefit from the therapy. In time many patients get off the medication, and some don't need it to start with.

I have seen the brain lock approach work well with such typical OCD problems as fear of germs, hand washing, checking compulsions, compulsive second-guessing, and incapacitating hypochondriacal fears. As patients apply themselves, the “manual gear shift” gets more and more automatic. The episodes become shorter and less frequent, and though patients can relapse during stressful times, they can quickly regain control using their newfound technique.

When Schwartz and his team scanned the brains of their improved patients, they found that the three parts of the brain that had been “locked” and, firing together in a hyperactive way, had begun to fire separately in a normal way. The brain lock was being relieved.

I was at a dinner party with a friend, whom I shall call Emma: her writer husband, Theodore; and several other writers.

Emma is now in her forties. When she was twenty-three, a spontaneous genetic mutation led to an illness called retinitis pigmentosa that caused her retinal cells to die. Five years ago she became totally blind and began using a seeing-eye dog, Matty, a Labrador.

Emma's blindness has reorganized her brain and her life. A number of us who were at the dinner are interested in literature, but since she has gone blind, Emma has done more reading than any of us. A computer program from Durzweil Educational Systems reads books aloud to her in a monotone that pauses for commas, stops for periods, and rises in pitch for questions. This computer voice is so rapid, I cannot make out a single word. But Emma has gradually learned to listen at a faster and faster pace, so she is now reading at about 340 words a minute and is marching through all the great classics. “I get

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into an author, and I read everything he has ever written, and then I move on to another.” She has read Dostoyevsky. (her favorite). Gigol, Tolstoy, Turgenev, Dickens, Chesterton, Balzac, Hugo, Zola, Flaubert, Proust, Stendhal, and many others. Recently she read three Trollope novels in one day. She asked me how it might be possible for her to read so much more quickly than before she went blind. I theorized that her massive visual cortex, no longer processing sight, had been taken over for auditory processing.

That particular evening Emma asked me if I knew anything about needing to check things a lot. She told me that she often has a lot of trouble getting out of the house, because she keeps checking the stoves and the locks. Back when she was still going to her office, she might leave for work, get halfway there, and then have to go back to make sure she had locked the door properly. By the time she got back, she would be obliged to check that the stove, electrical appliances, and water were turned off. She’d leave, then have to repeat the whole cycle several more times, all the while trying to fight the urge. She told me that her authoritarian father had made her anxious when she was grown up. When she left home, she’d lost that anxiety but noticed that it now seemed to have been replaced by the checking, which kept getting worse.

I explained the brain lock theory to her. I told her that often we check and recheck appliances without really concentrating. So I suggested she check once, and once only, with utmost care.

The next time I saw her, she was delighted. “I’m better,” she said. “I check once, now, and I move on. I still feel the urge, but I resist it, and then it passes. And as I get more practice, it is passing more quickly.”

She gave her husband a mock scowl. He had looked that it was not polite to bother the psychiatrist with her neuroses while we were at a party.

“{Theodore,” she said, “it’s not that I’m crazy. It’s just that my brain wasn’t turning the page.”

The Brain the changes itself, Norman Doidge, M.D. Penguin Books. 2007, 427 pages. Chapter 6-Brain Lock Unlocked.

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There are two books by Jeffrey M. Schwartz M.D. that go into the subject of Brain Lock and The Mind and the Brain.

Brain Lock is a four step self-treatment method to change your brain chemistry. It is a well researched method to change through free will where at best psychotropic drugs only serve as 'water wings' in the process rather than a lifelong treatment. His groundbreaking studies show that by using his Four Step program you can actually "rewire" you brain and modify your genetic disposition. The simplistic but demanding formula has an eighty percent cure rate (?). The four step procedure is Relabel, Reattribute, Refocus and Revalue.

The Mind and the Brain was co-authored by Sharon Begley who is the science editor for the Wall Street Journal. The sub-title of the book is Neuroplasticity and the Power of Mental Force. There is a chapter here called Free Will, and Free Won't that focuses on Free Will, mind over matter as well as the convergence of medicine, quantum physics and Buddhism. I found it a very well written and well organized chapter that added a whole new dimension on free will as well as to meditation as we practice it.

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Brain Lock

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Step 1: Relabel

Relabel answers the question, "what are these bothersome, intrusive thought?" the important point to keep in mind is that you must **Relabel these unwanted thoughts, urges and behaviors**. You must call them what they really are: **they are obsessions and compulsions**. You must make a conscious effort to keep firmly grounded in reality. You must strive to avoid being tricked into thinking that the feeling that you need to check or to count or to wash, for example, is a real need. It is not.

Your thoughts and urges are symptoms of obsessive-compulsive disorder (OCD), a medical disease. (**Obsessive** thoughts and **compulsive** urges) Mindful awareness is essential. Mindful awareness differs from simple, superficial awareness in that it requires you to consciously recognize and make a mental note of that unpleasant feeling, relabeling it as an OCD symptom cause by a false message from the brain.

In Relabeling, you bring into play the Impartial Spectator, a concept that Adam Smith used as the central feature of his book The Theory of Moral Sentiments. He defined the Impartial Spectator as the capacity to stand outside yourself and watch yourself in action which is essentially the same mental action as the ancient Buddhist concept of mindful awareness.

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Record your obsessive thoughts and compulsive behaviors on a tape recorder or in a diary.

Passivity is your enemy. Activity is your friend. The biggest enemy is boredom. Having something else you really need to do-something much more important than that nonsensical ritual-is a great motivator. People with nothing to do may not develop the mental and emotional strength to shift those gears in the brain and move on to a positive behavior.

Key points to Remember

- Relabel means calling the intrusive unwanted thoughts and behaviors what they really are: obsessions and compulsions.
- Relabeling won't make unwanted thoughts and urges go away immediately, but it will prepare you to change your behavioral responses.
- When you change your behavior, you change your brain.
- The key to success is to strengthen your impartial spectator, your ability to stand outside yourself and observe your actions with mindful awareness.

Step 2: Reattribute

“Unlocking your Brain”

Reattribute answers the questions, “**why don't these bothersome thoughts, urges, and behaviors go away?**” “**Why do they keep bothering me?**” “**what should I attribute them to?**”

The answer is that they persist because they are symptoms of obsessive-compulsive disorder (OCD), a condition that has been scientifically demonstrated to be related to a biochemical imbalance in the brain that causes your brain to misfire. There is now strong scientific evidence that in OCD a part of your brain that works much like a gearshift in a car is not working properly. Therefore, **your brain gets “stuck in gear.”** As a result, it's hard for you to shift behaviors. Your goal in the Reattribute step is to realize that the sticky thoughts and urges are due to your balky brain.

“IT'S NOT ME-IT'S MY BRAIN”

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Because these thoughts and urges make your life unbearable, you must devise active, positive strategies for working around them. you need to adapt, to keep telling yourself, “It’s not me-it’s just my brain.”

Key Points to Remember

- Reattribute means answering the questions “Why do these thoughts and urges keep bothering me? Why don’t they go away”? the answer is, because of a medical condition called OCD
- OCD is related to a biochemical imbalance in the brain that results in a malfunction of the brain’s gearshift. The brain gets “stuck in gear.”
- Because the brain is stuck in gear, its “error-defection circuit” keeps firing inappropriately. This causes very uncomfortable feelings.
- Changing your behavioral responses to the uncomfortable feelings and shifting to useful and constructive behaviors will, over time, make the broken gearshift come unstuck.
- As the brain starts to shift gears properly, the uncomfortable feelings begin to fade and become easier to control.

Step 3: Refocus **“Wishing Won’t Make it so”**

Refocus tells you what to do when you are trying to overcome those urges to do the compulsive behaviors. It instructs you to “work around” those nagging, troublesome thoughts by Refocusing your attention on some useful, constructive, enjoyable activity, such as gardening or playing a computer game. The key to the Refocus step is to do another behavior. When you do, you are repairing the broken gearshift in your brain. Your brain starts shifting more smoothly to other behaviors. The more you practice the Refocus step, the easier it becomes. That’s because your brain is beginning to function more efficiently.

But if you take OCD’s false messages at face value, you will spend your time fretting and worrying. “did that guy touch me? maybe he scraped against me when I wasn’t looking. Oh, my God. What does it mean?” Deep

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down, to be honest, you know it doesn't mean anything. You know that you are not contaminated because of your "encounter" with that mystery man. But without the Fourth Steps as tools to reassure you, the feeling is so strong that you're apt to buy into it.

One thing our patients at UCLA learn early is that no matter how real their obsessive thoughts with dangerous content may seem, they will never act on them. no one ever does anything morally objectionable because of OCD. Performing an activity that requires your full attention is an excellent way to diver yourself from your OCD symptoms. This is what Howard Hughes was probably doing when he was piloting his airplane..

Key Points to Remember

- Refocus means to change your behavioral responses to unwanted thoughts and urges and focus your attention on something useful and constructive. DO ANOTHER BEHAVIOR.
- This is the no pain, no gain step. You must be ACTIVE. You cannot be passive.
- Use the fifteen-minute rule: work around your symptoms by doing something wholesome and enjoyable for at least fifteen minutes. After fifteen minutes, make mental notes of how your symptoms have changed and try to Refocus for another fifteen minutes.
- Use your impartial spectatot. It will strengthen your mind.
- When you change your behavior, you change your brain.

Step 4: Revalue

Revalue is a natural outcome of diligent practice of the first three steps..Relable, Reattribute, and Refocus. With consistent practice, you will quickly come to realize that your obsessive-thoughts and compulsive behaviors are worthless distractions to be ignore. With this insight, you will be able to Revalue and devalue the pathological urges and fend them off until they begin to fade. As your brain begins to work better, it will become easier to see the obsessions and compulsions for what they really

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are. Your brain will function in a much more normal, automatic way. As a result, the intensity of your symptoms will decrease.

Key Points to Remember

- Step 4 is the Revalue Step
- Revalue means don't take your symptoms at "face value"—they don't mean what they say. See them for what they are.
- Work to Revalue in an active way, by seeing the reality of the situation as quickly and clearly as possible. Strengthen the clarity of your observation with assertive mental notes, such as "It's not me. it's just OCD.
- When you Revalue and devalue unwanted thoughts and urges, you are strengthening your impartial Spectator and building a powerful mind.
- A mind that can take note of subtle changes and understand the implications of those changes is a powerful mind.
- A powerful mind can change the brain by altering responses to the messages the brain sends.
- This is true self-command. It results in real self-esteem.

From the book *Brain Lock* (free yourself from Obsessive-Compulsive Behavior) by Jeffrey M. Schwartz, M.D. with Beverly Beyette.

The Four R's
Step 1. Relabel
Step 2. Reattribute
The two A's
Anticipate
Accept
Step 3. Refocus
Step 4. Revalue

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Kids Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder

Some kids like to wash their hands, but Sarah does it too much. She wants to stop, but her hands just don't feel clean enough and she can't make herself turn off the water. Sometimes she scrubs her hands until they are red and raw. After eating, she feels she has to wash again.

Because she spends so much time washing, Sarah has to rush to get to school on time. At school, she tries not to touch doorknobs or handrails, worrying that if she does she may catch a serious disease. Sometimes, Sarah gets behind in her classwork because she feels that she needs to keep checking it over and over.

During a quiz or test Sarah checks and rechecks every answer and erases anything that isn't perfectly straight or neat. Sometimes she erases so hard it tears the paper, but she can't help it. Sarah gets a bad feeling that if everything isn't exactly right, something terrible may happen. All this worrying, checking, and fixing takes so long that Sarah hardly ever finishes the test before time is up. So even though she knows the work, she often gets an incomplete mark or even fails.

Sarah tries so hard to hide her habits. She worries that she might be going crazy or that people would think she's weird if they knew what she was doing. Sarah knows that the time she spends washing and checking could be spent having fun with friends or doing her schoolwork, but she can't seem to stop herself. That's because Sarah has **obsessive-compulsive disorder (OCD)**.

What Is OCD?

OCD is a type of **anxiety** (say: ang-zye-uh-tee) that happens when there is a problem with the way the **brain** deals with normal worrying and doubts. Kids

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with OCD worry a **lot**. Sometimes they feel afraid that bad things could possibly happen to them, sometimes they feel that something bad could happen to people they love, or sometimes they feel like they have to get things "just right" and have to check to make sure.

Like Sarah, some kids with OCD are afraid of getting dirty or catching **germs**. Others always worry that their parents will get sick or hurt. Others worry that something bad might happen to them. Some kids feel that they have to say things a certain number of times, ask questions over and over again, or keep things super-clean as a way to keep bad things from happening.

Some kids even worry about thinking bad thoughts. They sort of believe that thinking bad things could make them come true.

People with OCD worry so much that they can spend many hours, or even the whole day, worrying about things and trying to make sure the bad things they worry about don't happen.

Normal Worry or OCD?

Of course, it's normal to worry now and then. Everyone does. Kids may **worry about** getting lost or that something will happen to their parents. They may sometimes feel afraid that they will get sick or hurt. It's normal for kids to worry once in awhile about burglars, **fires**, or earthquakes. Sometimes, worrying can help kids learn how to be safe and careful. Normal worries come and go without causing too much of a problem.

But OCD is much more than normal worry. Instead, the worry is really intense and it can happen over and over again. With OCD, the brain replays the worry thoughts and if nothing is done, the worry feeling can get worse and worse.

These frequent worry thoughts are called **obsessions** (say: ahb-**seh**-shunz), and the behaviors people do to try to make the worry thoughts go away are called **compulsions** (say: kum-**pul**-shunz).

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What Are Obsessions?

A kid who has OCD might have obsessions about illness or injury or cleanliness. And these obsessive worries just don't quit. The brain keeps repeating them instead of moving on to something else. It can be a lot like that awful song you hear that gets stuck in your head. No matter how much you don't want to hear it, your brain just keeps playing it back. The difference is that the obsessive thoughts come with anxiety.

