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A Step-by-Step Plan to Convince a Loved One to Get Counseling

MARK S. KOMRAD, MD

Foreword by Rosalynn Carter, **Former First Lady of the United States**

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and cofounder of One Mind for Research

"My family did a fantastic job with handling the challenge of being related to me, but I think it would have made their burden much lighter if they'd had a book like this."

— Carrie Fisher, author and actress

"This is an authoritative and smart guide for the perplexed in need of care, written by an experienced clinician and teacher."

— Steven S. Sharfstein, M.D.,
clinical professor of psychiatry, University of Maryland

"How do I get my child/spouse/friend to see someone? *This is the most common question psychiatrists hear from families. I recommend this book to all of you in this predicament."*

— J. Raymond DePaulo, Jr., M.D.,
Henry Phipps professor and director, Department of Psychiatry
and Behavioral Sciences, Johns Hopkins Hospital

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The names, details, and circumstances may have been changed to protect the privacy of those mentioned in this publication.

This publication is not intended as a substitute for the advice of health care professionals.

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For my patients, who taught me everything in this book,
and my family—the "psychiatrist's psychiatrist"

"I found [mental health treatment] to be one of the healthiest experiences of my life. I grew up in a working-class family where that was very frowned upon. So it was very, very difficult for me to ever get to a place where I said I needed some help. You know, I stumbled into some different, very dark times where I simply had no other idea of what to do. It's not necessarily for everybody maybe, but all I can say is, I've lived a much fuller life. I've accomplished things personally that felt simply impossible previously. It's a sign of strength, you know, to put your hand out and ask for help, whether it's a friend or a professional or whatever."

— Bruce Springsteen

"Not everything that is faced can be changed, but nothing can be changed until it is faced."

— James Baldwin

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Foreword

Since I first began campaigning for my husband for political office, I have been interested and involved with people who have suffered from mental health problems as well as their families and the communities in which they live. I've written books about how effective the treatment for these problems has become but how difficult access to that treatment can be. As the President's Commission on Mental Health informed my husband back in 1979, so many people who would benefit from it are not getting mental health care. For some, this is because of where they live; for others, it's because of who they are. Reaching out for help, however, is sometimes the most difficult step. Often, people don't know how or when or even whether to seek help. It may be that others—family, friends, coworkers—are the first to see that someone is troubled and could benefit from seeing a trained professional in order to understand the nature of the problem and how it can be addressed. Our children, the elderly, our incredibly stressed veterans, those whose lives have been crushed by economic setbacks or disaster, those raised in hardship, or those who have inherited mental illness—all need to have some way to get started, some assistance to reach out for help and begin their process of recovery.

If you are that family member or friend who first really grasps that someone may be in emotional trouble, this book

can give you sound guidance about how to approach the individual. There are so many reasons why he or she may not believe or be aware that there is a problem, or perhaps doesn't want any kind of professional help, or simply may not know how or where to start.

The father of medicine, Hippocrates, wrote over 2,400 years ago: "diagnosis is half the cure." Comprehending the problem is the first step in the journey to recovery. Modern psychiatric treatment starts with trying to determine that knowledge. Since I first got involved in mental health advocacy, much more has been learned about the brain and mind to further our understanding of how someone's mental life becomes troubled and what to do about it. So, that first step—getting to a professional who can begin to sort things out, do an evaluation, make a proper diagnosis, and get treatment started in the right direction—is crucial.

Much can stand in the way of getting professional mental health treatment. I've been working for years trying to improve access for people to get the help they need. At the most basic level, though, it starts with the troubled person in your life: the reason you have picked up this book. This person may be more or less agreeable to getting help, more or less aware that there is a problem. Sometimes all it takes is kind, supportive guidance. Sometimes it may take greater efforts at persuasion or mobilizing outside assistance.

Dr. Komrad has guided thousands of people (and those who care about them) in the process of taking the first step to getting a mental health evaluation and has spoken about it often on his radio show. His book will start you off with the simplest and more supportive approaches. If these don't work, he guides you toward stronger measures, as appropriate. Dr. Komrad points out the resources that

are available within families, communities, and even in the courts.

We have come a long way in the understanding and treatment of mental disorders since I chaired the President's Commission on Mental Health in 1979. But we still have a way to go, and every effort is important. After all the policy discussions, legislation, and advocacy, it comes down to one person at a time starting down the path of evaluation, treatment, and recovery. Helping someone to get a proper assessment by meeting with a mental health professional is vital, even blessed work. I believe this book can help you do that work.

— Rosalynn Carter,
former First Lady of the United States

Acknowledgments

I would like to acknowledge the invaluable assistance of my "book doctor," Martha Murphy. I am a professional psychiatrist, but not a trained writer. Martha has schooled me in the craft of book writing, helped me navigate the strange world of publishing, and provided the kind of developmental editing that helped make this, my first book, more accessible to readers. My agent, Linda Konner, helped me make the invaluable connection with Hazelden Publishing. My wife, Kim, herself an experienced editor, gave the same glow to this manuscript that she brings to my life in general. I am grateful to Steve Sharfstein, M.D., for his mentorship, for his belief in this project, and for introducing me to Rosalynn Carter, who graciously wrote the foreword to this book. Her life's work, advocating for people who need psychiatric treatment, inspires me. Finally, I appreciate my editor, Sid Farrar, at Hazelden, who helped to transform a manuscript that should be read into a book that is worth reading.

Introduction

"The only end of writing is to enable the readers to enjoy a better life, or better to endure it."

— SAMUEL JOHNSON

In the 1990s, I had a radio show on the American Radio Network called *Komrad on Call*, which was syndicated nationally. It was a call-in show, and my conversations with on-air guests and callers covered the spectrum of psychological concerns. Over the course of the show's four-year run, the single-most-common call-in question went something like this: *My sister* [brother/husband/wife/child/colleague at work] *is clearly experiencing some real emotional problems. I think she needs psychiatric help. How do I broach the subject?*

In my private practice, too, this has been a frequent query. And in social settings, I am often approached by someone who, in a low tone, poses the same question. I came to see that a need existed, and the seeds for this book were planted.

