HOW TO HELP THOSE YOU CARE ABOUT

1. Understand that emotional consequences follow "bad times."

2. Don't expect that the person you care about will "get better" in a certain amount or time or in a certain way. Often recovery is a long and difficult process. If the person requires more time than you expected, you may feel frustrated or even angry.

3. Tell the "hurting person" how you feel: that you are sorry they are hurting.

4. Encourage the "hurting person" to talk to you about how they feel. When they do, listen without interrupting or making judgements about what you hear. All the "hurting person's" feelings are OK even if you might not feel the same way.

5. Remind the "hurting person" that under the circumstances their emotions are normal.

6. Do not attempt to impose you explanation on why this has happened to the "hurting person". It probably won't be the explanation the survivor believes and imposing yours might hurt your relationship with him/her.

7. Do not tell the "hurting person", "I know how you feel" or " Everything will be all right." Often these statements are really efforts to relieve your own anxiety about how you feel about the "hurting person."

8. Be willing to say nothing. Just being there is often all that you can do to help.

9. Don't be afraid to encourage a "hurting person" to ask for help in the form of counseling.

Suicide Prevention

Francine Klagsbrun in her book *Too Young To Die: Youth and Suicide* identifies ways that you can help when you suspect that someone is thinking about suicide.

1. Recognize the signs of suicide
2. Trust your own judgment. If you believe someone is in danger of suicide, act on your beliefs. Do not let others mislead you into ignoring suicidal signals.
3. Tell others. As quickly as possible, share your knowledge with parents, friends, teachers, or other people who might help in a suicidal crisis. Do not worry about breaking a confidence if someone reveals suicidal plans to you. You may have to betray a secret to save a life.
4. Stay with a suicidal person until help arrives or the crisis passes.
5. Listen intelligently. Encourage a suicidal person to talk to you. Do not give false reassurances that everything will be OK. Listen and sympathize with what the person says.
6. Urge professional help. Put pressure on a suicidal person to seek help from a psychiatrist, psychologist, social worker, or other professional person during a suicidal crisis or after a suicide attempt. Encourage the person to continue with therapy treatments.
7. Be supportive. Show the person that you care. Help the person feel worthwhile and wanted again.

Practical Tips to Cope with Depression

Five Steps You Can Take to Beat the Blues

Like a dark cloud that obscures the sun, depression can cover over our feelings of joy and happiness. Just way the appearance of a cloud can be brief and fleeting or dense and long-lasting, feelings of depression range from a floating day or two of the "blues" or the "blahs" to months, or even years, of incapacitating unhappiness.

While everyone feels depression in their own unique way, there are certain symptoms which are almost always found to be present. Restlessness, loss of concentration, insomnia, change in eating patterns, unexplained fatigue, vague aches and pains, instability and, above all, a sense of sadness and hopelessness should make suspect that depression is the culprit.

It is normal to experience some depression following a loss or after a severe blow to our self-esteem. However, sometimes, this temporary normal state of sadness deepens and begins to affect our happiness and functioning. It is during these times that it is important to take steps to cut depression down to its proper size.

Depression is so frequent that it is often referred to as the 'common cold' of emotional disorders. It has no respect of class, race, age or sex. Paupers and princes alike have endured the suffering that depression can bring. Abraham Lincoln, Queen Victoria, William Styron and Buzz Aldrin are among millions of others around the world that have experienced painful bouts of depression. It has been reliably estimated that at any one time approximately 14 million Americans are seriously depressed, and a far greater number of people experience a milder form of depression.

Because depression is so prevalent and so emotionally and financially draining, scientists from many disciplines are rapidly zeroing in on its causes and cures and so there are many current theories and treatments available.

Some psychologists and psychiatrists feel that serious depression sets in after a long period at unresolved stress in some manner, our stress reserves become exhausted. Depression, therefore, can be *seen* as a form "depletion." When this occurs, certain biochemical changes may occur in our brain and this temporary chemical imbalance can cause the myriad of depressive symptoms. Some people, because of their genetic make-up, are more susceptible to depression than others who might be biologically programmed to respond to stress in different fashion.

Other psychologists and psychiatrists feel that the source of depression can be found in angry feelings that are not expressed and are then turned "inward." Still other scientists are convinced that depression is the result of patterns of faulty thinking in which a person consistently views the world through 'black-tinted" glasses an sees every situation as the beginning of a negative event.

Most recently, many psycholo gists have convincing evidence, that depression often results from a state of "learned helplessness". When a person feels there is nothing they can do, they simply "give up" and when they stop resisting, they sink rapidly into a state of depression,

From my own clinical work experience with many patients, I am convinced that all these theories are really pieces of the same "jigsaw puzzle" of depression.