Having upsetting thoughts that you can't get rid of can feel terrible and scary. And having so many worry thoughts can make it hard to concentrate on anything else. OCD can take the fun out of almost anything.

With OCD, someone may have obsessions about:

- germs or dirt
- illness or injury (involving the person or someone else)
- coming across unlucky numbers or words
- things being even or straight
- things being perfect or just right in a certain way
- making mistakes or not being sure
- doing or thinking something bad

What Are Compulsions?

Compulsions are the behaviors, or actions, that someone with OCD does to try to shut down the worry thoughts. Another name for compulsions is rituals. By doing compulsions, people with OCD hope to keep bad things they worry about from happening. They believe that doing a certain ritual will make the bad feeling go away and, for a while, it often does. They feel scared that if they don't do the ritual something bad will happen.

Of course, plenty of people who **don't** have OCD have rituals or actions that are important to them. Maybe you tap your pencil three times before starting a tough test or sing a certain song just before diving off the high dive. Perhaps you

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have a lucky number or even a lucky pair of socks. But OCD compulsions are much more than doing something just for luck.

Kids with OCD feel they **have** to do certain things over and over to feel protected from unlucky events or make the anxiety go away. Kids with OCD don't really **want** to be doing rituals. But when you have OCD, performing the rituals seems like that's the only way to feel safe from bad things happening.

And the more kids with OCD do these rituals, the more they feel like they have to do them. Kids with OCD can end up spending so much time on rituals that they have little time left for the things they really do want to do.

Here are some OCD compulsions:

- lots of hand washing or showering (doing this way more than usual or having a hard time stopping)
- counting (like having to count 25 white cars before going into school)
- touching (like touching every single fence post between home and the bus stop)
- checking things over and over (such as doors, locks, or stoves)
- doing things a certain number of times (like having to try on five dresses before leaving your room)
- arranging things in a very particular or neat way
- asking the same question over and over
- tying and retying shoes over and over until they feel just right

What Causes OCD?

Obsessive-compulsive disorder isn't contagious, so you can't catch it from someone like you can a **cold**. Second, kids with OCD have not done anything wrong or bad to get it. It's not their fault that they have it.

Nobody knows exactly how and why some people get OCD, though scientists are beginning to learn about it. Experts know that:

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- OCD runs in families. Many kids with OCD have another person in their family who has OCD or another type of anxiety. Exactly how OCD is passed on in a family is not yet known, but scientists are trying to learn about **genes** that may get passed on that make people more sensitive to worry problems like OCD.
- OCD comes from a problem with the way the mind handles messages about fear and doubt. This problem probably has to do with the chemicals that carry messages to nerve cells in the brain. If the flow of these chemicals gets "blocked," or if there is not enough of them, messages about doubts and worry seem to get "stuck." This leaves a person with a feeling that something's not right and creates lots of worry thoughts.
- In rare cases, OCD can start when the body's immune system responds to a **strep infection** in a certain way. When OCD starts after a strep infection, the symptoms appear suddenly and very intensely. Most people who get strep infections, though, **don't** get OCD.

Who Gets OCD?

Kids with OCD are not alone. In the United States, about 1 million children and teens, both boys and girls, have OCD. That's about 1 in every 200 children and teens. In some studies including adults, OCD was reported as commonly as 1 in 50 people. You might know someone who has OCD and not even realize it.

What's Life Like for Someone With OCD?

Living with OCD can be very hard. Compulsions often take up lots of time and energy, making it hard to finish homework, do chores, or have any fun. Some kids even find it difficult to go to school or make friends. Sometimes kids feel ashamed. They know the behaviors seem silly to other people, so they often keep it to themselves. It can be really difficult to talk about OCD! But dealing with something all alone can make it even harder.

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Sometimes, even parents and friends who know about a person's OCD have a hard time understanding that OCD is not just a bad habit. They might act impatient or make it seem like a person could just stop if he or she tried hard enough. But with OCD, the need to do rituals can feel too strong to ignore. Some kids say that OCD is like hearing a constant, nagging voice that tells them bad things could happen if they don't do certain things. Some kids say it seems like OCD takes over everything.

Treatment for OCD

Treatment can really help kids with OCD get better. OCD can be treated in two ways: with [medicine](#) and behavior therapy. Medicines that help brain chemicals work properly can help kids with OCD. How? These medicines can make the obsessions and compulsions feel less intense, and they also help tone down the worry and fear. By itself, medicine doesn't completely fix OCD, and many kids with OCD don't need medicine to get better. But for some kids, medicine sure does help.

With or without medicine, a special type of "talk therapy" is the most important part of treatment for kids with OCD. This type of therapy is called cognitive behavior therapy (also called cognitive-behavioral therapy). For most kids with OCD, cognitive behavior therapy helps them learn to deal with anxiety, to face fears, to resist compulsions, and to slowly but surely conquer OCD.

What's Behavior Therapy for OCD Like?

Lots of mental health specialists, psychiatrists, psychologists, and counselors (also called [therapists](#)) are trained to do the cognitive behavior therapy that works for OCD. The therapist might start by just getting to know the child and parents. The therapist might ask about favorite activities or TV shows, pets or hobbies, or particular sports.

The therapist will also ask some questions about problems with worry and rituals that the child has been having. Then the therapist will explain about OCD and how the cognitive behavior therapy works to help it get better. The

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therapist will help parents understand the child's OCD and what they can do at home to help it get better, too.

In cognitive behavior therapy for OCD, kids learn different ways to deal with their worries **without** doing a ritual. At first, it may seem hard to stop doing rituals, but the therapist can teach kids how to feel safe enough to try. It's definitely tough at first, but if they stick with it, kids begin to feel stronger and braver against OCD.

After learning about ways to get their worries under control, kids start to practice them. As with anything new (such as playing the piano or kicking a soccer goal), the more someone practices, the better he or she can do it. When kids practice what they learn in behavior therapy, they find out it actually works!

Kids with OCD usually go to therapy about once a week (or sometimes more often) for a while, then less often as they begin to get better. Getting better can take anywhere from a few months to a few years.

It's important to remember that with some help, kids with OCD can get better. Kids usually are really relieved when the symptoms of OCD get weaker and they begin to feel stronger. It feels good to be free of OCD!

Reviewed by: [David V. Sheslow, PhD](#)

Date reviewed: November 2007

<http://kidshealth.org/kid/feeling/emotion/ocd.html>

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Coping with Traumatic Stress Reactions

Importance of Active Coping

When ex-offenders take direct action to cope with their stress reactions and trauma-related problems, they put themselves in a position of power and start to be less helpless.

- Active coping means recognizing and accepting the impact of trauma on your life, and taking direct coping action to improve things.
- It means actively coping even when there is no crisis: coping is an attitude of mind and a habit that must be strengthened.

Understanding the Recovery Process

Knowing how recovery happens puts you in more control of the recovery process.

- Recovery is an ongoing daily gradual process. It doesn't happen through being suddenly "cured".
- Some amount of continuing reactions is normal and reflects a normal body and mind. Healing doesn't mean forgetting traumatic war experiences or having no emotional pain when thinking about them.
- Healing my mean fewer symptoms and less disturbing symptoms, greater confidence in ability to cope with your memoires and reactions, and improved ability to manage emotions.

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Coping with Traumatic Stress Reactions: Ways the DON'T Help

- Using drugs and alcohol as ways to reduce anxiety or relax, stop thinking about war experiences, or go to sleep. Alcohol and drug use cause more problems than they cure.
- Keeping away from other people. Social isolation means loss of support, friendship, and closeness with others, and more time to worry or feel hopeless and alone.
- Dropping out of pleasurable or recreational activities. This leads to less opportunity to feel good and feel a sense of achievement.
- Using anger to control others. Anger helps keep other people away and may keep bad emotions away temporarily, but it also keeps away positive connections and help from loved ones.
- Trying to constantly avoid people, places, or thoughts that are reminders of the traumatic event. Avoidance of thinking about trauma or seeking treatment doesn't keep away distress, and it prevents progress on coping with stress reactions.
- Working all the time to try and avoid distressing memories of the trauma (the "workaholic").

Coping with Traumatic Stress Reactions: Ways that CAN Help

There are many ways you can cope with posttraumatic stress. Here are some things you can do if you have any of the following symptoms:

Unwanted distressing memories, images or thoughts

- Remind yourself that they are just that – memories.
- Remind yourself that it's natural to have some sorts of memories of the event(s).
- Talk to someone you trust about them.

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- Remember that although reminders of trauma can feel overwhelming, they often lessen over time.

Sudden feelings of anxiety or panic

These are a common part of traumatic stress reactions, and include sensations of your heart pounding and feeling lightheaded or “spacey” (often due to rapid breathing). If this happens, remember that:

- These reactions are not dangerous. If you had them while exercising, they would not worry you.
- It is the addition of inaccurate frightening thoughts (e.g., I’m going to die, I’m having a heart attack, I will lose control) that makes them especially upsetting.
- Slowing down your breathing may help.
- The sensations will pass soon and you can still “go about your business” after they decrease.

Each time you think in these positive ways about your arousal/anxious reactions, you will be helping them to happen less frequently. Practice will make it easier to cope.

Feeling like the trauma is happening again (“Flashbacks”)

- Keeping your eyes open. Look around you and notice where you are.
- Talk to yourself. Remind yourself where you are, what year you’re in, and that you are safe. Trauma happened in the past, and you are in the present.
- Get up and move around. Have a drink of water, and wash your hands.
- Call someone you trust and tell them what’s been happening.
- Remind yourself that this is quite common traumatic stress reaction.
- Tell your counselor or doctor what happened to you.

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Trauma-related dreams and nightmares

- If you awaken from a nightmare in a “panic,” remind yourself that you are reacting to a dream and that’s why you are anxious/aroused...and not because there is real danger now.
- Consider getting up out of bed, “regrouping,” and orienting yourself.
- Engage in a pleasant, calming activity (e.g., listen to soothing music).
- Talk to someone if possible.
- Talk to your doctor about your nightmares: certain medications can be helpful.

Difficulty falling or staying asleep

- Keeping to a regular bedtime schedule.
- Avoid strenuous exercise within a few hours of going to bed.
- Avoid using your sleeping area for anything other than sleeping or sexual intimacies.
- Avoid alcohol, tobacco, and caffeine. These harm your ability to sleep.
- Do not lie in bed thinking or worrying. Get up and enjoy something soothing or pleasant; reading a calming book, drink a glass of warm milk, do a quiet hobby.

Irritability, anger, and rage

- Take a “time out” to cool off or to think things over. Walk away from the situation.
- Get in the habit of using daily exercise as a friend. Exercise reduces body tension and helps get the “anger out” in a positive and productive way.
- Remember that anger doesn’t work. It actually increases your stress and can cause health problems.
- Talk to your counselor or doctor about your anger. Take classes in “anger management.”

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- If you blow up at your family or friend, find time as soon as you are able to talk to them about it. Let them know how you feel, and what you are doing to cope with your reactions.

Difficulty concentrating

- Slow down. Give yourself time to “focus” on what it is you need to learn or do.
- Write things down. Making “to do” lists may be helpful.
- Break task down into small do-able “chunks.”
- Plan a realistic number of events or tasks for each day.
- Perhaps you may be depressed; many who are do have trouble concentrating. Again, this is something you can discuss with your counselor, doctor, or someone close to you.

Having difficulty feeling or expressing positive emotions

- Remember that this is a common reaction to trauma, that you are not doing this on purpose, and that you should not feel guilty for something you do not want to happen and cannot control.
- Make sure to regularly participate in activities that you enjoy or used to enjoy. Sometimes, these activities can re-ignite feelings of pleasure.
- Take steps to communicate caring to loved-ones in little ways: write a card, leave a small gift, phone and say hello.

Final Word

Experiment with these ways of coping to find which ones are helpful to you. Practice them, because, like other skills, they work better with practice. Talk to your counselor or doctor about them. Reach out to people in your family, and your community that can help. You’re not alone.

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What if I have Sleep Problems?

Many people who have been incarcerated experience sleep problems, for various reasons. Some individuals may suffer from nightmares related to prison, and wake up feeling terrified. Others may feel the need to stay awake to protect them from danger. For example, some ex-offenders who have been in prison may feel a need to “stand guard” at night, rather than sleep. Individuals may also have poor sleep habits that lead to insomnia, such as extended napping or an irregular sleep schedule.

What Can I Do If I am Having Sleep Problems?

We are creatures of habit. Our sleep habits can either make sleeping easier or more difficult. The following 10 suggestions have been shown to help reduce sleep problems:

1. **Keep bed only for sleep** – Do not watch TV, talk on the phone, review work, study, or solve problems while in bed. Go to bed when you are drowsy and ready for sleep.
2. **If you don't fall asleep within 30 minutes, get up** – Go to another room and do something relaxing until you feel drowsy.
3. **“Wind down” before bedtime** – Do something calming, like light reading, listening to soothing music, praying, taking a warm bath, doing a crossword puzzle, or playing an enjoyable computer game before bedtime.
4. **Have a regular bedtime and rising time** – Go to sleep and wake up at the same time every day.
5. **Limit naps** – A mid-day nap as short as 10 minutes can improve mood and mental performance. However, limit your nap to 15 minutes and don't take it later than 4pm, or the nap may interfere with your sleep cycle.
6. **Increase regular exercise** – Just not too close to bedtime.
7. **Decrease stimulants** – Avoid smoking, or drinking coffee or soda with caffeine in the afternoon or evening.

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8. **Decrease alcohol** – Because alcohol causes mid-night awakenings, have no more than one serving of alcohol with dinner. Of course if you are in recovery from alcohol abuse, it is important to avoid alcohol entirely.
9. **Inspect your bedroom environment** – Is your bedroom dark and free of noise? Is your bed comfortable? Is the temperature comfortable? Do you feel safe and serene in your bedroom? If not, you can add images that are calming – a picture of your children, pet, an outdoor scene, a poem, or a prayer – to your room.
10. **Get help** – There are treatments that can help your sleep problems. If you continue to have sleep problems, see a trained sleep specialist to help identify what is the best treatment for you.

