Generalized anxiety disorder

People who worry about everything—and nothing in particular—have several treatment options.

When people turn on the television, chances are they will experience a barrage of anxiety-provoking news—a sagging economy, international political conflicts, natural disasters. At the same time, they may be dealing with their own personal stress—such as worries about job security or health. Anxiety is often a healthy response to uncertainty and danger, but constant worry and nervousness may be a sign of generalized anxiety disorder.

This common disorder affects about 5% to 6% of Americans at some point in their lives. Women are twice as likely as men to develop generalized anxiety disorder. Some research suggests that prevalence of this disorder increases with age. Generalized anxiety disorder usually first appears from young adulthood through the mid-50s—a later onset than seen with other psychiatric disorders.

While other types of anxiety disorders—such as specific phobias or social anxiety disorder—arise from particular situations, generalized anxiety disorder is characterized chiefly by debilitating worry and agitation about nothing in particular or anything at all. The constant and continually changing worries of people with generalized anxiety disorder are mostly about everyday matters. They can't shake the feeling that something bad will happen and they will not be prepared. They may worry to excess about missing an appointment, losing a job, or having an accident. Some people even worry about worrying too much.

Physical symptoms—racing heart, dry mouth, upset stomach, muscle tension, sweating, trembling, and irritability—are an integral part of generalized anxiety disorder. Over time, these physical manifestations of anxiety may adversely affect health. One example: people with generalized anxiety disorder are at greater risk than other people for heart attack and other cardiovascular problems.

Generalized anxiety disorder often occurs in conjunction with other psychiatric disorders. About two-thirds of people with generalized anxiety disorder also have major depression. About one-quarter have panic disorder. Many have substance use disorders or alcohol dependence.

Generalized anxiety disorder can also affect cognition—although in a different way than depression does. People with generalized anxiety disorder tend to ruminate about potential misfortune, while people with major depression are more likely to have difficulty making a mental effort.

Brain basis of anxiety

Generalized anxiety disorder, like other types of anxiety, probably arises from an excessive activation of the brain mechanism underlying fear and the fight-or-flight response.

When someone confronts a dangerous situation, two brain circuits become active and relay sensory information about the danger—such as the sight and smell of fire—to different parts of the brain. One circuit extends to the cerebral cortex, the outermost part of the brain, which is used for thinking and decision making. The other circuit involves a deeper structure called the amygdala that is central to emotional processing. The amygdala monitors the body's reactions to the environment, evaluates an event's emotional significance, and organizes responses that a person may or may not be conscious of.

Although several brain circuits are activated simultaneously, the amygdala initiates a fast response to danger. It communicates with the hypothalamus at the base of the brain, which is used for thinking and decision making. The amygdala initiates a fast response to danger. It communicates with the hypothalamus at the base of the brain, which is used for thinking and decision making.

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brain, prompting quick release of hormones that raise heart rate and blood pressure, tense the muscles, and generally ready the body to fight or to flee. This system is activated before the cerebral cortex can process what is happening. This has survival value. For example, a person crossing the street may lunge out of the way of a speeding car before being consciously aware of the danger.

The amygdala also works with other brain structures to store emotional memories, including memories of frightening events. In people with anxiety disorders, however, this can become a problem. The amygdala may be so sensitive that it overreacts to situations that aren’t really threatening, inadvertently triggering the brain circuits that provoke an emergency stress response. Over time, anxiety becomes attached to situations, thoughts, and memories unrelated to genuine sources of danger. In this sense, the brain may inadvertently create its own fears.

Certain genetic variations may predispose people to develop anxiety disorders. A leading gene candidate is 5-HTT, a gene that regulates the neurotransmitter serotonin. Other neurotransmitters associated with anxiety are gamma-aminobutyric acid (GABA) and norepinephrine. GABA directs nerve cells to stop signaling and await further instructions.