The good news is that with competent treatment almost everyone who is depressed can be helped. The bad news is that many people still view depression as some sort of character flaw or as a sign of weakness.

If your depression is severe or long-lasting, you should certainly consider professional help. With or without professional help, however, here are several psychological "first aid" tips that can help you lift the clouds of depression.

1) SPOT CHECK YOUR THINKING:

Many research studies indicate that many depressed people constantly make errors in their thinking. They have learned to see everything around them as being a result of their faults or lack of ability. They often indulge in a form of erroneous thinking that is called "over-generalization." For example, one depressed patient of mine was an extremely gifted legal stenographer. Her two employers valued her work and her accuracy. One day, in a marathon rush to type a lengthy brief, she made two typographical errors which her employer asked her to correct. She appeared at my office the next day depressed and tearful. When asked what was troubling her, she told me that she was "a failure" as a stenographer. When she was able to correct her thinking so that it was more realistic, she accepted the fact that everyone makes an error or two. Are you thinking realistically about events in your life?

2) GET COMFORTABLE WITH YOUR ANGER:

Anger is a part of life and a natural reaction to frustration. Handling anger properly is a great skill. Exploding with anger rarely helps. "Stuffing" anger, however, often can result in an implo-

SION THAT CAUSES DEPRESSION

In dealing with depression, your goal is to identify the source of your anger and to learn not to feel guilty about your feelings. You are responsible not for what you feel but for what you do with your feelings. You must learn to express your anger in an appropriate manner that can help undue the source of your frustrations.

3) TAKE CARE OF YOUR BODY:

The ancient Greeks know that it was impossible to have a "sound mind' unless you also had a "sound body".

Too often in our rush to miracle drugs, and quick fixes, we forget this ancient wisdom. Many people who are depressed can improve their mental outlook by simply taking better care of their bodies. Lack of rest and sleep can result in a sense of fatigue which often deepens into depression. Not exercising our bodies makes us feel sluggish and dull. Alcohol which is often used by people to lift their spirits, plays a cruel trick by actually producing a state of depression. Indeed, depression and alcoholism are twin sisters of despair. Often, when a heavy drinker stops drinking, they are surprised how much their mood improves after a period of several weeks.

4) ARE YOU GETTING ANY "PAY-OFF" FROM YOU DEPRESSION:

Sometimes, a person who is depressed has learned (often unconsciously) that being the unhappy victim and staying sad has its special rewards.

One college student that I knew, learned that each time she would begin to cry to her boyfriend about her dorm conditions and her roommate, he would try to cheer her up by taking her to a movie or to dinner. Without realizing it, rewarding her behavior in this manner, only served to increase her depressive behavior. After a while, the boyfriend became disgusted with her constant unhappiness and found himself another girlfriend who had a more balanced view of life.

When someone is sad or complains, most friends and close associates are initially sympathetic. After awhile, however, people withdraw their support and the depressed person is more lonely than ever. Is anyone that you know "rewarding" your sad mood by giving you some special privilege or attention? **Think hard!**

5) DO! DO! DO!

Considerable recent research points to the fact that both people and animals can learn to be helpless.

In one classic experiment, dogs in a laboratory learned they could not escape a harmless by slightly painful electric shock. When these dogs were later placed in a situation where they could, in fact, escape the shock- they did nothing. They learned to be helpless.

Many people, after a series of frustrating failures or disappointments, simply give-up and give-in. Like the dogs in the laboratory, they have learned to be helpless and they generalize their helplessness and pessimism to new situations which, in reality, they could do something about, In the last analysis, depression is a disease of hope. When you are sad or down, our greatest enemy is inactivity and passivity. To combat this tendency, it is important to stay active and involved. If one solution doesn't seem to work, try another. If a second doesn't work- try a third. Start becoming involved in new and constructive activities. learn a new skill, play some tennis, volunteer at a shelter for the homeless. Return to some of the healthy activities that used to bring you pleasure.

If, after a period of self-help you find that you are still down, do yourself a favor and get the help of a qualified professional person who can be your all in you battle against the "blues"

YOU CAN WIN!!!

About Dr. Sugarman

Dr. Dan Sugarman is a full professor of Psychology at the William Paterson College in Wayne, NJ, He is on the staff of the Wayne General Hospital in Wayne, NJ and St. Joseph's Hospital in Paterson, NJ. Dr. Sugarman also maintains a private practice in Wayne, NJ.