What If I Am Having Nightmares?

After a traumatic event, many people experience nightmares. For some, nightmares may continue to repeat for a long period of time. During nightmares, you may feel like you are “reliving” the event, with the same fear, helplessness, or rage experienced during the original trauma. Nightmares are not a sign that you are “going crazy”. They are a way of working through a trauma.

Some people try to avoid nightmares, by using drugs or alcohol, or by avoiding sleep altogether. These “solutions” only lead to new problems, such as substance dependence and sleep deprivation. When you wake up from a nightmare, leave the bedroom and go to another room to get your bearings. It may take a while to re-orient yourself to the present. Do something relaxing. If possible, reach out to someone who supports you. If you live with others, discuss the fact that you are having nightmares. Discuss ways in which you might want to handle the situation and share this handout with them. A small percentage of sufferers act out their nightmare in their sleep. You may want to rearrange your bedroom so that you are safe. If you share your bed with a partner, you may need to make sure he/she is not in harm’s way.

How Are Sleep Problems Treated?

There are effective treatments for sleep problems. Choosing one that is right for you will depend on the situation. Medications are available for quick, short-term

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relief of insomnia and nightmares. Some medications can be addictive, however, so check with your doctor to find out which is best for you.

Some “talk therapies” will help bring about long-term relief of sleep problems. “Cognitive Behavioral Therapy” targets your beliefs and behaviors that can make sleep problems worse. “Sleep Hygiene” Therapy helps people develop habits that can improve sleep. Breathing and relaxation therapies also may be used to help reduce muscle tension and promote sleep.

Therapies to treat nightmares are also available. For example, “Imagery Rehearsal Therapy” focuses upon helping people change the endings of their nightmares, while they are awake, so the dream is no longer upsetting. This therapy has been shown to reduce nightmares in survivors of combat and sexual assault.

Where Can I Find More Information About Sleep Problems?

National Center for Post-Traumatic Stress Disorder: www.ncptsd.org

National Alliance for the Mentally Ill: <http://www.nami.org/ContentGroups/HelpLine1/SleepDisorders.htm>

Stanford University Center for Excellence in the Diagnosis and Treatment of Sleep Disorders: <http://www.med.stanford.edu/school/psychiatry/coe/>

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Stress, Trauma, and Alcohol, and Drug Use

Drinking to Reduce Stress

Many ex-offenders experience stress related to their incarceration, and return home. These quite natural stress reactions can range from mild to severe and may be either short-lived or persist for a very long time. One common approach to managing stress that seems a simple and easy solution is use of alcohol or drugs. Ex-offenders, like civilians, may use alcohol and drugs as a way to relax or reduce anxiety and other bad feelings. In some cases, alcohol and drugs are not only used to decrease stress but also to manage severe symptoms that can arise from a traumatic experience in the prison. You might find yourself drinking or using drugs for a variety of reasons when under stress or after trauma, including to:

- Help yourself sleep
- Relax
- Decrease emotional pain
- “Drown” your worries
- Escape present difficulties
- “Shake off” stress
- Decrease sadness
- Help yourself be around others
- Increase pleasurable experiences
- Keep upsetting memories from coming to mind
- Calm anxiety

Becoming Dependent on Alcohol/Drugs

Initially, alcohol and drugs may seem to make things better. They may help you sleep, forget problems, or feel more relaxed. But any short-term benefit can turn

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sour fast. In the long run, using alcohol and drugs to cope with stress will cause a whole new set of very serious problems, as well as worsening the original problems that lead you to drink or use. Alcohol and drug abuse can cause problems with your family life, health, mental well-being, relationships, finances, employment, spirituality, and sense of self-worth.

Think about family impact as an example. It's difficult to create good relationships when you are regularly drunk or high. Being intoxicated decreases intimacy and creates an inability to communicate well. Family members can feel rejected by someone who is always under the influence. In addition, witnessing someone's behavior while under the influence can be distressing. Children may not understand the aggressive behavior, the shutting down, or the hiding out that can occur along with substance abuse. The fallout from an accident or an arrest can have a long-lasting impact on a family, Alcohol and drug problems are dangerous for loved ones, because they are often linked with family violence and driving while intoxicated.

When is Use of Alcohol a Problem?

It is hard to decide whether alcohol or drug use is becoming a problem. It can happen gradually, and sometimes can be hard to notice by the person who is using. Here are things that people sometimes say to themselves to convince themselves that they do not have a problem. Do you recognize any?

- "I just drink beer (wine)"
- "I don't use hard drugs"
- "I'm not an alcoholic"
- "I gave it up for 3 weeks last year"
- "I don't drink every day"
- "I've never missed a day of work"
- "I don't need help, I can handle it myself"

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Alcohol or drug use can be considered a problem when it causes difficulties, even in minor ways. Here are some questions that you can ask yourself to see if you are developing a problem:

Have friends or family members commented on how much or how often you drink?

Have you found yourself feeling guilty about your drinking or drug use?

Have you found yourself drinking (using) more over time?

Have you tried to cut down your alcohol (drug) use?

Does your drinking (using drugs) ever affect your ability to fulfill your personal obligations such as parenting or work?

Do you drink (use) in situations that are physically dangerous such as driving or operating machinery while under the influence?

Have you found that you need more alcohol (drug) to get the same effect?

If you find that you are answering “yes” to one or more of these questions, perhaps it is time to re-evaluate your use, cut back, and seek help from friends, family, or a professional.

What to Do if Alcohol or Drugs are Causing Problems

If you think that alcohol (drug) use has become (or is becoming) a problem for you, there are a number of things that you can do. First, recognize that you are not alone and that others are available to lend support. Second, find help. Getting help is the most useful tool in decreasing or stopping problem drinking or drug use, even if you have doubts about being able to quit or if you are feeling guilty about the problem. Call your health provider, contact a physician or therapist, call your local VA hospital, or contact your local Alcoholics Anonymous for guidance in your recovery. These contacts can help you on the road to the life you want.

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Listed below are some useful websites if you are looking for more information about alcohol and drug use or about how to get help.

Alcohol and Drug Abuse Information and Resources:

<http://www.alcoholanddrugabuse.com/>

National Institute on Alcohol Abuse and Alcoholism: Frequently Asked

Questions: <http://www.niaaa.nih.gov/faq/faq.htm>

Substance Abuse Treatment Facility Locator: <http://findtreatment.samhsa.gov/>

Alcoholics Anonymous Homepage: <http://alcoholics-anonymous.org/>

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Depression

Depression is a common problem in which severe and long lasting feelings of sadness or other problems get in the way of a person's ability to function. In any given year, as many as 18.8 million American adults – 9.5% of the adult population – experience some type of depression. Unlike a blue mood that comes and goes, depression is a persistent problem that affects the way a person eats and sleeps, thinks about things, and feels about him-or herself.

What are the Symptoms of Depression?

The symptoms of depression can vary quite a bit, but most people who experience. Depression feel down or sad more days than not, or find that things in their life no longer seem enjoyable or interesting. Additionally, people with depression may notice changes in their sleeping, eating, concentration, or feelings about themselves, and may find themselves, and may find themselves feeling hopeless. These symptoms typically last for at least 2 weeks without letting up.

What Causes Depression?

Depression has many causes. Difficulty coping with painful experiences or losses contributes to depression. People returning from a war zone often experiences painful memories, feelings of guilt, or regret about their war experiences, or have a tough time readjusting back to normal life. Trouble coping with these feelings and experiences can lead to depression. Some types of depression run families, and depression s often associated with chemical imbalances and other changes in the brain.

How is Depression Treated?

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There are many treatment options for depression. An evaluation should be done by a healthcare professional to help determine which type of treatment is best for an individual. Typically, milder forms of depression are treated by psychotherapy, and more severe depression is treated with medications or a combination of psychotherapy and medication. Your doctor can help you determine which treatment is best for you.

Psychotherapy. There are a number of types of psychotherapy (or talk therapy) that are used to treat depression. These treatments may involve just a few sessions, or may last 10-20 weeks or longer. Psychotherapy treatments tend to focus on helping patients learn about their problems and resolve them, through working with a therapist and earning new patterns of behavior to help decrease depression. Two of the main types of psychotherapy for depression are interpersonal therapy and cognitive-behavioral therapy. Interpersonal therapy focuses on the patient's relationships with other people, and how these relationships may cause and maintain depression. Cognitive-behavioral treatments help patients change negative styles of thinking and acting that can lead to depression.

Medication. In addition to psychotherapy, there are several types of antidepressant medication used to treat depression. These include selective serotonin reuptake inhibitors (SSRIs), tricyclics, and monoamine oxidase inhibitors (MAOIs). The newer medications for treating depression, such as the SSRIs, generally has fewer side effects than older types of medications. A healthcare provider may try more than one type of medication, or may increase the dosage, to find a treatment that works. Improvements in symptoms of depression typically occur after the medication is taken regularly for 3 to 4 weeks, although in some medications it may take as long as 8 weeks for the full effect to occur.

Antidepressant medications are typically safe and effective. They help patients feel less depressed and generally do not make people feel "drugged" or different during their daily lives. The side effects of depression medications vary depending on the medication, and can include dry mouth, constipation bladder problems, sexual problems, blurred vision, dizziness, drowsiness, headache,

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nausea, nervousness, or insomnia. Because of side effects or because they begin to feel better, patients are often tempted to stop taking their medication too soon. Some medications must be stopped slowly to give your body time to readjust to not having the medication. Never stop taking an antidepressant without consulting a doctor.

What Can I Do About Feelings of Depression?

Depression can make a person feel exhausted, worthless, helpless, hopeless, or sad. These feelings can make you feel as though you are never going to feel better, or that you should just give up. It is important to realize that these negative thought and feelings are part of depression, and often fade as treatment begins working. In the meantime, here is a list of things to try to improve your mood:

- Talk with your doctor or healthcare provider
- Talk with family and friends, and let them help you
- Participate in activities that make you feel better, or that you used to enjoy before you began feeling depressed
- Set realistic goals for yourself
- Engage in mild exercise
- Try to be with others and get support from them
- Break up goals and tasks into smaller, more reachable ones

Where Can I Find More Information About Depression?

National Institute of Mental Health Depression Fact Sheet: www.nimh.nih.gov/pubcat/depression.com National Alliance for the Mentally Ill: www.nami.org National Center for Post-Traumatic Stress Disorder: www.ncptsd.org

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Incarceration-related Stress Reactions:

Traumas are events in which a person has the feeling that he or she may die or be seriously injured or harmed, or events in which he or she witnesses such things happening to other s or sees their effects. Traumatic events are of course common in prison, but they are also common in the civilian world too, so that addition to prison experiences, many ex-offenders will have experienced one or more traumatic events in their civilian lives

When they are happening, traumas often create feelings of intense fear, helplessness, or horror for those who experience them. In the days and weeks that follow, they often create longer-lasting stress reactions that can be surprising, distressing, and difficult to understand. By understanding their traumatic stress reactions better, ex-offenders can become less fearful of them and better able to cope with them. While reviewing the list of effects of trauma below, keep in mind several facts about trauma and its effects:

- It is very common to have problems following exposure to prison or other trauma. But traumatic stress reactions often become less frequent or distressing as time passes, even without treatment.
- Ex-offenders with PTSD often worry that they are going crazy. This is not true. Rather, what is happening is that they are experiencing a set of common symptoms and problems that are connected with trauma.
- Problems that result from trauma are not a sign of personal weakness. Many mentally and physically healthy people experience stress reactions that are distressing and interfere with their daily lives at times.
- If traumatic stress reactions continue to cause problems for more than a few weeks or months, treatment can help reduce them.

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Traumatic war experiences may cause many of the following kinds of (often temporary) reactions in ex-offenders:

Unwanted remembering or “re-experiencing.” Difficulty in controlling distressing memories of prison is experienced by almost all trauma survivors. Although these memories are upsetting, on the positive side, these memories mean that a person has a chance to make sense of what has happened in order to gain mastery over the events. The experience of these memories can include: *unwanted distressing memories as images or other thoughts; feeling like the trauma is happening again (“flashbacks”); dreams and nightmares; and distress and physical reactions (e.g., heart pounding, shaking) when reminded of the trauma.*

Physical activation or “arousal.” The body’s “fight-or-flight” reaction to a life-threatening situation continues long after the event itself. It is upsetting to have your body feel like it is over-reacting or out of control. Again, on the positive side, these fight-or-flight reactions help prepare a person in a dangerous situation for quick response and emergency action. Signs of continuing physical activation, so common *difficulty concentrating; remaining constantly on the outlook for danger (“hyper vigilance”); being startled easily, for example, when hearing a loud noise (“exaggerated startle response”); and anxiety and panic.*

Shutting down: Emotional numbing. When overwhelmed by strong emotions, the body and mind sometimes numb. The ex-offender may, as a result, have difficulty in experience loving feelings or feelings some emotions, especially when upset by traumatic memories. Like many of the other reactions to trauma, this emotional numbing reaction is not something the ex-offender is doing on purpose.

Active avoidance of trauma-related thoughts and feelings. Painful memories and physical sensations of fear and activation can be frightening, so it is only natural to try and find ways to prevent them from happening. One way that most ex-offenders try is to avoid anything – people, places, conversations, thoughts, emotions and feelings, physical sensations – that might act as a reminder of the trauma. This can be very helpful if it is used once in a while (e.g., avoiding upsetting news or television

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programs). But when it is used too much it can have two big negative effects. First, avoidance can reduce ex-offenders' abilities to live their lives and enjoy themselves, because they can become isolated and limited in where they can go and what they can do. Second, avoiding thinking and feeling emotions connected with the trauma may reduce ex-offenders' abilities to recover from it. It is through thinking about what happened, and particularly through talking about it with trusted others, that survivors may best deal with what has happened. By constantly avoiding thoughts, feelings, and discussions about the trauma, this potentially helpful process can be short-circuited.