Serotonin and norepinephrine, acting over time, regulate the responsiveness of brain circuits governing mood, stress responses, and conditioned fears. Anti-anxiety drugs alter the action of one or more of these neurotransmitters. Benzodiazepines act at receptors for GABA; antidepressants act at receptors for norepinephrine, serotonin, or both. (These drugs are described in detail at right.)

Life experiences also contribute to anxiety disorders. Severe or constant stress can produce a hyperactive anxiety reaction. People with some personality traits, such as shyness, may also be more vulnerable to developing anxiety disorders. Psychotherapies help people to recognize and address the psychological contributors to anxiety.

Medication options

The medications most often used to treat generalized anxiety disorder are antidepressants such as selective serotonin reuptake inhibitors (SSRIs) or dual serotonin and norepinephrine reuptake inhibitors (SNRIs). These drugs take longer to work than the traditional anti-anxiety drugs, benzodiazepines, but also may provide greater symptom relief over time.

Antidepressants. These drugs act on neurotransmitters involved in many regions of the brain, affecting anxiety, mood, and arousal. SSRIs prescribed for anxiety include fluoxetine (Prozac), sertraline (Zoloft), and citalopram (Celaxa). The SNRIs venlafaxine (Effexor) and duloxetine (Cymbalta) may also be effective. Side effects of antidepressants include sexual problems, weight gain, and insomnia. There may be a mild (and usually preventable) reaction when antidepressants are discontinued, but they present no risk of abuse.

Benzodiazepines. These drugs offer rapid relief of anxiety disorders and cause few side effects. The main risks are drowsiness, loss of coordination, and physical dependence (especially in people dependent on alcohol or other drugs). Options include alprazolam (Xanax), diazepam (Valium), and lorazepam (Ativan).

If people decide to stop taking benzodiazepines, they should do so gradually, lowering the dose over weeks or months. This approach reduces the risk of having a withdrawal reaction with symptoms that include anxiety, agitation, and, rarely, seizures.

Other options. Buspirone (BuSpar), a drug with a different mechanism of action, is less likely to cause physical dependence than a benzodiazepine but may not be as effective. Buspirone also takes longer to take effect than a benzodiazepine. Often it doesn’t work because a person is taking too low a dose. At therapeutic doses, however, buspirone has more physical side effects.

Clinicians may also prescribe both a benzodiazepine and an antidepressant. The person starts by taking the two drugs...
together, and then the benzodiazepine dose can gradually be reduced as the antidepressant begins to take effect.

Tricyclic antidepressants are a further option. These drugs have side effects that may be more uncomfortable than SSRIs or SNRIs (for example, dizziness, constipation, blurred vision, and trouble urinating). Still, some people with anxiety actually feel better on tricyclics and find the side effects manageable or even preferable to other drugs, underscoring the importance of individualizing treatment.

**Psychotherapy**

People with generalized anxiety disorder can also benefit from psychotherapy. Cognitive behavioral therapy (CBT) is probably the most studied approach, but other options show promise as well.

**CBT.** This therapy helps people with generalized anxiety disorder to recognize and correct misperceptions that contribute to anxiety. A cognitive behavioral therapist helps people with generalized anxiety disorder to recognize when they are misinterpreting events, magnifying difficulties, and making pessimistic assumptions on little evidence. People with generalized anxiety disorder tend to pay attention to anything that seems threatening and incorporate a vague sense of danger into all their thinking. They worry constantly in an attempt to define and describe their problems, reducing anxiety temporarily but in the end maintaining the feeling that they lack control. Anticipation of disaster and the physical symptoms of anxiety are mutually reinforcing.

During CBT, patients may keep a diary for recording and examining their thoughts and feelings, with special attention to those that cause or relieve anxiety. The therapist helps the patient to become aware of automatic thoughts and assumptions so that he or she can make vague worries more specific, evaluate them, and determine whether they are unrealistic.

The behavioral side of CBT involves learning new ways to solve problems and respond to anxiety-provoking situations. Patients may receive problem-solving skills training and learn how to set goals and establish priorities. The methods include role-playing, rehearsal, and modeling (learning by imitation).