When you are worried about someone in your life, someone whose life is in a downward spiral, you may be struggling with this same quandary. You may have tried to help and been rebuffed; or you've helped and things *did* get better for a while, but now you see the old patterns reemerging. Maybe you haven't said anything because you

don't know what to say or fear a negative response ("Are you telling me I'm crazy?") if you suggest a mental health professional might be helpful. Are these problems beyond your capacities as a friend, spouse, colleague, or relative? What *can* you do?

If you have reached this point with a loved one, a roommate, a friend—the point where you know he or she has problems beyond your ability to remedy and it's time for professional help—I'm glad you're here. This book will give you the understanding and tools to help your friend get what is so obviously needed—a consultation with a mental health professional.

As a psychiatrist in practice for twenty-five years, I meet with people who have concerns just like yours. They want to help someone, but they aren't sure whether to get involved, how to get involved, or how to help. During my years in practice, I have not only helped people with their own mental health problems but also coached caring people who want to know how to help a troubled friend or relative.

When I recall dramatic mental illness stories in the media, I am repeatedly struck by how often friends and family had observed the person become increasingly troubled, knew that this was abnormal, figured *something* was wrong in that person's mental life, but didn't say anything, do anything, or consult with anybody else about what they were seeing. The silence in these onlookers has always struck me as deafening. A caller to one radio show after the Tucson massacre where Congresswoman Gabrielle Giffords was shot described how her own son had a psychotic break at age eighteen. Later, when she spoke to his friends, they confessed they had seen the emergence of hallucinations and delusions in her son for a couple of months, but never

told his parents, or anyone else. He was showing things to his friends that he was able to hide from his family, but those friends said nothing. I had to write this book because I came to understand that one of the major missing pieces in approaching people with psychiatric problems is the efforts of friends and loved ones in directing them toward treatment. Those efforts are sometimes not even attempted or, if attempted, are ineffective. It is often left to the legal, medical, or mental health systems to get people into treatment. Those systems are quite imperfect. In contrast, family and friends are some of the most powerful forces in people's lives, and they can sometimes have far more effective (and benign) influence in getting people into treatment.

What stops most people who want to help is not knowing how to begin to talk to a troubled person. It's awkward. The person's responses can be sharp and rejecting. And so many areas are unfamiliar—where to turn for help, how to access resources that are already in place, how to learn about mental illness and its treatment, how to use legal mechanisms that can help people get treatment, how to link up with organizations that can help guide and support the process. Most people know how to help a friend who has discovered a lump in her breast. *Call your doctor right now and get in for an exam and mammogram!* In contrast, very few people know how to approach a friend or relative with an emotional problem. In this book, you will learn why it is vital to get beyond that awkwardness and be able to start the conversation. To say, *Can we talk?*

I know there are many reasons why you have avoided this conversation or had difficulties with it, and the chapters that follow examine those reasons. But know right now that there is no shame in needing mental health care.

State-of-the-art treatment for these kinds of problems can work very well, and people do *not* have to be "crazy" to avail themselves of such effective help. Many of us take comfort in finding that highly successful celebrities we admire have real-life problems, too. Actress Catherine Zeta-Jones has admitted publicly that she has bipolar disorder, and Congressman Patrick Kennedy and Carrie Fisher (Princess Leia from the *Star Wars* movies) have been frank about their bipolar disorder and substance abuse problems. One of the most famous psychotherapists in the nation today, Marsha Linehan, has admitted her own incredibly severe history of mental illness, which inspired her to develop pioneering and highly successful therapy techniques. Singer Bruce Springsteen, beloved by fans around the world, has been forthcoming about his clinical depression and how therapy helped him.

I became a psychiatrist because I always found psychological pain to be one of the most *human* forms of suffering. Physical pain is something that we closely share with our animal brethren. But depression, paranoia, anxiety, irrational obsessive thoughts, and other symptoms of mental distress are all particularly, if not uniquely, human. As a medical student, I discovered that ministering to this kind of suffering gave me a real sense of what it means to be a physician. Psychiatry allowed me to explore the deepest interior of others. I came to understand what Marcel Proust once eloquently wrote: "The only true voyage of discovery would not be to visit strange lands, but to behold the universe through the eyes of another."

The other reason I went into psychiatry was my belief in the power of words. Words are among the *most powerful* ways that human beings can influence the world, especially

each other. After all, in the Bible, speaking is the very tool with which God creates the entire universe: "And God *said*, let there be light!" I originally went to Johns Hopkins Hospital to train in internal medicine. In the middle of the first year, I was fed up with having so little time to spend with my patients. It seemed like I was constantly tracking down the results of lab tests and imaging studies. I was not particularly good with my hands either, so procedures like starting IVs—putting instruments into delicate tissues—were not easy for me. It was all very interesting, but not very satisfying. One night after being on call, I was walking in downtown Baltimore when I came across an unconscious homeless person lying on a steam grate. He was being ignored by everyone else on the sidewalk, and it was tempting to pass him by. I couldn't. I was able to arouse him and immediately saw that he was mentally ill. I called an ambulance and he was taken to a hospital down the street. Something inside me clicked during that act of reaching out. The next day I made an appointment to see Dr. Phillip Slavney, the director of residency training in the psychiatry department at Johns Hopkins, to find out more about the psychiatry residency. I lamented that I felt I wasn't very good with scalpels and such. What he said changed my life: "Well, you know, in psychiatry *words are our scalpels.*" *That* made sense to me. Words were something I felt competent wielding; their power was something I had experienced, both at the giving and receiving ends. I knew words could create, and destroy. Right there, on the spot, I asked if I could transfer over to the psychiatry residency program the next year. And I did.

Words that can help people change became my professional craft. In this book, I want to share words that can

help you help others. Speaking in ways that express concern, that do not shame, and that provide direction to help might allow you to reach the goal of this book: a professional evaluation for the person of concern in your life. Your words may, at times, need to be firm—even tough. Sometimes you may need to go beyond speaking with the particular person in trouble, speaking also with his or her family members, friends, doctors, clergy, and maybe even civil authorities. Sometimes, you may have to do more than talk—you may have to take firm actions.