In addition, he is the author of five books and has written over 60 articles which have appeared in magazines such as Seventeen, Woman's Day and Reader's Digest. He would welcome your comments and invites you to submit questions or topics about behavior that you would like to have addressed in future issues of The Gazette.

When asked what was troubling her, she told me that she was "a failure" ... When she was able to correct her thinking so that it was more realistic, she accepted the fact that everyone makes an error or two. Are you thinking realistically about events in your life?

MIND

Redefining Depression as Mere Sadness

By RONALD PIES, M.D.

Let's say a patient walks into my office and says he's been feeling down for the past three weeks. A month ago, his fiancée left him for another man, and he feels there's no point in going on. He has not been sleeping well, his appetite is poor and he has lost interest in nearly all of his usual activities.

Should I give him a diagnosis of clinical depression? Or is my patient merely experiencing what the 14th-century monk Thomas à Kempis called "the proper sorrows of the soul"? The answer is more complicated than some critics of psychiatric diagnosis think.

To these critics, psychiatry has medicalized normal sadness by failing to consider the social and emotional context in which people develop low mood — for example, after losing a job or experiencing the breakup of an important relationship. This diagnostic failure, the argument goes, has created a bogus epidemic of increasing depression.

In their recent book "The Loss of Sadness" (Oxford, 2007), Allan V. Horwitz and Jerome C. Wakefield assert that for thousands of years, symptoms of sadness that were "with cause" were separated from those that were "without cause." Only the latter were viewed as mental disorders.

A debate over when and how to treat a patient reeling from a loss.

With the advent of modern diagnostic criteria, these authors argue, doctors were directed to ignore the context of the patient's complaints and focus only on symptoms — poor appetite, insomnia, low energy, hopelessness and so on. The current criteria for major depression, they say, largely fail to distinguish between "abnormal" reactions caused by "internal dysfunction" and "normal sadness" brought on by external circumstances. And they blame vested interests — doctors, researchers, pharmaceutical companies — for fostering this bloated concept of depression.

But while this increasingly popular thesis contains a kernel of truth, it conceals a bushel basket of conceptual and scientific problems.

For one thing, if modern diagnostic criteria were converting mere sadness into clinical depression, we would expect the number of new cases of depression to be skyrocketing compared with rates in a period like the 1950s to the 1970s. But several new studies in the United States and Canada find that the incidence of serious depression has held relatively steady in recent decades.

Second, it may seem easy to determine that someone with depressive complaints is reacting to a loss that touched off the depression. Experienced clinicians know this is rarely the case.

Most of us can point to recent losses and disappointments in our lives, but it is not always clear that they are causally related to our becoming depressed. For example, a patient who had a stroke a month ago may appear tearful, lethargic and depressed. To critics, the so-called depression is just "normal sadness" in reaction to a terrible psychological blow. But strokes are also known to disrupt chemical pathways in the brain that directly affect mood.

What is the "real" trigger for this patient's depression? Perhaps it is a combination of psychological and neurological factors. In short, the notion of "reacting" to adverse life events is complex and problematic.

Third, and perhaps most troubling, is the implication that a recent major loss makes it more likely that the person's depressive symptoms will follow a benign and limited course, and therefore do not need medical treatment. This has never been demonstrated, to my knowledge, in any well-designed studies. And what *has* been demonstrated, in a study by Dr. Sidney Zisook, is that antidepressants may help patients with major depressive symptoms occurring just after the death of a loved one.

Yes, most psychiatrists would concede that in the space of a brief "managed care" appointment, it's very hard to understand much about the context of the patient's depressive complaints. And yes, under such conditions, some doctors are tempted to write that prescription for Prozac or Zoloft and move on to the next patient.

TRACY WALKER

But the vexing issue of when bereavement or sadness becomes a disorder, and how it should be treated, requires much more study. Most psychiatrists believe that undertreatment of severe depression is a more pressing problem than overtreatment of "normal sadness." Until solid research persuades me otherwise, I will most likely see people like my jilted patient as clinically depressed, not just "normally sad" — and I will provide him with whatever psychiatric treatment he needs to feel better.

Ronald Pies is a professor of psychiatry at Tufts and SUNY Upstate Medical Center in Syracuse.

NYT 9-16-2008

Is It Normal Grief, or Depression?

To the Editor:

Re "Good Grief," by Allen Frances (Op-Ed, Aug. 15):

Dr. Frances's point about the medicalization of normal human emotions is well taken. To set two weeks as the time allocated to mourning the loss of a loved one before receiving a diagnosis of major depression — as proposed in the American Psychiatric Association's fifth edition of the Diagnostic and Statistical Manual of Mental Disorders — is ridiculous.