**Applied relaxation.** This modified form of CBT helps patients learn relaxation techniques to tamp down the nervous system arousal that occurs during stress. Often that starts with controlling rapid breathing. They learn to apply these relaxation techniques as anxiety-provoking thoughts or situations occur.

**Psychodynamic therapy.** This type of therapy recognizes that early relationships and life history continue to affect people as adults, that behavior reflects both unconscious and conscious motivations, and that gaining insight into these factors in the context of a helping relationship can provide relief. A preliminary study found that short-term psychodynamic therapy was as effective as CBT for treating generalized anxiety disorder.

**Questions for the future**

There is still much to learn about how best to treat generalized anxiety disorder. People with anxiety would benefit from more detailed comparisons of treatments, including the various types of psychotherapy and the currently available medications. Specifically, we need more information about what combinations of psychotherapy and medication are most effective, and how to tailor treatment to individuals.

And new treatments for generalized anxiety disorder will also be welcome. The condition tends to be chronic, with symptoms that wax and wane throughout life. Identifying new treatment options will provide hope to those individuals who continue to struggle with debilitating anxiety after trying multiple medications and psychotherapy.


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**Symptoms of generalized anxiety disorder**

Generalized anxiety disorder is excessive anxiety and worry that is difficult to control and causes serious distress or interferes with daily activities. These symptoms occur more days than not for at least six months, along with at least three of the following:

- restlessness or feeling on edge
- tiring easily
- difficulty concentrating
- irritability
- muscle tension
- sleep problems.

The symptoms are not the result of a medical condition, a medication, or a nonmedical drug, and they don’t occur only during a mood disorder, a psychotic disorder, or post-traumatic stress disorder. The symptoms do not necessarily include fear of specific objects (simple phobias), fear of having a panic attack (panic disorder), fear of being embarrassed in public (social phobia or performance anxiety), fear of being contaminated (obsessive-compulsive disorder), fear of gaining weight (anorexia), or fear of having a serious illness (hypochondriasis).

Adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).*
Recognizing depression in men

Physical complaints, substance abuse, and other stealth symptoms may mask the problem.

In many respects, men fare worse than women when it comes to health problems. Men are more likely to have heart attacks than women, for example, and more likely to die of cancer. But men are only half as likely as women to develop one of the most disabling disorders worldwide—major depression. Men are also less likely than women to develop dysthymia (chronic mild to moderate depression) and may be less likely to experience bipolar depression (even though the rate of bipolar disorder is the same in both genders).

As we reported in last month’s article on women and depression, it is unclear what underlies this gender difference. The leading theory is that some combination of genes, hormones, and environmental stress contributes to it (see Harvard Mental Health Letter, May 2011).

Still, although men are less likely than women to develop depression, it remains a significant mental health problem for them. About 10% to 17% of men will develop major depression at some point in their lives. Moreover, depression may be more deadly for men than for women. Depression is a key risk factor for suicide, and four times as many men compared with women die from suicide. One reason may be men’s reluctance to convey their feelings and seek help when they are in despair.

Another mortal concern for men with depression is cardiovascular disease. Depression is a well-known risk factor for coronary artery disease, heart attack, and stroke. Men are especially vulnerable because they develop these diseases at a higher rate and at an earlier age than women.

Given the toll depression takes on men, it’s important that those who need help receive it. But often the symptoms of depression are different in men than in women—partly because of cultural pressures for members of each gender to behave in certain ways—a factor that may contribute to missed diagnoses.

Stealth symptoms
An analysis of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study, one of the largest investigations of depression in “real world” settings, found that while men and women shared some symptoms of major depression (such as low mood), the overall pattern of symptoms varied by gender. Women were more likely to gain weight when depressed; men were more likely to lose weight. Women reported symptoms overlapping with anxiety disorders; men reported symptoms more typical of obsessive-compulsive disorder. Women felt less energetic; men became agitated. Men were also more likely than women to develop alcohol or substance abuse in conjunction with major depression.