Depression. Most persons who have been traumatized experience depression. Feelings of depression then lead a person to think very negatively and feel hopeless. There is a sense of having lost things: one's previous self ("I'm not the same person I was"), sense of optimism and hope, self-esteem, and self-confidence. With time, and sometimes with the help of counseling, the trauma survivor can regain self-esteem, self-confidence, and hope. It is important to let others know about feelings of depression, and of course about any suicidal thoughts and feelings that are sometimes part of feeling depressed.

Self-blame, guilt, and shame. Many ex-offenders, in trying to make sense of their traumatic war experiences, blame themselves or feel guilty in some way. They may feel bad about some thing(s) they did or didn't do in the war zone. Feelings of guilt or self-blame cause much distress, and can prevent a person from reaching out for help. Therefore, even though it is hard, it is very important to talk about guilt feelings with a counselor or doctor.

Interpersonal effects. The many changes noted above can affect relationships with other people. Trauma may cause difficulties between a ex-offender and his or her partner, family, friends, or co-workers. The ex-offender who is experiencing high levels of irritability and anger may now have more conflicts with others and handle them less well. Particularly in close relationships, the emotional numbing and feelings of disconnection from others that are common after traumatic events may create distress and drive a wedge between the survivor and his or her family or close friends.

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Post Traumatic Stress Disorder & Relationships

Workshop presented at the North Florida/ South Georgia Veterans Health System 2008. This is was a workshop designed for those individuals suffering from PTSD and in committed relationships

- **Purpose of Workshop**
- Provide overview of posttraumatic stress disorder (PTSD)
- Facilitate greater understanding of the impact of PTSD on relationships (e.g., spouse/partner, children, social, vocational)
- Discuss the importance of coping skills and self-care
- Provide information on the various options for treating PTSD
- Recommend possible resources for additional supports
- Posttraumatic Stress Disorder (PTSD)
- **What is PTSD?**
- A psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as riots, violent crimes natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape.
- PTSD can develop at any age and symptoms generally develop within 3 months of the traumatic event.

However, development of symptoms can be delayed and may occur many

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months or even years after an event. Duration of symptoms may vary over time and can range from mild to moderate to severe.

- Symptoms (continued)
- Symptoms:
 - Reliving the experience through nightmares & flashbacks
 - Experiencing unwanted/intrusive memories , thoughts, images of the trauma, playing over and over in the mind
 - Having difficulty sleeping
 - Feeling detached or estranged from family, friends, etc.
 - Making efforts to cope with symptoms by avoiding exposure to reminders of the traumatic event
 - Feeling emotionally numb, yet angry, irritable, & fear becoming violent
 - Having problems with concentration, attention, memory
 - Being easily startled and constantly “on guard”

Note: The disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting.

- Remember!
 1. Trauma can affect anyone ...
 2. People who react to trauma are not “going crazy” ... they are simply experiencing symptoms & problems related to their trauma.
 3. Having symptoms of trauma after a traumatic event is NOT a sign of personal weakness ... many competent, well-adjusted people develop PTSD.

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4. By learning about and better understanding the symptoms of PTSD, an individual learns to be less fearful and better able to manage his or her symptoms.

- PTSD and Effects on the Family
- PTSD and Relationship Factors

1. For individuals struggling with PTSD, relationships are very important because they can be a source for ...

- a) Companionship and decreased sense of isolation
- b) Self-esteem (helps reduce depression and guilt)
- c) Support and encouragement to help reduce the effects of stress

d) Being able to feel like s/he is contributing to the well-being of others (helps to increase self-efficacy)

- PTSD's Impact on Relationships

1. Anger

- More frequent, extreme, intense, and “unpredictable”
- Aggressiveness more prominent and automatic
- May result in family & others becoming fearful of ex-offender, as well as angry themselves

2. Avoidance and Phobias (crowds, loud places)

- Hinders interpersonal connectedness, increased isolation
- partner and others may be rejected
- Family members may actually end up being isolated and unsupported

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- Could be related to decreased ability to trust others and oneself

- Family members may learn to avoid speaking of the traumatic event- rigid rules and deep secrets

3. Constant Arousal Mode

Increased irritability, problems with sleep, poor concentration, inability to relax, easily startled => increases family stress and decreases ability to be present and intimate

- Relational Aspects of PTSD

4. Increased Drug & Alcohol Use

- Oftentimes use to “avoid” feeling, thinking about trauma; to relax; to “fit in”; to feel powerful; help with sleep and nightmares

Signs of substance abuse/dependence

- Failure to fulfill responsibilities at home, school, work
- Using when situations are dangerous
- Increased fights, legal problems
- Continued use even with problems
- Needing increased amt to get desired effect
- Spending a lot time and/or money to get the substance(s)
- Relationships, PTSD, and Emotions

5. Depression

- Can “infect” others

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- like anger, is not just a feeling, it is a complex blend of thoughts, behaviors, emotions, physiological changes that create a sense of being “stuck” in a dark mood

6. Feeling emotionally numb (trouble having loving feelings or feeling any strong emotions)

- Partner, family members, etc. may be distant from ex-offender

7. Sleep Problems – due to nightmares, anxiety, etc.

- Can cause sleep problems for partner

- PTSD & Relationships...

8. Cognitive problems (concentration, memory, attention, etc.)

- May be frustrating for ex-offender and family member

- May present as inability to make decisions, so partner and family members may think it is best not to include ex-offender in decisions

- Others may feel that they can't dialogue with ex-offender

9. Faith Issues

- Loss of important beliefs, due to trauma and the atrocities witnessed, not feeling safe in the world, no predictability

- May cause family members to lose hope and feel lost

10. Identity & Self-Esteem issues

- Feeling like you are forever “damaged” or changed

- Believing that what they did is unforgivable (self-blame, guilt, shame)

- Feeling incapable of doing things they were capable of before trauma

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- PTSD & Parenting

11. Parenting

- Family members may become over-involved with their children's lives due to feeling lonely and in need of some positive emotional feedback, or feeling that the partner can't be counted on as a reliable and responsible parent.

- The partner may feel s/he must be the sole caregiver to their children if the survivor is uninvolved with their children (often due to trauma-related anxiety or guilt) or is overly critical, angry, or even abusive.

- PTSD and Effects on Relationships

12. Catastrophizing

- Ex-offender is controlling, demanding, overprotective, extremely anxious and fearful of things getting out of control – catastrophe!

- Family and others may find it difficult to interact w/ ex-offender or ask them for advice or input re: family matters

13. Health Problems

- Due to long term effects of agitation, stress, fear, hyper-arousal
 - May be due to avoidance of obtaining medical care b/c seeking treatment reminds ex-offender of trauma

- Can also be related to less than healthy coping skills (alcohol, drugs)

-Family members are also at high risk for developing chronic medical problems

- PTSD and Health (continued)
- PTSD may promote poor health through a complex interaction between biological and psychological mechanisms.

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- The experience of trauma brings about neurochemical changes in the brain. These changes may have biological, as well as psychological and behavioral, effects on one's health.
- Depressive and anxiety disorders, as well as hostility and anger (Type A personality) may lower well-being and physical health
- Some evidence to indicate PTSD is related to cardiovascular, gastrointestinal, and musculoskeletal disorders.
- PTSD and Effects on Relationships

14. Flashbacks

- Ordinary activities (i.e., shopping, movies, driving) may feel like ex-offender is reliving past trauma, due to flashbacks
- Unexpected changes may arise in ex-offender's demeanor, emotions, etc., because s/he goes into "survival mode" or on "automatic pilot,"
- "Anniversary Reactions" : Patterns of behaving/symptoms that relate to specific date of traumatic event
 - Family members may feel shocked, stranded, helpless, and worried
- PTSD and Effects on Relationships

15. Self-Harm Tendencies

- Individuals with PTSD are more prone to contemplate and attempt suicide than similar people who have not experienced trauma or are not suffering from PTSD.
- Family and friends may end up dealing with extreme worry, guilt, grief and anger

“ By understanding your symptoms you will feel less out-of-control...”

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- Elements of a Strong Relationship
- Emotional Intelligence
- Being able to identify and describe/label your emotions
- Being willing to own your feelings – taking responsibility!

Productive: “I feel ____ when ____.”

Non-productive: “**You** make me feel ____ when ____.”

- Being Emotionally Wise
- Picking battles wisely. Decide with whom, when, where, and how you want to express emotions... work with your partner to determine when it is good for them as well.
 - Decide how much of your emotion you want to express.
 - Skilled at both speaking and listening.
 - Taking a Closer Look

at Anger

- Identifying Anger
 1. Anger is a *normal emotion* that results when people think they have been mistreated.
 2. Many ex-offenders with PTSD have issues with anger control. **Why?**
 3. Anger is not healthy when:
 - Felt too frequently, too long, or too intensely
 - Results in inappropriate reaction/behaviors (e.g., hurting yourself or others)

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- Recovery takes a long period of time

- Remember:

PTSD is not an excuse
for violence!

- Taming the
Sneaky Anger Monster
(worksheet)

1. Make a list of “anger” triggers – What are those things that make you mad?
2. Identify the bodily sensations that signal anger
3. On a scale of 1-10, rate the level of anger for each trigger (1: complete calm; 10: loss of control)
4. Determine how you have handled anger in the past – and now list ways that you can better handle anger.

- Ways to De-escalate Anger

1. Leave the situation and come back later.
2. Talk it out with a partner, friend
3. Determine what might have caused the anger
4. Practice stress management techniques

- Listening & Speaking: Clues to a Successful Interaction

- How to Encourage a Positive Interaction

Verbal and nonverbal language

– Maintain eye contact (attending skills)

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- Practice “Congruency” (matching)
- Pick nonjudgmental words, be respectful, sensitive
- Monitor your rate, volume, intensity of speech
- Provide partner with validation (nod of head, saying something that let’s them know you are present)
- Being the Listener
 1. Bilateral Listening: Being able to hear the other person’s concerns, as well as your own...
 - Listen with the goal of: Understanding with empathy!
 2. Remain calm and attentive/focused: Don’t be occupied with counter attacks or creation of “assumptions”
 3. Be respectful and don’t interrupt.
 4. Don’t respond to partner’s complaint with a complaint or a “Yes, but...”
 - About Speaking ...
 1. Remain calm and remember that your speech is a fork in the road... you can CHOOSE smooth or rocky.
 2. Watch your body language
 3. Say how YOU feel
 4. Remove statements that can inflict harm
 5. Be direct and clear, but tactful
 6. Don’t criticize, demean, mind read/make assumptions

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- Dealing with Conflict
- For those with PTSD, conflicts are especially risky because they can serve as reminders of the trauma, as well as strong emotions.
 - Conflicts can trigger relapses. For example, after an upsetting conflict, the ex-offender may experience hopelessness, guilt, extreme anger, the desire to isolate, become depressed, and/or increase intake of substances.
- Tips for Managing Conflict – Problem Resolution
 1. *Be aware of thoughts & defenses:* When someone approaches you about needing to discuss an issue, watch your automatic thoughts & defensive reactions.
 2. *Choose and, if needed, schedule an appropriate time and place for discussion* – Strive to be CALM
 3. *Structure your discussion:* Deal with one issue at a time- Focus!
 4. *Don't entangle the discussion with past memories or hurts.*
- ... more Tips for Managing Conflict
 5. *Respect each other's needs:* Agree at the start that at any time, if one of you needs a break, the other will allow the pause.
 6. *Think Co-operation not Domination!* ~ Leave out the threats
 7. *Allow yourself to be "human"* – We do not have to be perfect or always right.
 8. *When you have covered the one issue – take a break!*
 9. *Celebrate your accomplishment – resolution!*
- Take Three Steps

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Step 1: Clearly state your initial positions

- Be as clear and direct as possible – think of your statement as suggested directions or guidance.

– “I would like _____”

- “I would like to leave the party by 9 pm tonight.”

– “I felt ___ when ___.”

- “I felt abandoned when you did not call me as promised.”

- Step 2 of Conflict Resolution

Step 2: Clearly state the related concerns

– “I would like ___ **because** ___.”

“I am afraid that if we do not leave early, I will be too tired to go to work in the morning.”

- Resolving Conflict... Step 3

Step 3: Develop solutions set that considers each person’s concerns. Consider *what you, personally, can do to* bring about a win-win situation.

– “I could plan to take a nap before going to the party.”

– “We could take two cars and I could leave earlier and you can remain.”

- Recycle and Fine Tune

- Look at the proposed solutions and discuss with one another if you agree.

- May need to recycle through, in order to fine tune

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- *“Are there any questions that still need to be addressed?”*
- Remember...
 1. Don't give-up – remember, most relationships can be mended and strengthened.
 2. Talk it through - helps to think more clearly, get another perspective, decide what to do next
 3. Practice self-care/coping skills – write down your thoughts, feelings, experience; exercise; find a support grp.; do something you enjoy ... Abstain from using substances to cope!
 - Taking Stock
 - Take some time and think about the important people in your life...
 - Do any of these relationships have problems or unresolved issues? If “Yes” (and all relationships have problems)
 - List down what you think may be contributing to these problems.
 - Think about your role in contributing to these problems, not so you can beat yourself up, but so you can figure out a new way to handle things.
 - How do you normally handle conflict? What do you like about how you handle conflict? What would you like to change?
 - Coping/Self-Care Skills
 - What is Stress?

An internal process that occurs when a person is faced with a demand that is **“perceived”** to exceed the resources available to effectively respond to it, and where failure to effectively deal with the demand has important undesirable consequences.

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- Stress – Good? Bad? Ugly?