Also absurd is the current manual's standard of two months of grieving before one is considered clinically depressed. Dr. Frances was the chairman of the work group that approved this standard.

I am a psychiatrist and a bereaved parent. When I show this criterion to parents who have lost a child, they react with bitter amusement at the idea that normal grief is so quickly considered pathological.

It is shameful that organized psychiatry is so out of touch with such a fundamental, and often prolonged, human process as mourning. Only the pharmaceutical industry could be happy with such a decision. GORDON LIVINGSTON

Columbia, Md., Aug. 16, 2010

To the Editor:

Dr. Allen Frances suggests that the proposal to eliminate the grief exclusion criterion from DSM-5 is "radical" and would represent "a wholesale medicalization of normal emotion." But scientific evidence shows that there are no systematic differences between individuals who develop major depression in response to bereavement and those who develop depression following other severe stressors — like being raped or receiving a diagnosis of a terminal illness.

Most bereaved individuals do not develop major depression, although they may feel terrible sadness. Major depression — the clinical syndrome — is quite different from feeling sad or blue. It also involves marked, persistent changes in function like sleep, appetite and cognition, and sometimes suicidal thinking.

Diagnosis in psychiatry, as in the rest of medicine, includes the possibility that treatment may be initiated at the time of diagnosis or after a period of watchful waiting to determine if treatment is indicated. KENNETH S. KENDLER
DAVID KUPFER
CAROL A. BERNSTEIN

Arlington, Va., Aug. 16, 2010

The writers are all psychiatrists. Dr. Kendler is a member of the DSM-5 Mood Disorder Work Group. Dr. Kupfer is chairman of the DSM-5 Task Force. Dr. Bernstein is president of the American Psychiatric Association.

To the Editor:

As an adult and child psychiatrist who specializes in bereavement, I strongly agree with Dr. Allen Frances that we need to grieve, that in and of itself grief is not a pathological process and that grief differs from major depression.

But I equally strongly disagree with his perspective that having a diagnosis for the grief condition would necessarily medicalize it. In some instances, medication is necessary for severe symptoms that cause continuing dysfunction and distress. But there is no foregone conclusion that a diagnosis inevitably leads to a pill — magic or otherwise.

It is precisely because of my respect for the necessity of the grieving process that I can support its recognition in the diagnostic manual. The only way that many patients can afford therapy is with insurance — which covers only certain mental health diagnoses, and even then in very limited ways.

Our society does not provide mourners with the emotional support and capacity to "bear witness" that they need. We run from any intimations of our mortality. Until such time that we are better able to tolerate the intensity of feelings created by a significant loss, we must do all we can to preserve the option of psychological support for those in mourning. Therapy provides a unique relationship in which these feelings can be tolerated, understood and worked through. ELENA LISTER

New York, Aug. 16, 2010

The writer is a clinical associate professor of psychiatry at Weill-Cornell Medical Center and the author of "I Will Remember You: A Guidebook Through Grief for Teens."

To the Editor:

Allen Frances is right to oppose listing grief as a psychiatric illness. Grief is the most vivid, piercing and transcendent of emotions. People grieve in their own unique ways. The problem is that

GALIA OLFRI

we expect grief to follow the same throwaway, "get over it" ethic that drives too much of modern life.

Many people expect a funeral or memorial for the deceased to bring "closure" for the grieving, when, in reality, preparations for such ceremonies only postpone mourning. After a few bereavement days, a griever is often expected to go back to work without missing a beat. After two weeks, the mere mention of the deceased or your loss may be considered rude or burdensome to others.

Little wonder people are depressed.

CARLYN MEYER

Chicago, Aug. 15, 2010

To the Editor:

We agree with Allen Frances that "normal grief" two weeks after the death of a loved one shouldn't be diagnosed as major depression or considered a "mental disorder." Indeed, most recently bereaved individuals don't meet full criteria for major depression, though intense grief may be hard to distinguish from depression.

But should a recent death (or other loss) nullify the diagnosis of major depressive disorder when the bereaved meets all symptom and duration criteria for it? We think not. Most studies suggest that, given two people with identical symptoms of major depression, the recently bereaved person won't differ significantly from the nonbereaved regarding illness duration, impairment, suicide risk or treatment response.