Other research has found that because of cultural pressure to act “manly,” men may feel that it is weak to show despair or self-doubt. As a result, symptoms of depression may masquerade as anger or irritability. Research by the National Institute of Mental Health revealed that many men were not aware that physical problems such as headaches, stomach problems, and chronic pain might be symptoms of depression.

Men also may be reluctant to admit to depression because they are worried about how their boss, coworkers, or neighbors will react. Because of these concerns, when men develop depression they may actually work longer hours or engage in more volunteer activities—all in an effort to avoid confronting or revealing symptoms of depression.

The most important thing others can do for a man who shows signs of depression is to help him contact a primary care physician or mental health professional. Taking that first step is often the hardest. If necessary, accompany him to an appointment.

Clinicians can routinely screen adults for depression by asking two standard questions:

- Over the past two weeks, have you felt depressed or hopeless?

### Possible protective factors

The research suggests that several factors help buffer men against depression. Men—and women—who integrate these protective strategies into their lives may improve their odds of avoiding this mood disorder.

**Physical activity.** Men engage in more moderate to intense physical activity on a regular basis than do women. It’s not clear whether this is because men are more likely to be employed in occupations that involve activity (such as construction work) or whether they are more likely to exercise for recreation. No matter how men get this exercise, the research suggests it has a positive impact on their mental health.

**Psychology.** Men are less likely than women to ruminate over past events, are more likely to feel in control of their lives, and more likely to feel positive about themselves and their situation. Men with these psychological traits may have a mental buffer against depression.
Although in general, the side effects of Viagra, tadalafil (Cialis), or vardenafile (Levitra). Another option is adding the dose of a medication may help. If symptoms of depression are mild or moderate, it is often reasonable to start with either medication or psychotherapy alone. Generally, if symptoms are more severe, it is more important to consider medication earlier in treatment.

Improvement takes time. Although some patients experience symptom relief within one or two weeks after beginning a medication, for example, more often it takes from four to eight weeks for antidepressants to take effect. Selective serotonin reuptake inhibitors (SSRIs) are the medications most often prescribed for depression. Although in general, the side effects of SSRIs may be quite manageable, one drawback is that they frequently dampen sexual response, delay orgasm, or lead to erectile dysfunction. These side effects may subside in time on their own. It’s also possible that lowering the dose of a medication may help.

Switching to a new drug may also make sense. Mirtazapine (Remeron) and some older antidepressants—tricyclic antidepressants and monoamine oxidase inhibitors—are less likely to cause sexual side effects than SSRIs.

If erectile dysfunction remains a problem, men may obtain relief with an erection drug such as sildenafil (Viagra), tadalafil (Cialis), or vardenafile (Levitra). Another option is adding bupropion (Wellbutrin) to an SSRI, as this medication sometimes counters SSRI-induced sexual dysfunction, boosts sexual drive and arousal, and increases the intensity or duration of an orgasm. Another drug, buspirone (BuSpar), can restore the ability to have an orgasm and increase libido.

**Sticking with treatment**

Following a treatment plan can be a challenge, not only because medications can cause side effects and psychotherapy takes time—but because of stigma. Men with depression may feel at times as though they are all alone in their struggle. Support groups may be of help in this regard. (To find more information about support groups, contact the National Alliance on Mental Illness at [www.nami.org](http://www.nami.org), or the Depression and Bipolar Support Alliance at [www.dbsalliance.org](http://www.dbsalliance.org).)

And if a first depression treatment doesn’t provide sufficient help for a man, it’s important to explore alternatives. Perseverance, a trait that many men are proud to embrace, may be the most important characteristic when it comes to finding relief.