Telling other adults what to do is far more difficult than guiding and steering children. Thus, this book focuses specifically on approaching troubled adults, where the challenge is the greatest. That other adult may be your grown child; in fact, it is very likely that you picked up this book because you are struggling with approaching your older adolescent or adult child. But most of the following ideas can apply as well to friends, a spouse, even coworkers.

My method here is not to explore individual psychiatric conditions in detail. Many excellent books and websites are already available that describe nearly every psychiatric disorder (and I have provided many references in the resources section on pages 241–256). Nor is this book about the specifics of treatments and the many different methods for treating mental health problems. You don't need to know the diagnostic term for what afflicts your person of concern; you don't need to know if you should get a book on depression, or addiction, or anxiety, or psychosis. You just need to know: "This person needs more professional help than I can give."

This book is divided into two sections. The first four chapters provide the background to help you understand why you might have come to need a book like this. These

chapters help you focus on your primary goal: getting the troubled person to seek a professional psychiatric evaluation. The last six chapters are a step-by-step practical guide to accomplishing that goal. If you are in a hurry to use the "how-to" portion of this book, you can go directly to chapter 5 and come back later to the first section.

- Chapter 1 helps you to see when it's time for professional evaluation—when things have become too serious for your efforts alone, and a threshold has been crossed. Your reluctance to get involved is squarely addressed, and you are encouraged to overcome your own natural resistance.
- Chapter 2 demonstrates that mental problems are widespread, and it discusses the consequences of untreated mental disorders.
- Chapter 3 reviews many possible reasons why the troubled-other hasn't sought treatment on his or her own—hence your need to help.
- Chapter 4 clarifies the core goal of this book: the initial professional evaluation of the troubled person. I review what happens in the mental health evaluation, some of the available treatments, and who best to do the evaluation. I will also give you tips about how to find an appropriate professional.
- Chapter 5 helps you consider the timing—good times to approach the troubled-other, and times you want to avoid. Also, the chapter helps you think about the right place.
- Chapter 6 helps you with the opening pitch, that is, how to begin to talk about the problem one-on-one. The chapter suggests effective communication strategies that have a chance of "getting to *yes.*"

- Chapter 7 is useful if the private communications of chapter 6 are ineffective. You are encouraged to think of allies who might join you in the effort and how to mobilize their influence.
- Chapter 8 steps up the pressure further, moving from talk to action, spelling out approaches to "therapeutic coercion." I will show you how to use the power inherent in your relationship to channel the person toward that all-important initial evaluation. Although very powerful, these measures have the potential for conflict, and you may be tempted to avoid them. Yet, it is failure to engage the troubled-other at this level that often accounts for failure to get that professional evaluation, which might open the door to proper treatment. I will fortify your resolve and skill in using these more challenging approaches, should they be necessary.
- Chapter 9 is for situations that are acute and dangerous, where the softball approaches of the previous chapters are either ineffective or too slow. Here you will learn how to utilize the systems society has in place for involuntary evaluation of acutely mentally ill people. This chapter also considers your personal safety and the safety of children.
- Chapter 10 gives tips about what to do *after* the goal of evaluation is reached. If you can attend the evaluation, this chapter suggests how to most effectively use your presence, how to connect and stay connected with the care provider, and how to support the ongoing treatment of your person of concern. It raises the consideration of professional help for you, should you need it. This chapter also addresses the possibility that, in spite of everything you have tried, you may

still have an unexamined or untreated person with continuing psychiatric symptoms on your hands. What then?

- The appendix summarizes the book's recommended process and methods for convincing a loved one to get help, as well as offering further steps to take should you run into resistance. You can use this list as a handy reference guide while putting the different suggestions from this book into practice.
- The resources sections list sources for further information and ways to find professional help.

I encourage you to read this book from beginning to end, and then return to the chapters that are relevant as you progress in your efforts to help your friend or loved one. It is possible that you are facing a very urgent situation in which the person you are trying to help is in danger, either because of the threat of suicide or violent behavior. There may not be time to read this entire book right now. Chapter 6 offers suggestions for approaching the subject of suicide with your loved one and resources for additional support. Chapter 9 will help you get rapidly acquainted with how to mobilize the authorities to assist in a suicidal or violent situation. You can also call the National Suicide Prevention Lifeline at 1-800-273-TALK or visit www.suicidepreventionlifeline.org for more information.

Numerous studies have confirmed my own clinical observations: compared to other health problems, psychiatric problems can cause some of the worst suffering; and not just to those people who have a mental illness, but to those people who live and work with the mentally ill. This book will offer solutions to that suffering. *You Need Help!* includes

stories of real, suffering people and those who struggle to help them. You will read examples of conversations you can initiate with your loved one, friend, or colleague. My hope is that reading this book will help you bring well-being and sanity to the life of the troubled person and to your own life as well. This book will give you hope and comfort that *something* can be done and that *you* can be instrumental in bringing about positive change.

What a person with a mental disorder really needs is *you*. Why you? Because you have a *relationship* with this person. You care about him or her. Your caring may have many faces: you may love him, you may have to raise children together, you may have to work together, you may share a loyalty that comes from experience or blood, you may have known each other for years, you may have great respect for him, he may have helped you in the past, you may have promised another person to care for him. Whatever the reason, enough caring exists for you to have picked up this book. That means that the other person cares about you in return—cares about your opinions, your feelings, and your ideas. Maybe the other's ability to experience that caring is dimmed by the mental problem itself. But, somewhere, behind the symptoms, an ember of a relationship with you still glows—an ember of warmth you can reach.

Hippocrates, the ancient Greek father of medicine, wrote, "Sometimes doing nothing is the best remedy." You've tried that remedy, and it has failed. You are now more than ready to access other remedies that are available in our time, more than two thousand years later. Turn the page. You can start learning how, right now.

1

Should You Get Involved?

"If I cannot do great things,
I will do small things in a great way."
— MOTHER TERESA

You are reading this book because someone you care about has *changed* in a way that concerns you—and is getting worse. This is a person with whom you have a close relationship—family member, friend, or coworker—someone you have known since long before the problem began. Now, on a regular basis, you are witnessing behaviors that seem out of character, and you are worried.