1. Stress can be positive and negative.
2. Positive: Keeps us alert, serves as protective/survival mechanism, helps us with performance of tasks, etc.
3. Negative: Can wear you down and cause major medical and psychological concerns.

- Stressor

- Events, thoughts, etc. that cause our bodies to react with a stress response.

- It can be physical or psychological

Which one is the most frequent activator of the stress response?

- Strain

Negative consequences of stress, such as: fatigue, irritability, problems with concentrating, medical & physical problems, insomnia, depression, anxiety, over eating, drug and alcohol abuse, risk taking, diminished functioning, etc.

- How Stress Works...

- Ways to Handle Stress

<http://www.drnadig.com/stress.htm>

1. Increase awareness and address perceptions
2. Decrease the demands and/or increase capabilities
3. Decrease arousal and related tension(s)
4. Eliminate or decreased the negative results

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- Increase Awareness
- Know what triggers your reactions and how you respond to them (physically, emotionally, psychologically, etc.)

A - Trigger: Watch a war movie

B – Belief/perceptions: “I need to be on guard.”

C – Consequence/action/reaction: Irritable, fearful, easily angered by family, isolate

- Decrease Demands & Increase Capabilities
 1. Learn to be assertive (not aggressive) – setting healthy limits/boundaries
 2. Develop stress management skills
 3. Ask for help from others
 4. Acquire training to meet your needs
- Decrease Arousal & Tension
 1. Take a break – get some personal space.
 2. Relax and focus on something peaceful.
 3. Separate yourself from the trigger.
 4. Exercise
 5. Talk it out – or, journal about your concerns
- Lessening the Negative Consequences of Stress
 1. Plan “B” – Prepare for times of stress/anxiety

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2. Learn to accept what cannot be changed and work on those things that you can change!

3. Seek help... therapists, clergy, support groups, friends, etc.

4. Avoid triggers!

5. Monitor cognitions and reframe.

- Stress Management Techniques
- Diaphragmatic Breathing
- Imagery
- Meditation
- Listening to relaxing music
- Reading
- Yoga
- Exercise
- Eat balanced diet
- Maintain healthy sleep routine
- Seek social supports
- Learning to Breathe!

<http://www.noboundarieshypnosis.com/Breathing.htm>

- Take 10 Slow, Deep Breaths...

Make yourself as comfortable as possible... sitting or reclining with your spine straight and your arms and legs uncrossed. Close your eyes.

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- **Inhalation:** As you take your first breath, say silently, to yourself the number "One". Breathe in as deeply as is comfortable for you.... inhaling through your nostrils, filling and expanding your abdomen.

- 10 Slow Breaths

<http://www.noboundarieshypnosis.com/Breathing.htm>

- **Exhalation:** Breathe out fully and completely... through your mouth.... Allow all of the air to fully flow out of your body. Before you begin the next inhalation.... say, silently... to yourself, "Relax".

- **Repeat the above for each of the 10 breaths...** (numbers 2, 3, 4, 5, 6, 7, 8, 9 & 10) After the tenth exhalation is completed... slowly open your eyes and notice how relaxed you are.

- Relaxation Exercise (if time allows)

- Progressive Muscle Relaxation

- Imagery

- Ocean

- Mt Cabin

- Sanctuary

- Cloud

- PTSD and Treatment Options:
Psychotherapy & Medications

- <http://www.psychguides.com/ptsdhe.pdf>

- Treatment Option #1: Cognitive Therapy

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1. Learning to identify thoughts that are not healthy and may be irrational.
2. Learn to look for the evidence for and against those thoughts.
3. Learning to reframe unhealthy thoughts and develop more realistic beliefs.
4. Thus, being able to acquire more balance in your emotions.

• Treatment Option #2:
Anxiety Management

5. **Relaxation training:** Learn to control fear and anxiety by systematically relaxing your major muscle groups.
6. **Breathing retraining:** Learn to regulate your breathing (slow & through the abdomen) to achieve relaxation.
7. **Positive thinking and self-talk:** Learn to replace negative thoughts (e.g., “I’m going to lose control”) with positive thoughts (e.g., “I did it before and I can do it again”) when facing reminders of a stressor.
8. **Assertiveness training:** Learn how to express your wishes, opinions, and emotions without alienating others.
9. **Thought stopping:** Learn how to use distraction to overcome distressing thoughts (inwardly “shouting stop”)

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Anger Three Steps of the Imago Dialogue

Let's take a closer look at the three steps of the Imago Dialogue. The first is called "Mirroring." When one of you has something important to say, you begin by stating that the thought or feeling in a short sentence beginning with "I." For example, "I don't enjoy cooking dinner for you when you don't seem to appreciate all the effort involved." Your partner restates the sentence in his or her own words and then asks if the message was received correctly: "Let me see if I got it. You find it hard to put the effort into cooking dinner every night when I don't show my appreciation for all that you've done. Did I get you?" You repeat the process until your partner clearly understands what you mean to say.

Mirroring, like many of the tools we use in Imago Relationship Therapy, had its origin in my relationship with Helen.....

I was not a stranger to the value of listening. As a therapist, I made it a practice to listen carefully to all of my clients. I also encouraged couples to listen closely to one another. But I had always viewed mirroring as a way to help them understand each other's words and solve specific problems. Until that experience with Helen, I hadn't realized that mirroring has a deeper healing effect: it can strengthen the feelings of connection between couples, giving it a value in and of itself.

After a few years, I added another step to the mirroring portion of the exercise. Once the receiving partner had understood what the sending partner had said, I coached the receiver to add these words: "is there more?" this gave the sender a chance to expand on the topic. "It takes me at least an hour to cook dinner, and I do my best to make it attractive and delicious. I feel sad when you eat without comment." The sender continues adding more information until he or she has no more to say.

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In my ongoing work with couples, I have found that this “tell me more” part of the mirroring exercise is one of the keys to its success. When you ask your partner to continue talking it sends the message that you care about your partner’s inner experience. This deepens the sense of connection between you. You benefit in another ways as well, because you gain enough additional information about your partner that you can more fully comprehend his or her point of view. Meanwhile, your partner discovers that being encouraged to keep on talking can bring up thought and feelings that he or she hasn’t been able to put into words before, saying them out loud at long last helps your partner integrate them into his or her sense of self and become more whole.

Although mirroring is a relatively straightforward process, it is very different from the way that couples normally talk to each other, a phenomenon which might be called a “parallel monologue.” Breaking the old habits can require a great deal of practice. Here’s an example of the common problems that people have with mirroring (it’s also a good example of a parallel monologue). The conversation took place at an Imago Workshop when I asked a couple to volunteer to come to the front of the group and talk about a sensitive issue, just as they would at home. Greg and Sheila, a young couple who had been living together for only a few months, volunteered. Greg stated the conversation.

GREG: Sheila, I’m really bothered by your smoking, and I’d like you to be more considerate when you smoke around me.

Because I had yet to introduce Sheila and Greg to the mirroring exercise, Sheila followed her natural instincts and responded with an automatic defense.

SHEILA: You knew that I smoked when you asked me to live with you. You accepted that fact in the beginning. Why are you always so critical of me? You should accept me as I am. You know that I’m trying to cut down.

Greg, operating on automatic pilot, returned her remarks with an intensified criticism. The conversation was turning into a tennis match.

GREG: I acknowledge your efforts to smoke less, but I find it is interesting that, when we come here and the sign in the dining rooms says “No Smoking,” you

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follow it. Yet I feeling invaded at home with the smell of tobacco smoke all over the place.

SHEILA: Well, this is not my home. And I feel I have a right to smoke in my own home.

Sheila delivered this last message with some force, and there was a smattering of applause from the crowd. The score was love-fifteen. It was time for me to referee.

HENDRIX: OK, Let's start this all over again and see if we can turn it into an exercise in connections, not confrontation. Greg, would you repeat your opening statement?

GREG: I'm really glad that we're making a home together, but, with regard to your smoking, when we joined together I didn't realize how difficult it was going to be for me.

HENDRIX: OK, Now I would like you to simplify that statement so it will be easier to understand.

GREG: Let's see....Your smoking bothers me. I didn't think it would at first, but it does.

HENDRIX: Good, now, Sheila, I want you to paraphrase Greg, trying to mirror his feelings and thoughts without criticizing him or defending yourself. Then I want you to ask Greg if you have heard him correctly.

SHEILA: I'm truly sorry that my smoking interferes-

HENDRIX: no, I'm not asking you to apologize. Just reflect back to Greg what he was saying, and show your understanding and acceptance of his feelings.

SHEILA: could he possibly repeat himself?

GREG: your smoking bothers me. I didn't think it would at frist, but it does.

HENDRIX: Now, try to feed that back to him with receptive warmth.

SHEILA: I think I'd rather stop smoking!

HENDRIX: take a deep breath and be aware that he is experiencing some discomfort at one of your behaviors. Rather than hearing it as a criticism of your behavior, hear it with concern for his well being. Whether it's justified or not, he is feeling uncomfortable, and you care about him. I know this is hard to do in front of a lot of people, and I know that this is an issue you feel strongly about.

SHEILA: what could be done-

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HENDRIX: No, don't try to solve it. You just want to paraphrase his message and the emotional content behind it, so that he knows that you understand what he is feeling.

SHEILA: (takes a deep breath) OK. I think I get it now, I understand that it really bothers you that I smoke. You didn't realize how much it would bother you until we actually started living together. Now you are very troubled by it. Is that what you are saying?

HENDRIXS: Excellent. I could hear Greg's concern reflected in your voice. Did that check out with you, Greg? Is she hearing what you have to say'?

GREG: Yes! (I could see his facial muscles relax) that's just how I feel. What a relief This is the first time she's ever really bothered to listen to me.

As Greg's reaction shows, there is a tremendous satisfaction in simply being heard, in knowing that your message has been received exactly as you sent it. This is a rare phenomenon in most relationships. After demonstrating this exercise for workshops groups, I send the couple back to their rooms so they can practice sending and receiving simple statements. Invariably they return to the group reporting that it was a novel, exhilarating experience. It is such an unexpected luxury to have your partner's full attention.

Validation

Once couples have become adept at mirroring each other, I encourage them to go on to the next step of the Imago Dialogue: validation. In this part of the exercise, they learn how to affirm the internal logic of each other's remarks. In essence, they are telling each other, "What you're saying makes sense to me. I can see how you are thinking, and why you would think that way."

.....Adding Validation to Mirroring

When I first worked with couples, the communication exercise stopped with mirroring. I didn't require them to go on and validate the internal logic of each other's messages. As I gained more experience, I began to see that validation is a vital step in the process. I remember the first time I asked a couple to add validation to mirroring. The two people, I'll call them Rita and Doug, were in their forties. Rita was a schoolteacher, and Doug was an insurance salesman. Their central problem was their inability to connect emotionally, when Rita tried

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to talk with her husband about something important, Doug would answer half heatedly and then emotionally withdraw. Over time, I learned that one reason he withdrew was that he often felt critical of her, and he was trying to keep from being her constant critic. In his own way, he was trying to improve the relationship. But, understandably, his unwillingness to respond to Rita infuriated her. To get the sense of connection she was longing for, he would raise her voice and exaggerate her statements until he would finally respond. As I write this, I can almost see Doug react to one of Rita's outbursts. He would start breathing very shallowly. His face would flush. Then he would cross his arms and lean his body away from her. If Rita persisted long enough, Doug would finally react. Unfortunately, his response, once it came, was cold and accusatory and served only to throw gasoline on her fire.

To help them break out of this destructive pattern, I taught them the mirroring exercise. It helped a great deal because Rita had to slow down her torrent of words, and Doug had to stay in contact. But the exercise did not produce the kind of results I was used to seeing. Their communication improved dramatically, but there was little enhanced sense of connection. At a loss, I remember turning to Rita one day and asking her, "What do you want from Doug that you're not getting?" Her response was immediate, "I want him to tell me that I make sense. That I'm not crazy." A light went on in my head. Rita wanted more than to be heard. Rita wanted more than to be heard. She wanted her thought processes to be validated. She wanted her husband to tell her that her worldview made sense. I turned to Doug and asked him if he would be willing to add another step to the mirroring exercise. As soon as he had paraphrased Rita correctly would he tell her that what she was saying made sense to him? Doug thought for a long moment and then said, "But what if she doesn't make sense to me?" I told him that he didn't have to agree with Rita or give up his own point of view in order to validate hers, he just needed to suspend his view of the world for a moment and make an honest effort to see hers. Doug thought it over and said he would try.

Rita made a statement-I no longer remember what it was-and Doug paraphrased it back to her. Instead of waiting for me to structure the next part of the exercise, however, Rita blurted out, "Well, do you agree, Doug?"

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For once, Doug was equally quick on the draw. “No,” he said belligerently, “I do not agree?”

Rita persisted, “Bud I make sense to you? Does what I say make sense? Do you think I’m crazy?”

“No, I don’t think you are crazy,” Doug said, “but I certainly don’t agree with you.”

Rita got out of her chair and grabbed Doug’s forearms. “So, what I say makes sense to you?”

“Yes,” Doug acknowledged, “when I see it from your point of view, yes, you do make sense. I just see things differently.”

I’ll never forget how Rita responded. She sunk to her knees in front of Doug and began crying. “That’s all I wanted to hear!” she said. “I haven’t heard that before, from you or from anybody! I’m not crazy! I make sense!”

Finally, someone was affirming her truth.

Even today, I am impressed by how aggressively each of us defends our separate reality. It must be connected to our fear of the loss of self. If I see it your way, I will have to surrender my way. If I feel your experience, I will have to invalidate mine. If what you say is true, then what I say must be false. There can be only one center of the universe and that center is me! But if I muster the courage to suspend my own point of view for a moment and then manage to see a fraction of your reality, something miraculous happens. First of all, you feel safer around me. Because I am no longer challenging your worldview, you can start to lower your defenses. As you do this, you become more willing to acknowledge a portion of my’ reality. Because I have abandoned my centrist position, you are more willing to let go of yours. To our mutual surprise, a draw bridge begins to descend on its rust hinges, and you and I connect.