<table>
<thead>
<tr>
<th>Classic symptoms (in men and women)</th>
<th>Symptoms men are more likely to experience than women</th>
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<td>• Depressed mood, feeling sad or empty</td>
<td>• Irritability</td>
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<tr>
<td>• Less interest in or pleasure from daily activities</td>
<td>• Loss of interest in work or hobbies</td>
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<tr>
<td>• Significant weight loss or gain, or appetite changes</td>
<td>• Sleep problems</td>
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<tr>
<td>• Insomnia or excessive sleepiness</td>
<td>• Physical problems such as headaches, digestive disorders, and chronic pain</td>
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<tr>
<td>• Physical agitation or lethargy</td>
<td>• Alcohol or substance abuse to self-medicate for depression</td>
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<tr>
<td>• Fatigue and lack of energy</td>
<td>• Changes in behavior, such as becoming abusive, controlling, or violent</td>
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<tr>
<td>• Feeling worthless or excessively guilty</td>
<td>• Taking physical risks, such as aggressive driving or unsafe sex</td>
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<tr>
<td>• Inability to think or concentrate</td>
<td>• Recurring thoughts of death or suicide</td>
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</tbody>
</table>


*Miller M, editor. Understanding Depression (Harvard Medical School, 2011).*

*National Institute of Mental Health. Men and Depression (2005).*


For more references, please see [www.health.harvard.edu/mentalextra](http://www.health.harvard.edu/mentalextra).
The psychology of risk perception

Understanding why certain perils seem more perilous than others.

In the past two years, two environmental accidents in different parts of the world—along with media and public reaction to them—have dramatically illustrated some of the basic psychological principles of risk perception. In 2010, the Deepwater Horizon oil spill sent millions of gallons of oil into the Gulf of Mexico. In 2011, the Fukushima Daiichi nuclear power plant in Japan—damaged after a devastating earthquake and tsunami—leaked radiation into the atmosphere.

These incidents dominated news coverage for weeks and created widespread anxiety, even in people living miles away and not directly affected. For example, news that potassium iodide pills could help prevent radiation-induced thyroid cancer sparked a run on pharmacy supplies in the United States, thousands of miles away from the disaster, even when there was no evidence of increased radiation exposure.

Factors affecting perception

Risk perception is rarely entirely rational. Instead, people assess risks using a mixture of cognitive skills (weighing the evidence, using reasoning and logic to reach conclusions) and emotional appraisals (intuition or imagination). After reviewing the research, risk expert David Ropeik identified 14 specific factors that affect perception of danger:

Trust. When people trust the officials providing information about a particular risk—or the process used to assess risk—they tend to be less afraid than when they don’t trust the officials or the process.

Origin. People are less concerned about risks they incur themselves than the ones that others impose on them. This helps explain why people often get angry when they see someone talking on the cell phone while driving—and yet think nothing of doing so themselves.

Control. Perceived control over outcomes also matters. This helps explain why someone is not afraid of driving a car—even though automobile crashes kill thousands of people each year—but may be afraid of flying in an airplane.

Nature. Dangers in nature—such as sun exposure—are perceived as relatively benign, whereas man-made harms—nuclear power accidents or terror attacks—are more menacing.

Scope. Cataclysmic events, capable of killing many people at the same time, are scarier than chronic conditions—which may kill just as many people but over a longer period. That helps explain why a tsunami or earthquake feels scarier than heart disease or diabetes.

Awareness. Saturation media coverage of high-profile disasters raises awareness of particular risks more than others. Likewise, an event that hits close to home, such as having a friend diagnosed with cancer, heightens risk perception.

Imagination. When threats are invisible or hard to understand, people become confused about the nature of the risk, and the event becomes scarier.

Dread. Events that invoke dread—such as drowning or being eaten alive—scare people more than those that do not.

Age affected. Risks are more frightening when they affect children. Asbestos in a school building, for example, may bother people more than asbestos in a factory.

Uncertainty. Events inspire more fear when officials don’t communicate what is known—or when the risks are simply unknown. In the Deepwater Horizon spill, for example, officials could more easily estimate the amount of oil spewing into the ocean than they could predict what effect that would have on wildlife and fisheries.