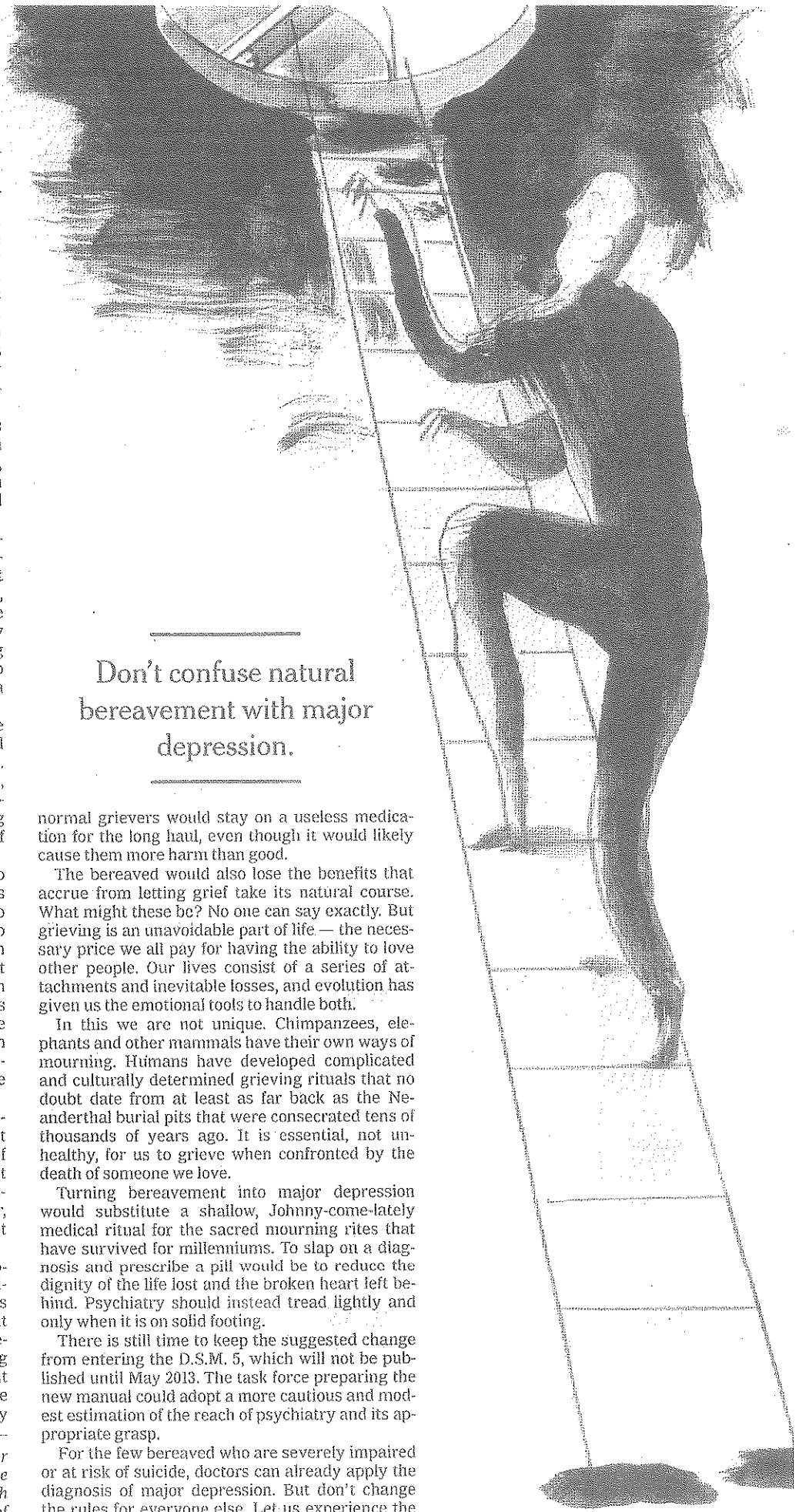
Grief can be a terribly painful and prolonged experience. But vulnerable individuals may have a severe depressive episode triggered or worsened by the recent death of a loved one, rendering their grief even more disabling and persistent. The humane response is to recognize and treat both their grief and depression. RONALD PIES
SIDNEY ZISOOK

Lexington, Mass., Aug. 15, 2010

The writers are both professors of psychiatry, Dr. Pies at Upstate Medical University, SUNY, and Tufts University, and Dr. Zisook at the University of California, San Diego.

Good Grief

By Allen Frances



CORONADO, Calif.

A startling suggestion is buried in the fine print describing proposed changes for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders — perhaps better known as the D.S.M. 5, the book that will set the new boundary between mental disorder and normality. If this suggestion is adopted, many people who experience completely normal grief could be mislabeled as having a psychiatric problem.