Should you ignore what you see and hear? Laugh it off? Deliver a pep talk? Or have things reached the point where your support alone would be insufficient? Perhaps you're beginning to sense that more substantial help is needed—help from a mental health professional. Yet, you're not sure if your hunch is correct or, even if it is, whether you should interfere. You may be wondering, *Why am I thinking about getting involved at all? Can't (my spouse, son, daughter, friend, colleague) seek mental health treatment without my assistance?* You are in an uncomfortable position, and you may be tempted to play the waiting game. How *do* you know

if you should get involved? The first step is recognizing when help *is* needed. Lonnie's friends wish they had.

• **LONNIE** •

Lonnie, a professional basketball player, had experienced a difficult childhood. His father had abandoned the family when Lonnie was five, and he was raised by a single mother in a poor inner-city neighborhood. She took great pains to protect him from the allure of gangs, scraping together the funds to enroll him in an after-school basketball league. He showed incredible natural talent and, with good coaching, Lonnie excelled. His success on the basketball court influenced him in the classroom and his grades improved. Eventually, he earned a basketball scholarship at a major southern university. After graduation, he was drafted into the NBA.

As happy as he was to be playing basketball for a living, Lonnie was not one of the stars on his team. Over time, he became jealous of the players who garnered the attention of the media and fans. At the same time, he was using cocaine and alcohol with increasing frequency. To those who knew him, he began to appear increasingly negative. Eventually, he began talking about not wanting to live. Some of his teammates ridiculed him for talking like this. His friends knew this was out of character but couldn't believe it was serious. After all, wasn't he making a lot of money, and at a "dream" job?

Lonnie began sleeping for twelve hours a day, missing practices, and becoming more temperamental. His friends were concerned, but figured, "It goes with the territory" of professional sports. When Lonnie

mentioned that he wanted to kill himself, his friend thought he was "just being dramatic."

One morning, Lonnie was found unconscious in a hotel room by a teammate who had come by to get him for breakfast. He had taken an overdose of a girlfriend's cocaine. That's when I met him, in the ER, where an ambulance had brought him. In addition to evaluating him, I spent time with his distressed friends, who were shocked and feeling guilty that they hadn't taken him seriously.

The Difference Between Ordinary and Serious Problems

In the United States today, many adults have slightly elevated blood pressure. Most of these folks don't need medication; a few changes in diet and lifestyle are sufficient to get their numbers down to a healthy range. Similarly, not every troubled person needs psychotherapy or medication. Psychiatrists and other mental health care providers recommend good mental health habits and encourage preventive measures—relaxation techniques, stress reduction techniques, meditation, exercise—all the things you read about in consumer magazines. Compared to psychotherapy or medication, these are considered "first aid" rather than "treatment." Psychotherapy and medication are powerful measures, and both have side effects. Treatment providers need to be certain that the gains outweigh the risks, and to obey the primary ethical mission of the Hippocratic Oath: "Above all else, do no harm."

The majority of problems with thoughts, feelings, and behaviors are run-of-the-mill, and most people can "work it out" themselves. We don't need professional mental health

experts for our common stresses and distresses. A good friend, someone who's a good listener, maybe even an attentive hair stylist, is enough.

What is the difference, then, between the everyday troubles we all face and "clinically significant" problems that can benefit enormously from modern treatment techniques? And how do you recognize the difference?

It's one thing to be down in the dumps—anxious about whether you can pay the bills, worried about your child's school performance, short-tempered with your kids, or sad that so many of your friends are dying (common among the elderly). It's altogether different, however, if you are so distressed or out of control that *your functioning begins to shut down*, or *you are hurting those around you*, or *you are destroying your relationships by slow degrees*.

What Is "Normal"?

Callers to my radio show would sometimes urge me to give an answer to a popular question: "What is normal anyway?" My answer was often, "Normal is just somebody you don't know very well!" When the laughing was over, I'd give Sigmund Freud's definition of normal: "The ability to love and work effectively." This is so clear and sensible it is still quoted by psychiatrists, to each other and to our patients. Let this be your guide: when things start to go significantly haywire in the world of love and work (and self-coping measures don't cut it), it's time to take advantage of some expertise. It's time to "get some help!"

When Is It Time to Get Professional Help?

There are many signs that a threshold has been crossed: You can't eat or sleep adequately. You are so exhausted you can't get up in the morning. You are unable to concentrate and

start making mistakes at work. You are angry all the time and so irritating to others that you are repeatedly rejected. You can't form an enduring attachment. Your temper outbursts are so bad you are fired from your job, or your spouse leaves you. As bad as it looks to the concerned onlooker, for the troubled person experiencing these problems, the need for professional help may not be obvious. That's why it often takes the concern of a friend, relative, or colleague to start the conversation.

The American Psychiatric Association (APA) has a list of ten warning signs that indicate the need for evaluation by someone with expertise in the mind and brain. Any *one* of them is enough to raise a flag that help might be needed:

1. Marked personality change
2. Inability to cope with problems and daily activities
3. Strange or grandiose ideas
4. Excessive anxieties
5. Prolonged depression and apathy
6. Marked changes in eating or sleeping patterns
7. Talking or even thinking about suicide
8. Extreme moods—highs and lows
9. Abuse of alcohol or drugs
10. Excessive anger, hostility, or violent behavior

The U.S. Department of Health and Human Services has published its own list of nine warning signs, which partially overlap the APA's. The list can be found on the website www.samhsa.gov/economy, under Getting Through Tough Economic Times:

1. Persistent sadness/crying
2. Excessive anxiety

3. Lack of sleep/constant fatigue
4. Excessive irritability/anger
5. Increased drinking
6. Illicit drug use, including misuse of medications
7. Difficulty paying attention or staying focused
8. Apathy—not caring about things that are usually important
9. Not being able to function as well at work, school, or home

Some Signs That Help Is Needed

Here is my own personal list, with real-life examples, of some basic signs that someone needs to "get help." What follows isn't intended to be a complete list—when a mother talks about wanting to kill her children, you don't need a mental health professional to point out that such a person is in need of *urgent* help. It is a list of the most common (yet serious) signals and circumstances that indicate mental health problems, and any one of them should cause you to take notice. Examples are grouped within categories, based on the nature of the problems. (Note: An asterisk (*) indicates that a certain behavior is more commonly seen in that gender.)