Familiarity. Novel risks are perceived to be more dangerous than more familiar threats. That’s why West Nile virus may be perceived as more of a risk to health than not testing a smoke detector regularly.

Specificity. Victims who are publicly identified evoke a greater emotional reaction than those who remain nameless and faceless.

Personal impact. Risks that affect people personally are more frightening than those that affect strangers.

Fun factor. Engaging in risky behavior may not seem that way if it involves pleasure. Some examples are drug taking, unsafe sex, and high-risk sports.

Risk in perspective

There is no question that people living in the direct vicinity of high-profile disasters suffer mentally as well as physically. Hurricane Katrina, for example, was followed by an increase in psychiatric disorders, substance abuse, and domestic violence among people living in the areas affected.

For people who are affected indirectly by reading media reports, however, the real danger is heightened or exaggerated perception of risk that may not have a solid basis in fact. Keeping the risk in perspective will help prevent needless anxiety or counterproductive coping strategies.


For more references, please see www.health.harvard.edu/mentalextra.
IN BRIEF

**Premenstrual mood disturbances increase chances of relapse in women with bipolar disorder**

Most women have mild mood fluctuations and physical distress in the days before menstruation. One-fifth have moderate to severe symptoms that interfere at least partially with work, school, and relationships—although only a minority of them meets the diagnostic criteria for premenstrual dysphoric disorder detailed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). In spite of how common premenstrual mood disturbances are, little is known about how they affect women with bipolar disorder.

To learn more, researchers at Massachusetts General Hospital and colleagues in Brazil and Italy analyzed symptoms and outcomes for 293 women with bipolar disorder enrolled in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) trial. This federally funded, multi-site investigation enrolled patients typical of those treated in the community, so that the results are considered clinically relevant.

As in the general population, premenstrual mood symptoms were common, affecting 65% of women with bipolar disorder enrolled in STEP-BD. These symptoms worsened outcomes. Women with premenstrual symptoms experienced more mood episodes (most often bipolar depression)—and more severe symptoms—over a 12-month period. (However, they did not experience so many different mood cycles that they could be diagnosed with rapid-cycling bipolar disorder, generally defined as four or more distinct mood cycles within a 12-month period.)

In addition, women with premenstrual symptoms were more likely to relapse, and do so more quickly, than those who did not have such symptoms. On average, women with subthreshold symptoms of premenstrual dysphoric disorder (meeting some of the criteria for this disorder) relapsed in 4.5 months, while those with milder premenstrual symptoms, or without these symptoms, relapsed in 8.5 months.

The study suggests that women who have bipolar disorder and also experience moderate to severe premenstrual symptoms may want to take extra effort to maintain their mental health. This means adhering to medications as prescribed, increasing doses as needed, and maintaining healthy lifestyle habits such as getting enough sleep and eating and exercising regularly.


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**Nicotine replacement therapy may ease agitation for hospitalized patients with schizophrenia**

As many as eight in 10 people with schizophrenia smoke cigarettes. When they enter a hospital, they often have to stop smoking abruptly and involuntarily. Withdrawal symptoms may contribute to agitation that makes psychiatric treatment more challenging. Researchers at the University of Colorado and colleagues in Switzerland conducted a pilot study to determine whether nicotine replacement therapy might reduce agitation in patients with schizophrenia who suddenly had to stop smoking during hospitalization.

The researchers recruited 40 hospitalized smokers with schizophrenia and randomly assigned half to receive a 21-mg daily nicotine patch, while the others received a placebo patch. Like other forms of nicotine replacement therapy, a nicotine patch delivers small amounts of nicotine—the addictive component of tobacco—to the bloodstream without the other toxic components of cigarettes. (All participants took antipsychotic medications as well.)