Suppose your spouse or child died two weeks ago and now you feel sad, take less interest and pleasure in things, have little appetite or energy, can't sleep well and don't feel like going to work. In the proposal for the D.S.M. 5, your condition would be diagnosed as a major depressive disorder.

This would be a wholesale medicalization of normal emotion, and it would result in the overdiagnosis and overtreatment of people who would do just fine if left alone to grieve with family and friends, as people always have. It is also a safe bet that the drug companies would quickly and greedily pounce on the opportunity to mount a marketing blitz targeted to the bereaved and a campaign to "teach" physicians how to treat mourning with a magic pill.

It is not that psychiatrists are in bed with the drug companies, as is often alleged. The proposed change actually grows out of the best of intentions. Researchers point out that, during bereavement, some people develop an enduring case of major depression, and clinicians hope that by identifying such cases early they could reduce the burdens of illness with treatment.

This approach could help those grievers who have severe and potentially dangerous symptoms — for example, delusional guilt over things done to or not done for the deceased, suicidal desires to join the lost loved one, morbid preoccupation with worthlessness, restless agitation, drastic weight loss or a complete inability to function. When things get this bad, the need for a quick diagnosis and immediate treatment is obvious. But people with such symptoms are rare, and their condition can be diagnosed using the criteria for major depression provided in the current manual, the D.S.M. IV.

What is proposed for the D.S.M. 5 is a radical expansion of the boundary for mental illness that would cause psychiatry to intrude in the realm of normal grief. Why is this such a bad idea? First, it would give mentally healthy people the ominous-sounding diagnosis of a major depressive disorder, which in turn could make it harder for them to get a job or health insurance.

Then there would be the expense and the potentially harmful side effects of unnecessary medical treatment. Because almost everyone recovers from grief, given time and support, this treatment would undoubtedly have the highest placebo response rate in medical history. After recovering while taking a useless pill, people would assume it was the drug that made them better and would be reluctant to stop taking it. Consequently, many normal grievers would stay on a useless medication for the long haul, even though it would likely cause them more harm than good.

> Don't confuse natural bereavement with major depression.

The bereaved would also lose the benefits that accrue from letting grief take its natural course. What might these be? No one can say exactly. But grieving is an unavoidable part of life — the necessary price we all pay for having the ability to love other people. Our lives consist of a series of attachments and inevitable losses, and evolution has given us the emotional tools to handle both.

In this we are not unique. Chimpanzees, elephants and other mammals have their own ways of mourning. Humans have developed complicated and culturally determined grieving rituals that no doubt date from at least as far back as the Neanderthal burial pits that were consecrated tens of thousands of years ago. It is essential, not unhealthy, for us to grieve when confronted by the death of someone we love.

Turning bereavement into major depression would substitute a shallow, Johnny-come-lately medical ritual for the sacred mourning rites that have survived for millenniums. To slap on a diagnosis and prescribe a pill would be to reduce the dignity of the life lost and the broken heart left behind. Psychiatry should instead tread lightly and only when it is on solid footing.

There is still time to keep the suggested change from entering the D.S.M. 5, which will not be published until May 2013. The task force preparing the new manual could adopt a more cautious and modest estimation of the reach of psychiatry and its appropriate grasp.

For the few bereaved who are severely impaired or at risk of suicide, doctors can already apply the diagnosis of major depression. But don't change the rules for everyone else. Let us experience the grief we need to feel without being called sick. □

Allen Frances, an emeritus professor and former chairman of psychiatry at Duke University, was the chairman of the task force that created the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders.

Six steps to giving bad news

By **STEPHANIE BEASLEY**
THE BALTIMORE SUN

When her partner, Mickey Barron, was diagnosed with breast cancer in 2001, Dr. Rhonda Fishel accompanied her to the oncologist's office. As an experienced surgeon, Fishel was no stranger to the delivery of bad news. She was the one who jotted notes furiously as the doctor discussed treatment options, while Barron's mind struggled just to get past the word "cancer."

"He was going on about treatments, and I was gone," Barron recalled. "I was too stressed out."

Four years later, when Fishel was diagnosed with a rare cancer called uterine sarcoma, it was Barron's turn to listen carefully as her partner sat numbly.

"I never understood what it felt like physically, until I had to go through it. It's like a pain in your chest," said Fishel, 51, who has reduced her hours as associate chief of surgery at Sinai Hospital in Baltimore and director of its intensive care unit since being diagnosed and treated.

Fishel is convinced that patients often remember more about how their doctor broke bad news than they do about their diagnosis.