1. Making others suffer or feel scared:

- Behavior that repeatedly scares you (you fear for his* safety, your safety, or someone else's safety).
- A significant temper problem that is consistently frightening or intimidating to others, and he* is not aware that his temper is having that effect on others.

2. Problems taking care of or regulating one's self:

- She stops taking care of her basic hygiene—bathing, changing clothes, brushing teeth, etc.
- A change in sleep, appetite, or energy that has lasted at least two weeks.
- She starts doing things that seem reckless and are "just not like her"—such as drinking too much, going on shopping sprees and making impulsive purchases, going on frivolous trips, taking on an excessive number of projects, or needing less sleep (zero to four hours/night) without being tired the next day.
- She* keeps going to medical doctors for physical complaints and is repeatedly told that there are no significant physical findings, but continues to "doctor-shop," relentlessly searching for physical explanations for bodily complaints.
- She* tries to lose weight and can't stop dieting. Fear of being fat (despite being a fairly normal weight or even being slightly underweight) is dominating her thoughts and conversations.
- Day and night are reversed and he is sleeping most of the day and awake most of the night.
- He has repeatedly behaved in embarrassing or mean ways when drinking. Sometimes he doesn't remember behaving in these ways. You or others have mentioned to him that he might do well to cut back. He did, for a while, but that effort was short-lived, and the drinking is again frequent and disturbing to others.
- She* has deliberately cut or hurt herself, or tried to take her life.

3. Problems with thinking:

- He is making more mistakes than usual, forgetting important things, misplacing possessions, making unusual messes of the house or office. Be especially concerned if forgetfulness causes potentially dangerous situations (leaving the stove on, letting the bathtub overflow, etc.).
- She starts to talk about things that are obviously not true—saying she* is fat when she is really thin, thinking her walls and phones are bugged, believing there is some conspiracy against her, thinking she is dreadfully sick when there is little or no evidence of it, etc.
- He is increasingly confused and disoriented, and can't seem to think straight.
- She is seeing or hearing things that nobody else does.
- She* can't remember buying certain clothes in her closet, believes strangers call her by a different name (that she doesn't recognize), or can't remember what she did or where she was for hours at a stretch.

4. Intense feelings:

- She* is having anxieties that make it difficult for her to leave the house, or she fears "going crazy" or having a heart attack (often, under these circumstances, people will make multiple trips to the emergency room, and they will usually leave with a surprisingly good bill of physical health after the panic attack subsides).
- He has repeating and intrusive thoughts or rituals that he knows are irrational, but can't seem to control, often thinking thoughts or doing things until "it feels right to stop."

- He talks or writes about wanting to die, or he repeatedly wishes natural causes would "just take me."
- She believes that she should be punished for terrible things she has done (they might not seem so terrible to you). These things may have never bothered her this much before.

5. Problems relating or socializing:

- She has withdrawn from the things she used to do and from people she used to enjoy.
- He can't sustain significant social relationships, starts losing friends, becomes increasingly isolated, and can't initiate sustained intimate relationships.
- He* is having problems functioning sexually, or desiring sex, or is having highly unusual and risky sexual fantasies. Or he is engaged in sexual behaviors that are risky or hurtful to his partner.

6. Problems working:

- She can't seem to hold or get a job, especially if she has shown early promise by doing well in school; or she had a good work record for a while, but it suddenly goes awry.
- He used to be an adequate or better student, but his grades have been declining now for more than a semester. He is neglecting assignments, something he hasn't done before. He is not working at the same level as he used to and seems not to notice or care about this decline.

7. Traumatic life events:

- She* was sexually or physically abused as a child.

- He was exposed to some kind of accident or other event in which he believed his life was ending. Since then, he is having problems with a variety of functions such as concentrating and sleeping, and is experiencing frequent and inappropriate anxiety.
- She has experienced the death of a child or the loss of a family member by suicide.
- He or she has just experienced a marital separation or divorce or breakup of a longstanding, significant personal relationship.

As previously stated, these lists are not exhaustive. Moreover, these are *possible* warning signs of mental health problems. These might also be symptoms of physical illnesses—hormonal problems, cancers, metabolic problems, and so on. And even if it is determined that there is a mental health issue, the evaluation may not lead to treatment; sometimes the right approach is "wait and see." At the very least, however, a relationship needs to be established with a mental health professional so that if problems worsen access to help is in place. (Making the *second* call for help is much easier than the first.)

Problems with Thoughts, Feelings, or Behaviors

As you look over the preceding lists, it is helpful to think about the ways that things can go wrong as falling into one of three categories: problems of *thoughts*, *feelings*, or *behaviors*.

In general, treatment approaches to problems in each of these three areas are somewhat different, as we now understand that different neurological and chemical systems in the brain are relevant for thoughts, for feelings, and for

behaviors. Similarly, life experience can influence these three domains in different ways.

You've Changed

One thing clinicians look for is "change from baseline." We all have a baseline—a "business as usual" way of behaving, feeling, and living. Healthy people are surprisingly consistent in this way. So, when behavior deviates markedly from a long-established pattern, it should be considered a potential warning sign. This kind of change in a person's behavior is a critical sign of a possible psychiatric disorder.

An example of change from baseline that made headlines is the case of Lisa Nowak, the astronaut who suddenly deviated from leading an accomplished life that included a remarkably successful career in the astronaut corps. She began to behave in a way that was out of step with social norms and very unlike her "baseline" behavior. Eventually, armed with a variety of paraphernalia, she drove nine hundred miles to confront her rival in a love triangle, threatening kidnapping and mayhem. In clinical terms, her actions represented a "deviation from a prior, established baseline." Her behavior left no doubt in anyone's mind: *This woman needs help!*

More on Traumatic Life Events

Traumatic life events refer to having been through an experience that can predispose a person to mental health issues. A history of being physically or verbally abused as a child, witnessing repeated violence to others in a childhood household, the breakup of a major long-term relationship (especially a marriage), the death of a child and/or suicide of a loved one, or a near-death experience are some of the most wounding things that can happen to anyone. No one gets

through these events without significant emotional pain, embarrassment, or shame. These experiences can inflict scars on the psyche that critically alter the rest of one's life.