EMPATHY

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THE THIRD STEP in Imago Dialogue is empathy. It makes sense that empathy would follow on the heels of validation. If you listen carefully to your partner, understand the totality of what he or she is saying, and then affirm the logic behind your partner's words, you are ready to acknowledge and respond to the feelings behind those thoughts. Your first task is to try to imagine what those feelings might be. If your partner's feelings are conveyed beyond his or her words, by facial expressions or tone of voice, you will have little trouble intuiting them. If your partner's feelings are not so obvious, you will have to imagine what they might be. In either case, you need to check with your partner to see if you perceived their feelings accurately."Given the fact that you said I neglected you, I'm wondering if you feel hurt by my neglect. Is that how you feel?" checking to confirm the accuracy respects your partner's reality and enhances your emotional "presence," an essential ingredient of healing. Asking for confirmation also deepens your partner's experience of empathy; he will think: "My partner is being very respectful of my feelings. She cares how I really feel."

For some people, validation of their thought processes is more important to them than validation of their feelings. But for others, empathy is the key to their healing. Once someone affirms their raw emotions, they begin to feel loved and whole. I hate to say it because it perpetuates our gender stereotypes, but, in my experience, women tend to value empathy more than men. At least at first. If you stop and think about, this makes sense. In our culture, indeed in most cultures, women are allowed to express their feelings more freely than men. Although this is beginning to change, many men still believe it is unmanly to disclose their emotions, especially their tender feelings of feelings of fear and weakness. So if we men feel uncomfortable showing our feelings to others in the first place, you can hardly expect us to want our partners to empathize with us should we happen to let a feeling slip out? We'd just as soon that they overlook the momentary lapse and focus on our steely logic instead.

Many women, on the other hand, have had the opposite experience. The culture has allowed them to keep more of their emotional wholeness, but they've had to live with men who are relatively devoid of feeling. Their partners not only fail to empathize with them, they'd just as soon ignore the fact that they have feelings altogether. "Why can't you be more rational? Why can't you be more like me?"

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When couples master the three-step process of mirroring, validation, and empathy, these gender differences begin to diminish. A man who is emotionally repressed starts to value empathy as much as his female partner the reason this occurs is that seeing and acknowledging his partner's feelings makes him more comfortable with his own. Meanwhile, a woman who is emotionally volatile can become less so. Because she no longer needs to amplify her feelings in order to have her stoic partner acknowledge them, she can express them with less force. This is especially true for anger. It is always surprising to me to see how quickly anger will dissipate once it's been received and fully acknowledged.

As you might imagine, the ease with which you can empathize with your partner depends a great deal on the situation. It's very easy to be sympathetic when the two of you share the same experience and react similarly to that event. Let's suppose you and I have just been through a major earthquake. We survived the quake without any injuries, and we are relieved to see that the house still stands on its foundation. But there were several frightening minutes when we both thought we were going to die. "I was so terrified!" your partner exclaims. You respond immediately, "I can see that you were! I was, too!" because you've had the same response to the same situation, there is no stretching involved. What you feel, I feel. We had the same reaction.

Empathy is a more challenging response. It is the ability to understand what another person is experiencing even though you have not had that identical experience. Let's assume that your partner was in the earthquake but you were gone on business 500 miles away. Your partner reaches you on the phone, describes the horrific event, and then cries out to you, "was so terrified!". Although you didn't experience the earthquake yourself, it's not too much of a stretch to imagine that you might have been terrified as well. "I can imagine you were," you reply with only a moment's hesitation.

Problems tend to rise when two people react quite differently to similar events. For example, your partner might be terrified of flying but you can fall asleep during takeoff or landing. You're going to have a harder time empathizing with your partner's fear because you've never experienced it in this situation. "Just breathe deeply, "You tell your partner." Think about something else, and the

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feelings will go away.” and, quite frankly, you wish that they would disappear. They seem so irrational. You want to deflect your partner’s feelings, not empathize with them.

The most difficult situation of all, however, may be those times when your partner has strong, negative emotions, and you, poor soul, seem to have triggered them: “I am so angry at you that you told Janice she could go to the movies when you know I already told her she has to stay home and clean her room! You always do this!” or “I felt so humiliated when I saw you flirting with Paul in front of all of our friends. You know how jealous that makes me!” Your instinctual response is to defend yourself and then counter attack. Being empathetic is the farthest thing from your mind. To do so requires tremendous discipline, practice, and emotional maturity.

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Controlling Anger – Before It Controls you

We all know what anger is, and we've all felt it: whether as a fleeting annoyance or as full-fledged rage.

Anger is a completely normal, usually healthy, human emotion. But when it gets out of control and turns destructive, it can lead to problems—problems at work, in your personal relationships, and in the overall quality of your life. And it can make you feel as though you're at the mercy of an unpredictable and powerful emotion. This brochure is meant to help you understand and control anger.

What is Anger?

The Nature of Anger

Anger is "an emotional state that varies in intensity from mild irritation to intense fury and rage," according to Charles Spielberger, PhD, a psychologist who specializes in the study of anger. Like other emotions, it is accompanied by physiological and biological changes; when you get angry, your heart rate and blood pressure go up, as do the levels of your energy hormones, adrenaline, and noradrenaline.

Anger can be caused by both external and internal events. You could be angry at a specific person (Such as a coworker or supervisor) or event (a traffic jam, a canceled flight), or your anger could be caused by worrying or brooding about your personal problems. Memories of traumatic or enraging events can also trigger angry feelings.

Expressing Anger

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The instinctive, natural way to express anger is to respond aggressively. Anger is a natural, adaptive response to threats; it inspires powerful, often aggressive, feelings and behaviors, which allow us to fight and to defend ourselves when we are attacked. A certain amount of anger, therefore, is necessary to our survival.

On the other hand, we can't physically lash out at every person or object that irritates or annoys us; laws, social norms, and common sense place limits on how far our anger can take us.

People use a variety of both conscious and unconscious processes to deal with their angry feelings. The three main approaches are expressing, suppressing, and calming. Expressing your angry feelings in an assertive—not aggressive—manner is the healthiest way to express anger. To do this, you have to learn how to make clear what your needs are, and how to get them met, without hurting others. Being assertive doesn't mean being pushy or demanding; it means being respectful of yourself and others.

Anger can be suppressed, and then converted or redirected. This happens when you hold in your anger, stop thinking about it, and focus on something positive. The aim is to inhibit or suppress your anger and convert it into more constructive behavior. The danger in this type of response is that if it isn't allowed outward expression, your anger can turn inward—on yourself. Anger turned inward may cause hypertension, high blood pressure, or depression.

Unexpressed anger can create other problems. It can lead to pathological expressions of anger, such as passive-aggressive behavior (getting back at people indirectly, without telling them why, rather than confronting them head-on) or a personality that seems perpetually cynical and hostile. People who are constantly putting others down, criticizing everything, and making cynical comments haven't learned how to constructively express their anger. Not surprisingly, they aren't likely to have many successful relationships.

Finally, you can calm down inside. This means not just controlling your outward behavior, but also controlling your internal responses, taking steps to lower your heart rate, calm yourself down, and let the feelings subside.

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As Dr. Spielberg notes, "when none of these three techniques work, that's when someone—or something—is going to get hurt."

Anger Management

The goal of anger management is to reduce both your emotional feelings and the physiological arousal that anger causes. You can't get rid of, or avoid, the things or the people that enrage you, nor can you change them, but you can learn to control your reactions.

Are You Too Angry?

There are psychological tests that measure the intensity of angry feelings, how prone to anger you are, and how well you handle it. But chances are good that if you do have a problem with anger, you already know it. If you find yourself acting in ways that seem out of control and frightening, you might need help finding better ways to deal with this emotion.

Why Are Some People More Angry Than Others?

According to Jerry Deffenbacher, PhD, a psychologist who specializes in anger management, some people really are more "hotheaded" than others are; they get angry more easily and more intensely than the average person does. There are also those who don't show their anger in loud spectacular ways but are chronically irritable and grumpy. Easily angered people don't always curse and throw things; sometimes they withdraw socially, sulk, or get physically ill.

People who are easily angered generally have what some psychologists call a low tolerance for frustration, meaning simply that they feel that they should not have to be subjected to frustration, inconvenience, or annoyance. They can't take things in stride, and they're particularly infuriated if the situation seems somehow unjust: for example, being corrected for a minor mistake.

What makes these people this way? A number of things. One cause may be genetic or physiological: There is evidence that some children are born irritable, touchy, and easily angered, and that these signs are present from a very early age. Another may be sociocultural. Anger is often regarded as negative; we're taught

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that it's all right to express anxiety, depression, or other emotions but not to express anger. As a result, we don't learn how to handle it or channel it constructively.

Research has also found that family background plays a role. Typically, people who are easily angered come from families that are disruptive, chaotic, and not skilled at emotional communications.

Is It Good To "Let it All Hang Out?"

Psychologists now say that this is a dangerous myth. Some people use this theory as a license to hurt others. Research has found that "letting it rip" with anger actually escalates anger and aggression and does nothing to help you (or the person you're angry with) resolve the situation.

It's best to find out what it is that triggers your anger, and then to develop strategies to keep those triggers from tipping you over the edge.

Strategies To Keep Anger At Bay

Relaxation

Simple relaxation tools, such as deep breathing and relaxing imagery, can help calm down angry feelings. There are books and courses that can teach you relaxation techniques, and once you learn the techniques, you can call upon them in any situation. If you are involved in a relationship where both partners are hot-tempered, it might be a good idea for both of you to learn these techniques.

Some simple steps you can try:

- *Breathe deeply, from your diaphragm; breathing from your chest won't relax you. Picture your breath coming up from your "gut."*
- *Slowly repeat a calm word or phrase such as "relax," "take it easy." Repeat it to yourself while breathing deeply.*
- *Use imagery; visualize a relaxing experience, from either your memory or your imagination.*

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- *Nonstrenuous, slow yoga-like exercises can relax your muscles and make you feel much calmer.*

Practice these techniques daily. Learn to use them automatically when you're in a tense situation.

Cognitive Restructuring

Simply put, this means changing the way you think. Angry people tend to curse, swear, or speak in highly colorful terms that reflect their inner thoughts. When you're angry, your thinking can get very exaggerated and overly dramatic. Try replacing these thoughts with more rational ones. For instance, instead of telling yourself, "oh, it's awful, it's terrible, everything's ruined," tell yourself, "it's frustrating, and it's understandable that I'm upset about it, but it's not the end of the world and getting angry is not going to fix it anyhow."

Be careful of words like "never" or "always" when talking about yourself or someone else. "This !&*%@ machine never works," or "you're always forgetting things" are not just inaccurate, they also serve to make you feel that your anger is justified and that there's no way to solve the problem. They also alienate and humiliate people who might otherwise be willing to work with you on a solution.

Remind yourself that getting angry is not going to fix anything, that it won't make you feel better (and may actually make you feel worse).

Logic defeats anger, because anger, even when it's justified, can quickly become irrational. So use cold hard logic on yourself. Remind yourself that the world is "not out to get you," you're just experiencing some of the rough spots of daily life. Do this each time you feel anger getting the best of you, and it'll help you get a more balanced perspective. Angry people tend to demand things: fairness, appreciation, agreement, willingness to do things their way. Everyone wants these things, and we are all hurt and disappointed when we don't get them, but angry people demand them, and when their demands aren't met, their disappointment becomes anger. As part of their cognitive restructuring, angry people need to become aware of their demanding nature and translate their expectations into desires. In other words, saying, "I would like" something is

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healthier than saying, "I demand" or "I must have" something. When you're unable to get what you want, you will experience the normal reactions—frustration, disappointment, hurt—but not anger. Some angry people use this anger as a way to avoid feeling hurt, but that doesn't mean the hurt goes away.

Problem Solving

Sometimes, our anger and frustration are caused by very real and inescapable problems in our lives. Not all anger is misplaced, and often it's a healthy, natural response to these difficulties. There is also a cultural belief that every problem has a solution, and it adds to our frustration to find out that this isn't always the case. The best attitude to bring to such a situation, then, is not to focus on finding the solution, but rather on how you handle and face the problem.

Make a plan, and check your progress along the way. Resolve to give it your best, but also not to punish yourself if an answer doesn't come right away. If you can approach it with your best intentions and efforts and make a serious attempt to face it head-on, you will be less likely to lose patience and fall into all-or-nothing thinking, even if the problem does not get solved right away.

Better Communication

Angry people tend to jump to—and act on—conclusions and some of those conclusions can be very inaccurate. The first thing to do if you're in a heated discussion is slow down and think through your responses. Don't say the first thing that comes into your head, but slow down and think carefully about what you want to say. At the same time, listen carefully to what the other person is saying and take your time before answering.

Listen, too, to what is underlying the anger. For instance, you like a certain amount of freedom and personal space, and your "significant other" wants more connection and closeness. If he or she starts complaining about your activities, don't retaliate by painting your partner as a jailer, a warden, or an albatross around your neck.

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It's natural to get defensive when you're criticized, but don't fight back. Instead, listen to what's underlying the words: the message that this person might feel neglected and unloved. It may take a lot of patient questioning on your part, and it may require some breathing space, but don't let your anger—or a partner's—let a discussion spin out of control. Keeping your cool can keep the situation from becoming a disastrous one.

Using Humor

"Silly humor" can help defuse rage in a number of ways. For one thing, it can help you get a more balanced perspective. When you get angry and call someone a name or refer to them in some imaginative phrase, stop and picture what that word would literally look like. If you're at work and you think of a coworker as a "dirtbag" or a "single-cell life form," for example, picture a large bag full of dirt (or an amoeba) sitting at your colleague's desk, talking on the phone, going to meetings. Do this whenever a name comes into your head about another person. If you can, draw a picture of what the actual thing might look like. This will take a lot of the edge off your fury; and humor can always be relied on to help unknot a tense situation.