"You go into these rooms knowing that you're going to destroy people's lives," Fishel said. Yet she has heard of colleagues who deliver bad news from the doorway of a patient's hospital room and then quickly back out.

It's a concern shared by other physicians who have developed a protocol for delivering news that they know will be devastating. "It acknowledges the fact that giving

See **SPIKES** Page **F-2**

RECORD 9-19-2006

Doctor guidelines

This is the protocol developed by oncologists and psychiatrists for delivering bad news to patients:

S — Setting. Pick a private location.

P — Perception. Find out how the patient views the medical situation.

I — Invitation. Ask whether the patient wants to know.

K — Knowledge. Warn before dropping bad news.

E — Empathy. Respond to the patient's emotions.

S — Strategy/summary. Once they know, include patients in treatment decisions.

— The Baltimore Sun

SPIKES

From Page F-1

bad news is very hard and doctors aren't taught those skills," said Dr. Walter Baile, chief of psychiatry at the MD Anderson Cancer Center in Houston.

Known as SPIKES, which stands for "Setting, Perception, Invitation, Knowledge, Empathy and Strategy/summary," it emphasizes skills that Baile says are useful for physicians who have to deliver bad news.

As part of the six-step process, Baile says, physicians should take their time when delivering news to ensure that patients understand what is being said. Too many doctors, he says, toss too much medical terminology at their patients.

Baile says it's also critical to choose a location that's comfortable for the patient and to pay attention to the patient's emotions as he receives the information.

"The most important thing is to make an empathetic statement, to say something like, 'I can see that you weren't expecting bad news,' or 'wish' statements like, 'I wish there was something I could do.' That's very different from saying, 'There's nothing I can do,' because that's abandonment," he added.

Fishel relies heavily on the SPIKES philosophy in a presentation she gives to young doctors and medical students titled "Giving and Receiving Bad News: Lessons I've Learned."

Fishel learned of SPIKES from a friend – an oncologist using it with her own patients. Fishel developed her talk after a nephew in medical school asked her to speak to his class last summer.

Having received her own cancer diagnosis by this time, she decided to develop something more substantive than the usual jargon-filled lecture accompanied by the gory pictures that medical students love.

ALGERINA PERNA/BALTIMORE SUN

Cancer survivor Dr. Rhonda Fishel tells medical students about the six-step protocol for delivering bad news to patients.

"I thought a more relevant talk for young, upcoming physicians was bad news," she said.

Here she parts company with Baile, who says he's reluctant to give presentations to young medical students who don't have the experience to put SPIKES into context.

Jay Bhatt, president of the American Medical Student Association, disagrees. "I don't think that it's ever too soon to understand human interactions, human emotions and how that impacts people's health," he said.

When she spoke to her nephew's class at the Kirksville (Missouri) College of Osteopathic Medicine, Fishel says that the medical students were interested in hearing her advice on delivering bad news.

"The response was incredible," she said.

After months of chemotherapy, Fishel's cancer is in remission. Likewise for her partner, Barron, 51, a nurse practitioner.

"People would make plans like 'Can you give this talk?' And I'm [saying], like, 'Well if I'm alive,'" Fishel recalled. "Now I have my energy back, which is one of the best things that you can have. I find myself using words like 'grateful.'"

The New York Times

WELL | Tara Parker-Pope

New Health Rule: Quit Worrying About

Have you had your five to nine servings of vegetables today? Exercised for an hour? Cut back on saturated fat and gotten eight hours of sleep?

Dictating the rules for healthful living has become a cottage industry, with Web sites, talk shows and books (and health columns like this one) devoted to the dos and don'ts of staying healthy.

But when it comes to achieving these goals, many of us feel we are falling far short. Whether you're a busy parent who can't find time for exercise, a chronic dieter struggling to lose 20 pounds or a multitasker who gets by on six hours of sleep, it is virtually impossible to follow the rules.

Now Dr. Susan M. Love, one of the country's most respected women's health specialists, offers a new rule: stop worrying about your health.

In the new book, "Live a Little! Breaking the Rules Won't Break Your Health" (Crown), Dr. Love makes the case that perfect health is a myth and that most of us are living far more healthful lives than we realize.