When such events are part of one's biography, psychiatric evaluation can be helpful even if there is *not* a current problem with thoughts, feelings, or behaviors. Why? It's very likely that there will be significant problems in these areas eventually. Effects are likely to eventually show up in relationships with one's children, coworkers, or significant others. They may drive a person to overwork, to be sexually compulsive, to be imperious with coworkers, or to demonstrate other problematic behaviors. The effects of traumatic experiences can manifest in a wide variety of dysfunctional behaviors or emotions, even if the traumatized person might *feel* that the memories are no longer specifically painful. Those experiences can still have a psychological legacy. Evaluation based on this kind of history *alone* offers an opportunity for a mental health professional to provide what is called "secondary prevention"—addressing a problem early to prevent it from leading to more hurtful consequences. If the evaluation doesn't reveal a current problem, it does create a connection with a health care professional—an open door that will be easier to walk through should symptoms emerge later. Think of it this way: if you had been in a burning building and inhaled smoke, you would get checked out by a doctor. It may turn out that no damage has been done. On the other hand, your lungs may have been scorched, which could lead to pulmonary problems down the road. Your doctor now knows you and can help anticipate and even prevent consequences.

When a marriage or a similar long-term committed relationship fails, I believe it is critical to debrief with an expert.

Sometimes when a significant relationship breaks up, people see themselves as more disturbed and "messed up" than they really are, and they need to be brought back to a more realistic view of themselves. Alternatively, people can dismiss the whole thing as the fault of an aberrant mate who is "the crazy one." It can be helpful to take an unflinching look at the emotional problems that you may have brought to the relationship, before possibly infecting your next relationship with those same problems. Either way, *all* individuals who experience the end of a significant committed relationship owe it to themselves, and to their future mates, to get some kind of expert evaluation, even if only a few sessions. This is *not* because they have an illness or disease or major clinical problem. They simply need to process what has happened in order to get back their sense of self, and to look at parts of themselves they may not have been able or willing to see. There is a principle well known to mental health professionals: a crisis often offers a valuable opportunity for critical self-examination. Even the stingiest insurance companies understand this. I have yet to see managed care reviewers deny coverage for psychiatric treatment (most commonly, talk therapy) of someone whose marriage is breaking up.

Should I Get Involved? The Moral Dilemma

Even if you've identified signs that your friend or loved one needs treatment or an evaluation by a mental health professional, you may not be sure you should intervene. You may question whether it's the right thing to do. Your internal struggle is not surprising. We live in a society that prizes individuality, individual rights, free speech, and self-determination. As a culture, we are highly suspicious of

anyone who wants us to curb our behavior in any way, except when we cross the threshold of hurting others or ourselves.

The balance between tolerating misbehavior and emotional malfunctioning on one hand, and the preservation of personal liberty and civil rights on the other hand, is a delicate one. Throughout the latter part of the twentieth century, civil rights have largely outweighed other considerations. This was the ethical argument behind ending forced institutionalization of the mentally ill, beginning in 1955, which ultimately led to the now 2.2 million Americans with untreated severe mental illness, of whom about 150,000 are homeless on any given day.

What gives anyone the right to get involved in another person's most personal business, his mental life, that most private of private realms? Are there legitimate, compassionate reasons to try and persuade someone we care about to go into treatment? There are, indeed, a few.

Consider this: If your mother was losing her memory and intellectual functioning, was leaving the stove on, letting the bathtub overflow, or wandering into the snow in her nightgown, would you hesitate to bring her to the doctor and secure her living environment? Probably not. You wouldn't speak about her eccentricity, her right to be different, and her freedom to do as she pleases. You would be crying out for help, and getting her to an expert as soon as possible. Perhaps you would justify this because she is "sick" and "in danger." Yet the idea of being "sick and in danger" is something that applies to a wide variety of mental health problems, not just dementia (senility).

When you are on the fence about getting involved in another's personal life, a review of the potential conse-

quences of untreated mental illness may prove to be the tipping point. These consequences include

- physical danger to self or others—physical violence, suicide, neglect of other health problems
- emotional harm to children—neglect, abuse, shaming, and emotional torment
- emotional abuse to partners or spouses
- financial problems
- accidents

Compassion Is a Moral Starting Point

It is heartbreaking to see another human being suffer in any way. Physical pain is something that we share with our animal brethren. But depression, paranoia, anxiety, irrational obsessive thoughts, and other symptoms of mental illness are uniquely human.

Our basic human empathy for the emotional pain of others causes us to respond with compassion. We want to *do* something to see our loved ones healed and their sufferings soothed. Why then, as a caring family member, friend, or colleague are we reluctant to suggest psychiatric help, let alone force it? Is it because we feel it's impolite? Is it because we are reluctant to meddle? Because we are afraid our friend will feel insulted, or become angry?

When someone you care about is in obvious emotional pain, giving a nudge toward a professional assessment or treatment is not meddling, it is *caring*. It is an expression of compassion. It is consistent with religious traditions to "Love thy neighbor as thyself."

In a pamphlet published by Hazelden in 1993 called *When Someone You Care about Abuses Drugs and Alcohol*,

the author talks poignantly about the obstacles faced when trying to help a loved one who is abusing alcohol and drugs. I find the situation applies equally well to *all* mental health problems:

> Why, when we have friends whose drinking behavior or drug use disturbs us, do we talk *about* them instead of directly *to* them? Is it because we are afraid? What are we afraid of? That our friends will become angry at us, will feel insulted and maybe even retaliate by telling us what they don't like about us? That we will not be considered *nice*? That it's rude and tactless to speak up when we are concerned about someone's behavior? That if we were a real friend, we would overlook almost anything? That our statement will be interpreted as criticism, and our friend will be hurt or react with resentment? All these fears come from a sense of propriety that is appropriate in certain situations. But if we're dealing with a friend who has a drinking or drug problem [or other psychiatric problem], silence can be deadly. Because when people who drink or use drugs are not held accountable for or made aware of their behavior, they may believe they're still okay and can get away with using a little longer.

Indeed, intervening on another's behalf with compassion is what medical ethicists call *beneficence*: doing something for the relief of another, rather than for ourselves. To approach another with beneficence requires three things. First, it requires the ability to see that someone is in distress. Second, it requires a clear understanding of your needs and

the other person's needs, so as to not confuse the two. Third, you need to know your limitations and when to call in additional help from an expert.