Agitation decreased in all patients within 24 hours after admission to the hospital, but decreased significantly more in those who received nicotine replacement patches. Although the absolute difference between the nicotine and placebo patches—the “effect” size of nicotine replacement therapy—was small, the researchers estimate that it was similar to that achieved with an antipsychotic injection.

Dr. Michael Allen, a psychiatrist at the University of Colorado School of Medicine who led the study, emphasized that nicotine replacement therapy is best used as part of a broader effort to more fully engage—in a cooperative rather than coercive manner—patients with schizophrenia. He suggested that nicotine replacement therapy be offered to patients along with their preferred antipsychotic medication, ideally in a calming environment with low sensory stimulation. This multipronged approach may offer the best chances of enlisting the patient in treatment—in itself a potent method of reducing agitation.

Safe use of social media: Guidance for parents

As many who were children before the era of cell phones will remember, contacting a friend by phone often involved mastering at least the following script: “Hi, Mrs. Doe. Is Johnny home?” Not so today, in the world of cell phones, texting, e-mail, Facebook, and Twitter.

If you are a parent and don’t use or understand the new technologies, the American Academy of Pediatrics (AAP) has just issued a guideline saying that you probably should. More than half of teens connect to a social media site at least daily. Three-quarters have cell phones that they can use for social networking as well as texting. In a guideline published in March, the AAP makes the important (if obvious) point that today’s children are growing up on the Internet. And, since children and adolescents now spend a great deal of time there, parents have good reasons to know what the place is like.

The Internet is both private (parents are often excluded) and immeasurably public. It’s the second half of this pair that has pediatricians and parents worried. The Internet is a new place for children to become vulnerable. They can be bullied or humiliated by peers. They may release private information and regret it later. Predators can exploit them. There are opportunities to become involved in sexual situations or relationships that are emotionally hurtful or dangerous.

But—in a helpful way—the AAP authors underscore that social media have enormous value for kids. Young people can use these channels to socialize, learn, create, and grow. They can find social support from peers with common interests. They can get involved in their community and strengthen their communication skills. Moreover, children can explore topics that they might be too embarrassed to ask about in person—sex, health, or any of the common and uncommon sources of childhood unhappiness.

The AAP authors suggest that pediatricians encourage parents to talk with their children about the following core issues: bullying, popularity, status, depression, social anxiety, risk-taking, and sexual development. This is an excellent list, because it is anchored in what we know about child and adolescent development rather than any perceived special influences of social networks.

Another good suggestion is advice for parents to narrow the “participation gap.” Just as parents inform themselves about the schools their children attend, the activities they take part in, or the parties they go to, it makes sense for them to know about their children’s online communities and activities. The AAP urges parents to talk with their children rather than spy on them. Children are, after all, entitled to (and benefit from) a zone of privacy so they can develop a sense of autonomy and independence.

The guideline includes one recommendation that appears impractical or unrealistic—the need for “a family online-use plan” and “regular family meetings.” There is no evidence that the privileges and limits of Internet use are substantially different from, for example, rules around bedtime, doing homework, or watching TV. The authors appropriately advise against punitive responses, emphasizing instead teaching or modeling healthy behavior and good citizenship. These are values that are relevant to much of parenting.

We don’t (and perhaps never will) have evidence to determine whether children are more or less at risk in the digital age. My impression is that, in many communities, today’s parents know a lot more about their children’s daily lives than did parents of earlier generations. The AAP has avoided the trap of inventing a special set of rules, developing instead a set of recommendations that fits into mainstream parenting.

And a word on children who refuse to “friend” you on Facebook: adolescents did not begin keeping things from their parents only when the Internet was invented. Children and adolescents have always had plenty of ways to get into trouble. (I know. I was there.) This guideline succeeds because it builds upon well-understood parenting principles. It helps pediatricians give practical advice to parents who want to extend analog parenting into the digital world.

To read the AAP guidelines, visit our Web site at www.health.harvard.edu/mentalextra.

Send us a question for Ask the Doctor

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