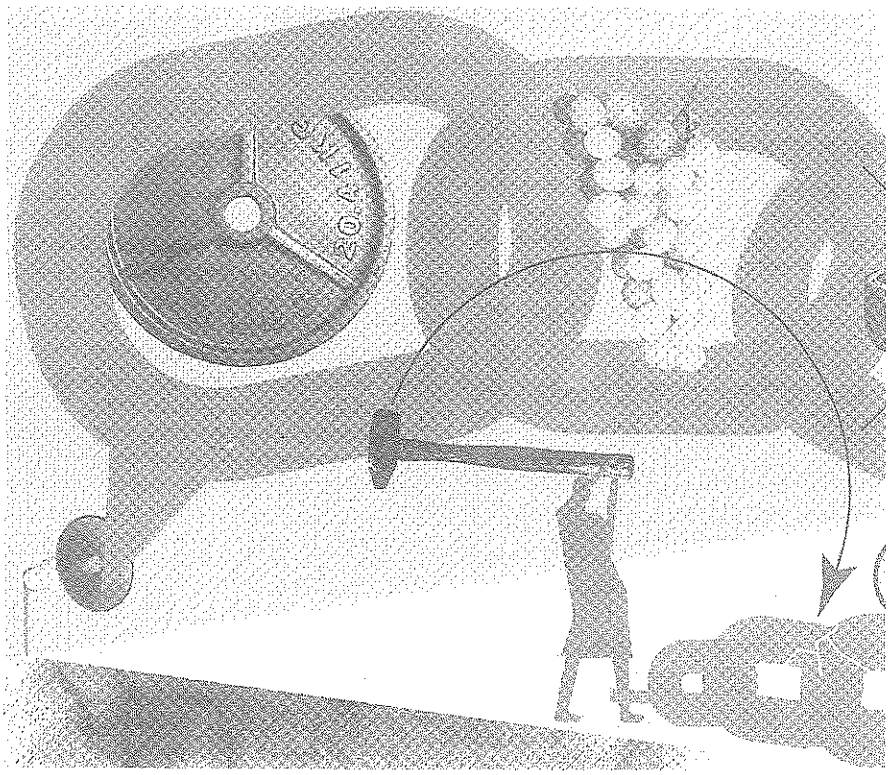
Dr. Love, a clinical professor of surgery at the David Geffen School of Medicine at the University of California, Los Angeles, says that failing to live by the various health rules is a major source of stress and guilt, particularly for women. For most of us, "pretty healthy" is healthy enough.

"Is the goal to live forever?" she said in a recent interview. "I would contend it's not. It's really to live as long as you can with the best quality of life you can. The problem was all of these women I kept meeting who were scared to death if they didn't eat a cup of blueberries a day they would drop dead."

The book, written with Alice D. Domar, a Harvard professor and senior staff psychologist at Beth Israel Deaconess Medical Center, explores the research and advice in six areas of health — sleep, stress, prevention, nutrition, exercise and relationships. In all six, they write, the biggest risks are on the extremes, and the middle ground is bigger than we think.

"Everything is a U-shaped curve," Dr. Love said. "There may be times in your life when you've gotten too much of this or too little of that, but being in the middle is better, and most of us are probably there already."

Take the issue of sleep. Most people believe that it's best to get at least eight hours a day. But the studies on which this belief is based look at how much men and women sleep under ideal conditions — silence, darkness and no responsibilities other than taking part in a sleep study. These studies tell us how much people will sleep when they have nothing else to do, but they don't tell us anything about how much sleep we really need on a daily basis or what will happen if we get less.



A specialist says most women are healthier than they think.

A 2002 report in Archives of General Psychiatry tried to address those issues by comparing sleep habits and mortality risk. The study found that people who slept seven hours a night were the least likely to die during the six-year study period. Sleeping more than seven hours or less than five increased mortality risk. It wasn't clear from the study whether more or less sleep increased risk or whether an underlying health problem was affecting sleep habits, but the findings did call the old "eight hours" rule into question.

The reality is that individual sleep needs can vary. Some people need very little while others need more than the average. "The issue of sleep causes a lot of guilt by women," Dr. Love said. "We need to be more realistic. If you're sleepy all the time, you're not getting enough sleep for you. If you're fine on six hours, don't worry about it."

Likewise, while exercise is important, many people don't place enough value on the fitness that comes from everyday tasks like lifting and chasing children, lugging groceries and cleaning house.

And there is nothing magic about losing weight. People who are obese or underweight have higher mortality rates, but people who are overweight are just as healthy as those of normal weight — and sometimes healthier. "The goal is to be as healthy and have as good of a quality of life as you can have," Dr. Love said. "It's not to be thin."

Health experts agree that moderation is important and that people should not panic about their health habits. But Dr. Elizabeth Barrett-Connor, professor of family medicine at the University of Cali-

Join the discussion at nytimes.com/well.