This third point is worth thinking about more closely. It is natural to try to talk with someone who is distressed, to give support, even to provide some advice. You don't have to be a bartender, hairdresser, or cab driver to have played that role. As a psychiatrist, I think about this kind of compassionate support as "first aid." But, when the bleeding starts—it's time to get the experts!

If you sense the problem is out of your league or you feel helpless in the face of the person's suffering, the compassionate—the *ethical*—thing to do is to convince that person to see a mental health professional.

Paternalism Is a Good Thing, If It Can Restore Autonomy

The word "paternalism" is out of fashion today. For young people, it conjures up images of controlling, authoritarian parents. For feminists, it calls to mind male-dominated patriarchy. Yet the concept of paternalism is one half of a pair of time-honored ethical concepts, the other half of which is "autonomy."

"Paternalism" is a word derived from the role a parent naturally has toward a child: caretaking, stewardship, and empowerment. What does paternalism hope to empower? One and one thing *only*—autonomy. "Autonomy" means an individual can choose his or her own actions. It is based on the assumption that the person is capable of making clear and rational decisions.

Medical ethicists have accepted the idea that sometimes, particularly when people are sick, the capacity to make rational decisions is diminished, even if only temporarily.

Then, the ability to act autonomously is lowered. In this circumstance, it is ethical and appropriate to exercise stewardship over the diminished person's welfare, according to the degree to which the person is impaired. This "taking charge" approach, helping do what needs to be done, taking the lead in getting help and making an intervention, is what we mean by "medical paternalism." Paternalism and autonomy are a seesaw in the arena of caring for sick people—when one is up, the other is down. For example, when a person arrives in the emergency room unconscious, it is ethically permissible to start medical interventions. As he recovers, awakens, and gradually gets his wits about him, more of his consent is sought with each improvement in mental clarity.

Of all things that can go wrong in the human body, a malfunctioning mind (sometimes due to a malfunctioning brain) has the greatest implications for a person's autonomy. As described later, in chapter 3, many psychiatric conditions can lead to states of reduced insight into one's self (like mania), produce a profound inability to relate to one's surroundings (like catatonia or delirium), or create irrational states of mind (like obsessive-compulsive disorder). So, by their nature, mental or emotional problems can diminish a person's autonomy. This invites (some ethicists might say *requires*) a paternalistic response on the part of those who are duty-bound, whether by profession or by the bonds of love and caring, to help. That means leading the way rather than watching, waiting, and hoping for the best.

You Are Not Being Selfish

Your desire to help someone get psychiatric treatment may also be due to your own needs, especially if you are feeling hurt, burdened, worried, or threatened by the person. There

is absolutely no shame in wanting some relief for yourself. Living with someone who has a mental illness or some kind of emotional disturbance can be challenging. Family members can suffer innumerable consequences because of a loved one's mental illness, including violence in a small number of cases. Life with a person who is de-pressed can be depressing, and quite frustrating. Emotions, both positive and negative, can become "infectious."

It can be hard to resist participating in the problem. Ron's story illustrates how easily one can be drafted into another's illness.

• **RON** •

For the last five years, Ron has been terrified of being contaminated by bacteria. He insists that his wife wipe off the bottoms of her shoes whenever she enters the house, take out the trash for him (he is too scared to touch it) five times a day, and flush the toilet for him. When the phone rings, Ron uses a tissue to pick up the receiver. He becomes incensed if his wife moves the box of tissues that he keeps by the phone. If she doesn't comply with these and the many other demands he makes to keep him from "contamination," he yells at her, insists that she doesn't care about him, even cries. She has found it easier to just give in and "keep the peace."

Sometimes, without meaning to, you become part of the problem and suffer the consequences of another's mental illness, even inadvertently supporting or enabling it. This is a remarkably common scenario. I have been shocked to see how long some families tolerate extreme behaviors without even *suggesting* the troubled person get help. Withdrawal,

anger, paranoia, depression, and other typical psychiatric symptoms rapidly take a heavy toll on others, far more so than symptoms of medical illnesses like fever, coughing, vomiting, or pain. What's more, psychiatric problems are often more chronic and enduring. They are wearing and corrosive to relationships, especially because (for reasons that will be discussed in chapter 3) they often take longer to get the attention they need compared to other medical problems. Let's face it: if someone is vomiting for two days, it's very likely that the doctor will be called. Depression can last months, even years, before a doctor might be called.

If *you* are in distress, know that it is quite common, appropriate, and expected to want to help someone for your *own* needs. Taking care of yourself is a first step in the process of helping another. If you have ever travelled by air, you are familiar with the flight attendants' instructions about the oxygen masks. What do you do if you are traveling with a small child? Do you put the mask on yourself or the child first? It is interesting how many veteran flyers answer this question incorrectly. The correct answer is that you put on *your* mask first before helping the child. This is because you need to take care of your own oxygen supply before you can help another who is less capable.

It may even be necessary for the helper to get some treatment of her own, which may include support for dealing with the person with mental health problems. Such counseling not only may help you keep your own head above water but also may show how you have unwittingly become part of the problem. You may see that you are enabling the problem by your need to "keep the peace." Perhaps the problem has triggered a psychiatric condition in you that needs treatment, such as depression or anxiety disorder. Getting

treatment for yourself, or other forms of support, is covered in coming chapters.

Not Every Problem Needs a Psychiatrist

Just as psychiatry has, at times, oversold itself, people sometimes overvalue psychiatry and related mental health professions. It is at least optimistic, maybe unrealistic, to think that every human problem can be solved by talking, taking medication, or some kind of professional behavioral plan. The famous psychiatrist Karl Menninger proposed early in the twentieth century to reform every prisoner with psychiatric treatment. There has always been a lurking hope that ultimately the science of the human mind can correct all wrongs, erase all evil inclinations, and stop all destructive or selfish behaviors. We are far from that horizon. Might the science of human psychology and the brain help in any particular situation? I maintain simply, "It can't hurt to ask." In other words, getting an evaluation to see *if* the troubling problems *might* be amenable to state-of-the-art treatment is worth it. A good, honest, competent professional (and, really, most are) will be able to say if you are in the wrong place, if the concepts and skills of a mental health professional are not applicable. A worldly and thoughtful professional might have suggestions for a *better* route: maybe a lawyer, an accountant, a clergyperson, or maybe an investment consultant, a career counselor, or a neurosurgeon. The point is *you* do not have to decide if psychiatric treatment is the right way to go. If the problem involves thoughts, feelings, or behaviors, getting the opinion of a psychiatric expert as to whether this is the right path could be the start of treatment, or the end of this particular line and the opening of a new idea.

