fenses. Therapy sessions may be scheduled once or even twice a week for a year or more. This type of therapy is appropriate when internal conflicts contribute significantly to a person’s problems. (For more information, see entry on Psychoanalysis).

Behavioral techniques

In contrast to the psychodynamic approach, behavior-oriented therapy is geared toward helping people see their problems as learned behaviors that can be modified, without looking for unconscious motivations or hidden meanings. According to the theory behind this approach, once behavior is changed, feelings will change as well. Probably the best-known type of behavioral therapy is behavior modification, which focuses on eliminating undesirable habits by providing positive reinforcement for the more desirable behaviors.

Another behavioral technique is systematic desensitization, in which people are deliberately and gradually exposed to a feared object or experience to help them overcome their fears. A person who is afraid of dogs may first be given a stuffed toy dog, then be exposed to a real dog seen at a distance, and eventually forced to interact with a dog at close range. Relaxation training is another popular form of behavior therapy. Through such techniques as deep breathing, visualization, and progressive muscle relaxation, clients learn to control fear and anxiety.

Cognitive methods

Some behavior-oriented therapy methods are used to alter not only overt behavior, but also the thought patterns that drive it. This type of treatment is known as cognitive-behavior therapy (or just cognitive therapy). Its goal is to help people break out of distorted, harmful patterns of thinking and replace them with healthier ones. Common examples of negative thought patterns include magnifying or minimizing the extent of a problem; “all or nothing” thinking (i.e., a person regards himself as either perfect or worthless); overgeneralization (arriving at broad conclusions based on one incident, for example); and personalization (continually seeing oneself as the cause or focus of events).

In cognitive-behavioral therapy, a therapist may talk to the client, pointing out illogical thought patterns, or use a variety of techniques, such as thought substitution, in which a frightening or otherwise negative thought is driven out by substituting a pleasant thought in its place. Clients may also be taught to use positive self-talk, a repetition of positive affirmations. Cognitive therapy is usually provided on a short-term basis (generally 10-20 sessions).

Family and group therapy

Family therapy has proven effective in treating a number of emotional and adjustment problems. While the client’s immediate complaint is the initial focus of attention, the ultimate goal of family therapy is to improve the interaction between all family members and enhance communication and coping skills on a long-term basis (although therapy itself need not cover an extended time period). Group therapy, which is often combined with individual therapy, offers the support and companionship of other people experiencing the same problems and issues.

Therapy is terminated when the treatment goals have been met or if the client and/or therapist conclude that it isn’t working. It can be effective to phase out treatment by gradually reducing the frequency of therapy sessions. Even after regular therapy has ended, the client may return for periodic follow-up and reassessment sessions.

Further Reading

Psychotic disorders

A diagnostic term formerly used in a general way to designate the most severe psychological disorders; now used in a much narrower sense in connection with specific symptoms and conditions.

Formerly, all psychological disorders were considered either psychotic or neurotic. Psychotic disorders were those that rendered patients unable to function normally in their daily lives and left them “out of touch with reality.” They were associated with impaired memory, language, and speech and an inability to think rationally. Neurotic disorders, by comparison, were characterized chiefly by anxiety; any impairment of functioning was primarily social. Psychotic conditions were attributed to physiological causes, neurotic conditions to psychosocial ones. Other distinguishing features associated primarily with psychotic disorders were hospitalization and treatment by biological methods—medication and electroconvulsive therapy. With the development of new types of psychoactive drugs in the 1950s and 1960s, medication became a common form of therapy for anxiety, depression, and other problems categorized as neurotic.
"Psychotic" and "neurotic" are no longer employed as major categories in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Instead, disorders that formerly belonged to either one category or the other appear side by side in Axis I of the manual under the heading "Clinical Syndromes." The term “psychotic” still appears in DSM-IV, most prominently in the categorization “Schizophrenia and Other Psychotic Disorders.” The disorders in this section have as their defining feature symptoms considered psychotic, which in this context can refer to delusions, hallucinations, and other positive symptoms of schizophrenia, such as confused speech and catatonia. In other parts of DSM-IV, “psychotic” is also used to describe aspects of a disorder even when they are not its defining feature, as in “Major Depressive Disorder With Psychotic Features.”

Further Reading

Puberty

The process of physical growth and sexual maturation that signals the end of childhood and the advent of adolescence. (Also, the period during which this process takes place.)

The word puberty is derived from the Latin pubertas, which means adulthood. Puberty is initiated by hormonal changes triggered by a part of the brain called the hypothalamus, which stimulates the pituitary gland, which in turn activates other glands as well. These changes begin about a year before any of their results are visible. Both the male reproductive hormone testosterone and female hormone estrogen are present in children of both sexes. However, their balance changes at puberty, with girls producing relatively more estrogen and boys producing more testosterone.

Most experts suggest that parents begin short and casual discussions about puberty with their children by the age of seven or eight. Offering the child reading materials about puberty can impart information to the young person without the awkwardness that may characterize the parent-child conversations. Parents can then offer their children opportunities to ask questions or to discuss any aspects of puberty and sexuality that may arise from their reading.

The first obvious sign of puberty is a growth spurt that typically occurs in girls between the ages of 10 and 14 and in boys between 12 and 16. Between these ages both sexes grow about nine inches. The average girl gains about 38 pounds, and the average boy gains about 42. One reason for the awkwardness of adolescence is the fact that this growth spurt proceeds at different rates in different parts of the body. Hands and feet grow faster than arms and legs, which, in turn, lengthen before the torso does, all of which create the impression of gawkiness common to many teenagers. In addition, there can be temporary unevenness of growth on the two sides of the body, and even facial development is disproportionate, as the nose, lips, and ears grow before the head attains its full adult size. The growth spurt at puberty is not solely an external one. Various internal organs increase significantly in size, in some cases with observable consequences. Increases in heart and lung size and in the total volume of blood give adolescents increased strength and endurance for athletics and for recreational activities such as dancing. (During puberty, the heart doubles in size.) Teenagers’ ravenous appetites are related to the increased capacity of the digestive system, and the decrease in respiratory problems (including asthma) is associated with the fact that the lymphoid system, which includes the tonsils and adenoids, actually shrinks in adolescence. Yet another change, the increase in secretions from the sebaceous glands, triggered by the growth hormone androgen, is responsible for acne, which affects about 75% of teenagers. The excess oil from these glands clogs pores, and they become inflamed, causing the reddening and swelling of acne.

Following the beginning of the growth spurt, the sexual organs begin to mature and secondary sex characteristics appear. In girls, the uterus and vagina become larger, and the lining of the vagina thickens. The first visible sign of sexual maturation is often the appearance of a small amount of colorless pubic hair shortly after the growth spurt begins. Over the next three years, the pubic hair becomes thicker, darker, coarser, and curlier and spreads to cover a larger area. Hair also develops under the arms, on the arms and legs (sufficiently so that most girls start shaving), and, to a slight degree, on the face. Around the age of 10 or 11, "breast buds," the first sign of breast development, appear. Full breast development takes about three or four years and is generally not complete until puberty is almost over. The single most dramatic sign of sexual maturation in girls is menarche, the onset of menstruation, which usually occurs after a girl’s growth rate has peaked. In virtually all cases it occurs between the ages of 10 and 16, with the average age in the United States being 12.8 years. The first menstrual periods are usually anovulatory, meaning that they happen without ovulation. Periods remain irregular for a while, and for at