The underlying message of highly angry people, Dr. Deffenbacher says, is "things oughta go my way!" Angry people tend to feel that they are morally right, that any blocking or changing of their plans is an unbearable indignity and that they should NOT have to suffer this way. Maybe other people do, but not them!

When you feel that urge, he suggests, picture yourself as a god or goddess, a supreme ruler, who owns the streets and stores and office space, striding alone and having your way in all situations while others defer to you. The more detail you can get into your imaginary scenes, the more chances you have to realize that maybe you are being unreasonable; you'll also realize how unimportant the things you're angry about really are. There are two cautions in using humor. First, don't try to just "laugh off" your problems; rather, use humor to help yourself face them more constructively. Second, don't give in to harsh, sarcastic humor; that's just another form of unhealthy anger expression.

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What these techniques have in common is a refusal to take yourself too seriously. Anger is a serious emotion, but it's often accompanied by ideas that, if examined, can make you laugh.

Changing Your Environment

Sometimes it's our immediate surroundings that give us cause for irritation and fury. Problems and responsibilities can weigh on you and make you feel angry at the "trap" you seem to have fallen into and all the people and things that form that trap.

Give yourself a break. Make sure you have some "personal time" scheduled for times of the day that you know are particularly stressful. One example is the working mother who has a standing rule that when she comes home from work, for the first 15 minutes "nobody talks to Mom unless the house is on fire." After this brief quiet time, she feels better prepared to handle demands from her kids without blowing up at them.

Some Other Tips for Easing Up on Yourself

Timing: If you and your spouse tend to fight when you discuss things at night—perhaps you're tired, or distracted, or maybe it's just habit—try changing the times when you talk about important matters so these talks don't turn into arguments.

Avoidance: If your child's chaotic room makes you furious every time you walk by it, shut the door. Don't make yourself look at what infuriates you. Don't say, "well, my child should clean up the room so I won't have to be angry!" That's not the point. The point is to keep yourself calm.

Finding alternatives: If your daily commute through traffic leaves you in a state of rage and frustration, give yourself a project—learn or map out a different route, one that's less congested or more scenic. Or find another alternative, such as a bus or commuter train.

Do You Need Counseling?

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If you feel that your anger is really out of control, if it is having an impact on your relationships and on important parts of your life, you might consider counseling to learn how to handle it better. A psychologist or other licensed mental health professional can work with you in developing a range of techniques for changing your thinking and your behavior.

When you talk to a prospective therapist, tell her or him that you have problems with anger that you want to work on, and ask about his or her approach to anger management. Make sure this isn't only a course of action designed to "put you in touch with your feelings and express them"—that may be precisely what your problem is. With counseling, psychologists say, a highly angry person can move closer to a middle range of anger in about 8 to 10 weeks, depending on the circumstances and the techniques used.

What About Assertiveness Training?

It's true that angry people need to learn to become assertive (rather than aggressive), but most books and courses on developing assertiveness are aimed at people who don't feel enough anger. These people are more passive and acquiescent than the average person; they tend to let others walk all over them. That isn't something that most angry people do. Still, these books can contain some useful tactics to use in frustrating situations.

- ***Remember, you can't eliminate anger—and it wouldn't be a good idea if you could. In spite of all your efforts, things will happen that will cause you anger; and sometimes it will be justifiable anger. Life will be filled with frustration, pain, loss, and the unpredictable actions of others. You can't change that; but you can change the way you let such events affect you. Controlling your angry responses can keep them from making you even more unhappy in the long run.*** <http://www.apa.org/topics/controlanger.html>

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Thirteen Steps Towards Anger Management

- Step 1. Learn to recognize the many faces of anger.
- Step 2. Admit that all angry expressions, good or bad, are the result of choices
- Step 3. Let go of excessive dependencies so your anger management is inwardly directed rather than externally determined.
- Step 4. Choose to relinquish your cravings for control in exchange for freedom.
- Step 5. Ground yourself in truth by setting aside idealistic myths.
- Step 6. Keep your lifestyle habits consistent with your emotional composure.
- Step 7. Live in humility rather than self-preoccupied pride.
- Step 8. Hold your defenses to a minimum; trust your healthy assertions.
- Step 9. Accept the inevitability of lonelishness as you struggle to be understood.
- Step 10. Relate to others as equals, neither elevating yourself above them nor accepting a position of inferiority.
- Step 11. Pass along to the next generation your insights about anger.
- Step 12. Avoid the temptation to rationalize your anger; assume full responsibility for who you are.
- Step 13. Be accountable for your ongoing growth and open about your anger management.

From *The Anger Workbook* by Les Carter, Ph.D. and Frank Minirth, M.D. as published by Thomas Nelson Publishers.

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Identifying your Anger

When most people think of anger, they picture a person in a rage. They have images of slamming doors, shouting, and intimidating communications. Certainly this is part of the angry response. But anger is not that one-dimensional. It is multifaceted; therefore it should not be stereotyped. It can be found in any temperament. Whether a person is shy or extroverted, perfectionistic or laid-back, he or she can show anger in many ways. We use the term anger to describe a number of expressions: frustration, irritability, annoyance, blowing off steam, fretting. It is important to realize how each of these reactions is tied to anger.....

The following inventory can help you in this process too. Check the statements that apply to you.

1. ___ Impatience comes over me more frequently than I would like.
2. ___ I nurture critical thoughts quite easily.
3. ___ When I am displeased with someone I may shut down any communication or withdraw
4. ___ I feel inwardly annoyed when family and friends do not comprehend my needs.
5. ___ Tension mounts within me as I tackle a demanding task.
6. ___ I feel frustrated when I see someone else having fewer struggles than I do.
7. ___ When facing an important event, I may obsessively ponder how I must manage it.
8. ___ Sometimes I walk in another direction to avoid seeing someone I do not like.

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9. ___ When discussing a controversial topic, my tone of voice is likely to become persuasive.
10. ___ I can accept a person who admits his or her mistakes, but I have a hard time accepting someone who refuses to admit his or her own weaknesses.
11. ___ When I talk about my irritations I don't really want to hear and opposite point of view.
12. ___ I do not easily forget when someone does me wrong.
13. ___ When someone confronts me from a misinformed position, I am thinking of my rebuttal as he or she speaks.
14. ___ Sometimes my discouragement makes me want to quit.
15. ___ I can be quite aggressive in my business pursuits or even when playing a game just for fun.
16. ___ I struggle emotionally with the things in life that are not fair.
17. ___ Although I know it may not be right; I sometimes blame others for my problems.
18. ___ When someone openly speaks ill of me, my natural response is to think of how I can defend myself.
19. ___ Sometimes I speak slanderously about a person, not really caring how it may harm his or her reputation.
20. ___ I may act kindly on the outside while feeling frustrated on the inside.
21. ___ Sarcasm is a trait I use in expressing humor.
22. ___ When someone is clearly annoyed with me I too easily jump into the conflict.

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23. ___ At times I struggle with moods of depression or discouragement.
24. ___ I have been known to take an “I-don’t-care” attitude toward the needs of others.
25. ___ When I am in an authority role, I may speak too sternly or insensitively.

Now go back through the inventory and count the number of statements you checked. Everyone will recognize some of these characteristics, so don't worry about marking them. If you checked ten items, your anger is probably more constant than you might like. If you checked fifteen or more, you can probably recount many disappointments and irritations. This indicates you are vulnerable to the extreme ill effects of anger, rage, and explosions or to guilt, bitterness, and resentment. But don't give up! Anger can be managed if you apply an awakened mind to it.

If you are interested in gaining a broader perspective of yourself, ask a close friend or family member to complete the inventory, answering the questions as he or she thinks you would respond.

From *The Anger Workbook* by Les Carter, Ph.D. and Frank Minirth, M.D. as published by Thomas Nelson Publishers. P 4 & 5.

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Why Anger breeds Anger

.....What was wrong with the exercise? First of all, some partners on the receiving end of the anger still felt threatened by the outburst, no matter how much they tried to deflect the torrent. Their old brains couldn't comprehend that their partner's anger was part of a clinical exercise. When the receiving partners felt threatened, they had a hard time feeling empathic. They might mirror their partner's experience and moan the right words—"I'm sorry you're in so much pain," but their primal instinct was to batten down the hatches or abandon ship.

There was another, more puzzling problem with the exercise. After the exercise, the partner who had vented the anger could feel angrier than usual in the coming days. The exercise that had been designed to *release* stored up anger seemed equally capable of *generating* it.

I began to understand why when Helen had started reading books about neuroscience. She was fascinated by this field, partly because it shed new light on relationship dynamics. She learned that the adult brain is far more adaptable than we first thought. I was intrigued and began reading the literature myself. I discovered that scientists have known for decades that a young person's brain is greatly influenced by experience. If nerve connections are not stimulated, they are "pruned" away. When a child has new experiences, however, new pathways are formed. This plasticity gives the child a highly efficient, adaptable brain, ready for all that life has to offer.

Once upon a time, scientists believed that the adult brain was hardwired, thus immune to experience. The only way the brain changed beyond adolescence, according to early thinking, was to lose neurons with advancing age. This bleak view of the adult brain has now been revised, thanks to sophisticated imaging devices that can show physical changes in brain activity. These images have made it very clear that what adults do, think, and even feel alters the physical structure of their brains. Although the adult brain is not as adaptable as a child's brain, it remains a highly responsive organ.

A number of studies have shown that the more time adults engage in a particular activity, the more nerve cells are marshaled to the task. The brain acts like a military commander summoning new troops as they are needed. In one such study, Harvard

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medical researchers instructed a group of volunteers to practice a simple piano exercise for two hours a day for a week. After each practice session, the neuroscientists took images of the volunteers' brains so they could measure the size of the area devoted to finger activity. By the fifth day, they observed a significant increase in the size and activity of that area. Apparently, one of the reasons that "practice makes perfect" is that repeating an activity commandeers more neurons to do the job.

Remarkably, researchers discovered that the same brain expansion takes place when people merely imagine doing a specific activity. As an extension of the piano experiment, the Harvard team asked another group of volunteers to imagine that they were playing a simple piece of music. They had no pianos in front of them. In fact, they were asked to keep their hands and fingers perfectly still. When the volunteers' brains were scanned at the end of a week, the scientists were amazed to see that the virtual piano players had the same expanded neural pathways as the people who actually played the piano. They had discovered that mental training and imagery can literally rewire the brain.

For the purpose of my work with couples, I was keenly interested in the fact that changing your thoughts can change your brain. In a type of therapy called Behavior Change Therapy, or BCT, people are trained in how to use their rational minds to challenge the thoughts and beliefs that can trigger depression. As an example, a person might generate this irrational train of thought: "I've made a number of calls to family friends, and only one person has called back. Nobody loves me anymore." Taken to its illogical extreme, it becomes "Because no one loves me, I'm going to be abandoned and die." The emotional part of the brain reacts to this depressing thought as though it were real, and the person feels rejected, lonely, and scared.

When people see the absurdity of this type of catastrophic thinking, they can begin to think more rationally: "So, people are not returning my calls. That doesn't mean they don't love me. They may be busy or out of town." Avoiding the doomsday thinking can prevent the depressive feelings.

Research now shows that BCT can relieve depression just as well as antidepressant medications. Brain scans help explain why. When people use their rational minds to defeat depression, the part of the brain that is linked with rumination and obsessive thinking calms down. On a computerized image, that area appears darker, indicating that less oxygen is being consumed. This calm state extends beyond the mental

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(Nkosi Johnson; a Zulu boy who died of Aids at the age of 12.)

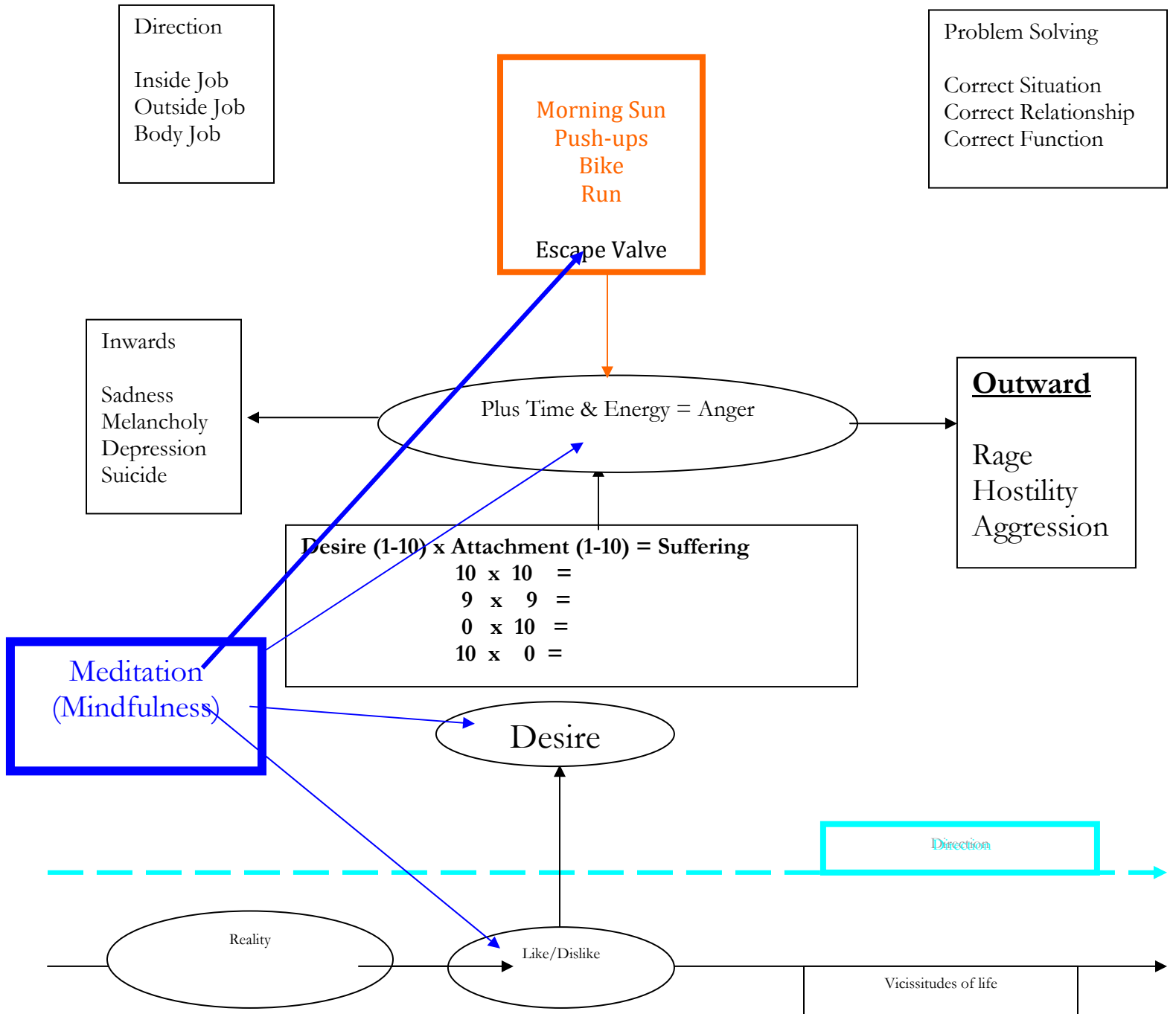
exercise. People trained in BCT can go through life with a less reactive brain, no longer triggering depressive or anxious thoughts. Once again, thinking alone has been shown to alter the physiology of the brain. Mind over gray matter.