• • •

In this chapter, you learned the most common ways things can go haywire in a person's mental life, under what circumstances a psychiatrist or other mental health professional can be helpful, and that intervening is a morally sound move. Next, I'll give you basic information on mental health problems so that you can be a more fully informed guide in your efforts to help the troubled other.

2

A Closer Look at Mental Health Problems

"Diseases of the soul are more dangerous and more numerous than those of the body."

— CICERO

It's likely that you want to help someone in your life in emotional or mental trouble because some tipping point has occurred, and you are no longer willing to be an observer of the problem—you want to find a solution. Your reasons for feeling this way can be myriad. The pain that's evident in your friend may move you. Or maybe the pain that *you* are experiencing—caused by your friend's behavior—has motivated you to seek a course of action. It could also be the disruption you see in the lives of those closest to him, or the chaos he is causing in his social and professional environment. Whatever the reason, you are ready to do something.

What's Going On?

Last night, your adult daughter was at your house for dinner, as she always is on Tuesdays. But she was short-tempered and rude. You've watched as over the last few months she has become more and more irritable. Lately, she arrives with

a bottle of wine and drinks most of it before dinner is served. The next day, when she calls to thank you for dinner, she appears to have forgotten how rude she was, and never apologizes. This morning she didn't call. Now you and your husband are worried that your daughter is abusing alcohol. You've tried to talk to her about her drinking, but she explodes. Now you're afraid to say anything because her temper is close to the boiling point.

A close friend of yours is acting strangely. You and she have a long-standing lunch date every other Tuesday, but lately she's been canceling at the last minute. When you call her at the office, the receptionist tells you that she's not in. You ran into her husband at the grocery store and he told you that she hasn't been sleeping well and she's been missing days at work. You don't know whether she has lost interest in your friendship, whether she's having an affair, or whether she's having emotional problems and needs help.

Your brother called and suggested you keep your living room curtains closed because "they might be watching." "Who is watching?" you ask him. "The people in the red cars; I saw three of them on my way home today, and they all had license plates beginning with the number three. I think they're watching people who have three kids, like you." This conversation only adds to the worries you have had about him, like noticing that he isn't changing his clothes very much and it seems to be a long time since he took a shower. At the last family dinner with your parents, he came late, seemed very uncomfortable, and left abruptly.

Your mother has been piling up magazines and newspapers for years. She genuinely intends to read them, but she now has thousands stacked in piles all over the main rooms of the house and in spare bedrooms; *thirty years of paper!*

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About the Author

Mark Komrad, M.D. is a psychiatrist with more than twenty-five years of experience treating depression, anxiety, personality disorders, substance abuse, and major mental illness. In addition, he consults with people struggling to convince a loved one who is having emotional or behavioral problems to get professional help. While hosting a nationally syndicated radio talk show about psychiatry, Dr. Komrad helped millions of listeners. He is a regular guest on National Public Radio and on television, discussing a variety of psychiatric issues and providing guidance on helping loved ones get the treatment they need. As a teacher and consultant in psychiatric ethics, Dr. Komrad has worked with Hollywood film and television directors to help them portray mental disorders and psychiatrists more accurately and ethically. He practices psychiatry in Baltimore, MD, where he lives with his wife and son. You can find him on the Internet at www.komradmd.com.

Hazelden, a national nonprofit organization founded in 1949, helps people reclaim their lives from the disease of addiction. Built on decades of knowledge and experience, Hazelden offers a comprehensive approach to addiction that addresses the full range of patient, family, and professional needs, including treatment and continuing care for youth and adults, research, higher learning, public education and advocacy, and publishing.

A life of recovery is lived "one day at a time." Hazelden publications, both educational and inspirational, support and strengthen lifelong recovery. In 1954, Hazelden published *Twenty-Four Hours a Day,* the first daily meditation book for recovering alcoholics, and Hazelden continues to publish works to inspire and guide individuals in treatment and recovery, and their loved ones. Professionals who work to prevent and treat addiction also turn to Hazelden for evidence-based curricula, informational materials, and videos for use in schools, treatment programs, and correctional programs.

Through published works, Hazelden extends the reach of hope, encouragement, help, and support to individuals, families, and communities affected by addiction and related issues.

For questions about Hazelden publications,
please call **800-328-9000** or visit us online
at **hazelden.org/bookstore.**

"My family did a fantastic job with handling the challenge of being related to me, but I think it would have made their burden much lighter if they'd had a book like this."

—**Carrie Fisher,** author and actress

Just about everyone knows a relative, friend, or coworker who is exhibiting signs of emotional or behavioral turmoil. Yet figuring out how to reach out to that person can feel insurmountable. We know it is the right thing to do, yet many of us hesitate to take action out of fear of conflict, hurt feelings, or damaging the relationship.

Through a rich combination of user-friendly tools and real-life stories, Mark S. Komrad, M.D., offers step-by-step guidance that will help you help your loved one. He will assist you in determining when professional help is needed, choosing when and how to make the first approach, gathering allies, selecting the right professional, and supporting your loved one. Included are scripts based on Dr. Komrad's work with his own patients, designed to help you anticipate next steps and arm you with the tools to respond constructively and compassionately.

You will also find the guidance and information you need to understand mental illness and get past the stigma still associated with it, so that you can provide your loved one with insight and compassion in his or her journey toward emotional stability and health.

Mark S. Komrad, M.D., is an award-winning psychiatrist on the teaching staff of Johns Hopkins, as well as the director of clinical ethics at the prestigious Baltimore-based Sheppard Pratt hospital, where he teaches psychiatric residents. He appears regularly on public radio and television and has had numerous articles and columns published in professional journals, newspapers, and on mental health websites.

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