Getting the Love you want, Harville Hendrix, Ph.D. , A Holt Paperback, 1988, page 189 – 191.

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Meditation/Mindfulness & Anger



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Conversational Hints

Starters:

1. Well tell me, what is it that you like best.....
2. What was the biggest thing that happened while I was gone.....
3. What was the best book you read last year.....
4. What do you like to eat when it thunders and lightning.....
5. What was your first job.....
6. What was the best movie you saw last year.....
7. When was the last time you left Florida.....
8. Do you cook much.....
9. Where is the best place to get a car fixed.....
10. What can I do for you.....
11. Tell me the three most important things I should know about you?
12. Do you like board games?
13. Where you ever in the military?

Keeping the conversation going:

You don't say.....

Then what happened?

How long ago did that happen?

Where did that come from?

You did that when?

Was it very hard?

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July 19th, 2007 in [Communication](#), [Featured](#)

How To Exit A Conversation

We've talked about making yourself [more approachable](#) and [initiating conversation](#). Now, hopefully, you've gone and got yourselves into some conversations you wish you hadn't.

There are 3 reasons you might stay in a conversation that you want to leave:

You're too polite - Many of us feel like it's rude to leave someone alone after talking to them for a few minutes. It isn't. People have things to do, and talking is just talking. As long as you excuse yourself politely, your exit will be comfortable.

You're afraid or lazy - Being in a conversation can be comforting and you might stick it out just because it's easier than heading out on your own into the 'unknown'. This isn't true and you might be selling your time short if you settle.

You don't know what else to do - Similar to the previous, this is counting on your lack of imagination. There is always something else to do and someone else to talk to. Grab a drink or hit the toilet and then [find a friend](#) or another contact.

There are plenty of situations that call for different kinds of exits. The only real rule I can think of is to stay polite. No matter where you are or who you're talking to, maintaining a civil attitude goes a long way - even when you're talking with a complete bastard.

At times it can be somewhat enjoyable giving someone the short end and letting them know how little you think of them. However, this is never productive or beneficial. You might just cause more trouble than it's worth.

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These first few examples can be used for brief encounters; those light conversations when you've made a drinking pal or just exchanged contacts for a possible project.

Excuse yourself - A simple "Excuse me" will suffice. There is usually no need for explanation. Don't feel compelled to justify your exit, it's no big deal. "I have to talk to so-and-so".

Leave an impression - Particularly in business related encounters, it helps to leave the conversation with something promising. Exchanging details and leaving by saying something like, "I'll get in contact with you tomorrow about this and that". Don't just say, "We'll talk" or "Let's work on something". Make a commitment to get something together. Shake hands and be on your way.

But, you don't want to see them again - The above example is counting on you actually wanting to talk with this person again. If that isn't the case, you still may not want to be vague about getting in contact. Don't say you want to work on something if it isn't true. Give them some details on how to find your [work](#), a website for example, and tell them they can see what you're working on there. This way they can gauge their own worth to your work and get in contact with you with some ideas.

Introduce a colleague - "I have to introduce you to so and so", works well. Introduce a third party and make sure to include a piece of information about either person. This should get another conversation going where you can slide off and make your exit.

It ain't all business!

I want to get right to the point with this one. Here's the situation: you've got yourself in a conversation with someone who isn't giving you much value. They're going on some rant about something you have very little interest in and isn't trying to engage in a real conversation. What do you do?

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Being polite and excusing yourself is still an option. But there are situations when this isn't enough. You're sitting at a party, shindig or what have you and you're essentially watching someone talk while you would rather just get up and do something, *anything* else.

Toilet and drink break - The easiest and most understandable. Skull the rest of your drink and get up. If you smoke, start rolling. If you're smart, you'll pick the option that can't possibly include this other person - for instance they're not a smoker.

Again, an introduction - As stated before, bringing a third party into the equation can work. Make mental notes of people who have similar interests with the person you're talking to and grab them when they are near. "Hey Mike, Jodie here just came from the snow. Didn't you have a board you want to sell?" Step away....

My friend's in trouble - Take a quick glance towards someone you know and tell your conversationalist you have to help them. "I'm sorry, Mike's had too much; I must go" or "Excuse me, but do you know when someone is in a bad conversation and they give a signal? Yeah, Mike just gave me the signal; I've got to help him".

Speaking of signals

You can usually tell if a friend is in a bad conversation, but it's handy to do the signal thing. Before you head into a party or gathering, think up something you'll each do if you want to get out of a conversation. A hand signal or a series of coughs etc.

This is very useful for people who have trouble getting out of bad conversations and will need someone's help. If you're the person to help them out, come in and just excuse them. Grab them by the arm and pull them away. The other person will assume it's important and not question it.

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Alternatively, you can come in with ‘big news’ or something you just have to tell your friend. It will no doubt supersede the existing conversation and possibly leave the other person no choice but to leave themselves. It’s a little anti-social, but works.

The fun way

Just because you’re in a bad conversation doesn’t mean you can’t have fun with it. There are a bunch of games you can play to entertain yourself. I’ll mention two that have different goals.

The first is to try and confuse the person into wanting to exit the conversation. You can achieve this by bringing the topic of conversation to something off topic, only constantly. Interrupt with strange anecdotes and respond incorrectly and indirectly to questions. Have your own conversation without considering what the other person is saying. Start your own rant.

The proper way

If you’re in a bad conversation, the actual proper and social thing to do is take charge. The funny thing is this is I see this done rarely. What you want to do is not succumb to someone’s poor choice of conversation or lack thereof, and rather gain control over the topic and how things run.

For instance, someone is ranting on about BMXs and it’s the only thing they seem to be able to talk about. The tournaments they’ve been in, how good they are and the latest gear they’ve bought. NO-ONE in the room wants to talk about bikes.

[Your job](#) should be to join his conversation and drive it to something people actually want to talk about. There are two basic ways to do this.

Interrupt - Begin talking, either to them or the other person [possibly your friend] about something completely different. Be confident and, most of all, direct. Ask a question that will change the topic instantly and will get someone else talking.

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Transition - Respond to something that this person has said and then direct the conversation elsewhere. “Is BMXing expensive?” “Oh really? I’ve been trying to save up for a holiday to Uruguay...” Yay! Holiday stories!

Participate

Generally, bad conversations result from someone not participating. There’s one passive listener who is allowing someone else to go on and on. If you ask questions and engage in *conversation*, all should work out.

You can do what you like in conversation. Not many people are that fragile that you wanting to leave is going to break them. If you want to talk about something else, do so. If you just want to talk to someone else, go do it.

But, be nice.

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May 12, 2008, 11:56 pm

What?

By [Marci Alboher](#)

According to [Gretchen Neels](#), a workplace consultant, most people have no idea when they are not listening — or when they are giving the impression to others that they are not listening. I wasn't surprised to hear that, having grown up in a family where conversation is more of a competitive sport than a polite interaction. In our home, talking over one another and interrupting were fairly standard, and as a result our communication probably suffered. Mastering listening, Ms. Neels says, allows you to get things right the first time, build better relationships and find the nuances behind what is being said.

Ms. Neels offers workshops in improving listening skills, and until I can get my family all together to attend one, I asked her for a quick tutorial on some ways to improve listening skills. Below, with some paraphrasing from me, are the six tips she provided:

1. Maintain good eye contact.
2. Sit or stand still without fidgeting. If you feel as if you may be losing concentration, shift around on your feet or in your seat, but try to do that while staying focused.
3. Try nodding your head or leaning in toward the speaker, both of which indicate to the speaker that you are listening, and also help you to stay engaged.
4. In a face-to-face or one-on-one situation, try “mirroring,” which means taking on the gestures of the speaker. So, for example, in an interview, if

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you are sitting across the table from someone and she leans her head to the right, you may try leaning your head to the left. While this might sound odd, apparently this kind of activity puts you into the same groove. Ms. Neels says that if you are with friends and feeling very connected, you are probably mirroring each other's body language since it something people automatically do in situations where they are comfortable.

5. If you are on the phone and you are taking in a lot of information, periodically repeat or summarize the information you are hearing. If you're not sure what is most important, you may want to recap what you have heard and ask for a clarification of anything you think you may have missed.

6. Finally, and Ms. Neels said this one is especially important: Do not interrupt, even if you think you're going to forget what you want to say. If you fear you will lose a thought, carry a pad and paper and make a note so that you can come back to it. Interruption is not only rude, it can undermine everything you are trying to accomplish. And even if you are truly listening, interrupting will convey the impression that you are not.

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The Happiness Project

http://www.happiness-project.com/happiness_project/2007/10/this-wednesda-3.html

Seven topics to avoid if you don't want to risk being a bore

I hesitate to disagree with the immortal La Rochefoucauld, but I think he was wrong when he wrote, "We are always bored by those whom we bore."

Not always (though I often remind myself of this observation when I'm feeling bored by someone else). I think that sometimes we find a topic so interesting that it's easy to lose sight of the fact that it might not be interesting to someone else. And most of us want to [make a good impression](#) and avoid boring other people.

Unless you get a truly enthusiastic response from your interlocutor—which is possible—be very wary of recounting...

1. A dream.
2. The recent changes in your child's nap schedule.
3. The route you took to get here.
4. An excellent meal you once had at a restaurant.
5. The latest additions to your wine cellar.
6. An account your last golf game.
7. The plot of a movie, play, or movie—in particular, the funny parts.

What do these subjects have in common? The listener has nothing to add. He or she must just hear you describe your experience.

Now, it's not as if these subjects could never be interesting to someone. A great story-teller, of course, can make anything interesting.

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And if a person has a child the same age as yours, or is a fellow oenophile, or is truly very curious about the latest addition to Philip Roth's oeuvre, you might have a happy conversational partner.

Be on guard, though, for glazed expressions, noncommittal grunts, or darting eyes.

And here's a point that I constantly prod myself to remember, because I love to tell a good, long, self-interested story as much as anyone: if you're having a conversation with someone, and it's interrupted, and that person shows no interest in picking up the thread of the dropped conversation, let it go.

"Oh, just to finish what I was saying, then we switched from I-95 to the Hutch, and then we took the next exit, which was wrong, so then we turned around and..."

Of course, the seven topics listed above are just examples. I'm sure I'm missing some topics on which it's easy to be boring. Any spring to mind? Help your fellow readers to [stay the life of the party](#)...

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The Invitation



It doesn't interest me what you do for a living.
I want to know what you ache for
and if you dare to dream of meeting your heart's longing.

It doesn't interest me how old you are.
I want to know if you will risk looking like a fool
for love for your dream
for the adventure of being alive

It doesn't interest me what planets are squaring your moon...
I want to know if you have touched the center of your own sorrow
if you have been opened by life's betrayals
or have become shriveled and closed
from fear of further pain.

I want to know if you can sit with pain
mine or your own
without moving to hide it
or fade it or fix it.

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I want to know if you can be with joy
mine or your own
if you can dance with wildness
and let the ecstasy fill you to the tips of your fingers and toes
without cautioning us to
be careful be realistic
remember the limitations of being human.

It doesn't interest me if the story you are telling me is true

I want to know if you can
disappoint another
to be true to yourself.
If you can bear the accusation of betrayal
and not betray your own soul.
If you can be faithless
and therefore trustworthy.

I want to know if you can see Beauty
even when it is not pretty every day.
And if you can source your own life
from its presence.

I want to know if you can live with failure
yours and mine
and still stand at the edge of the lake
and shout to the silver of the full moon,
"Yes."

It doesn't interest me
to know where you live or how much money you have.
I want to know if you can get up
after the night of grief and despair
weary and bruised to the bone
and do what needs to be done
to feed the children.

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It doesn't interest me who you know
or how you came to be here.
I want to know if you will stand
in the centre of the fire with me
and not shrink back.

It doesn't interest me where or what or with whom
you have studied.
I want to know what sustains you
from the inside
when all else falls away.

I want to know if you can be alone
with yourself
and if you truly like the company you keep
in the empty moments.

© Oriah Mountain Dreamer, from the book *The Invitation* published by
Harper San Francisco, 1999

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