MENTAL HEALTH NEWS™

YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES
FALL 2002 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 4 NO. 4

Mental Health News Salutes The

Mental Health Association Movement

The Mental Health Association movement began when Clifford W. Beers—a former psychiatric hospital patient—founded the Connecticut Society for Mental Hygiene (1908) and the National Committee on Mental Hygiene (1909). During his stays in public and private institutions, Beers witnessed and was subjected to horrible abuse; and, while in the hospital, he envisioned a mental health reform movement that would extend from local to international levels. His vision is the source of a network of advocacy organizations throughout the United States and Canada that includes local and state Mental Health Associations, the Canadian Mental Health Association, and The National Mental Health Association.

The National Committee on Mental Hygiene got a fresh infusion of commitment to improve care for people with mental illnesses when it merged with The National Mental Health Foundation to form The National Mental Health Association (1953).

The National Mental Health Foundation had been founded during World War II by conscientious objectors who were assigned to work in state mental hospitals. The horrible conditions they found led them to organize a movement to reform state hospitals.

To capture the impetus of the merger symbolically, The National Mental Health Association forged a bell—modeled on the Liberty Bell—from shackles and chains that had been collected from state hospitals. It serves as a strong reminder of the conditions which once characterized public care of people with serious mental illnesses in America.

The work of Mental Health Associations throughout America has resulted in innumerable positive changes. It has contributed to the humanization of mental health services, to the professionalization of services for people with mental illnesses, to the development of outpatient mental health models, to the reduction of barriers to treatment, to the effort to promote mental health and prevent mental illnesses, to the education of millions about mental illnesses and mental health, and to the reduction of stigma. As a result of their efforts, mental health services are vastly better than they were a century and even a half century ago, and many Americans with mental disorders have sought care and been helped to enjoy fulfilling, productive lives in their communities.

Nearly 100 years after it was founded, the NMHA continues to play a pivotal role in shaping federal mental health policy and programs. And over 340 affiliated community Mental Health Associations (MHAs) continue their advocacy for improvements in state and local mental health policy and programs. In addition many state and local MHAs provide vital direct services to individuals and families whose lives have been affected by mental illness.

Mental Health News is proud to salute the entire Mental Health Association family of organizations, for improving the mental health of all Americans—especially the 54 million individuals with mental disorders—through advocacy, education, research, and services.

Mental Health News wishes to express its deep appreciation for the support and ever-widening relationship it has with the Mental Health Associations which have joined with this newspaper in our mission to provide hope through direct community mental health education.

Please consult our table of contents for the full story in our salute to the Mental Health Association movement.

"Cast from shackles which bound them, this bell shall ring out hope for the mentally ill and victory over mental illness."

Inscription on NMHA Bell

Mental Health News recipient of the Silver Hill Hospital 2002 Media Award

Also in this issue of
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Mental Health News
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Ira H. Minot, C.S.W., President, Founder & Publisher
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Mental Health News Advisory Council

Mental Health News Wishes to Express Its Sincere Gratitude And Appreciation To The Members Of Our Advisory Council And To The Organizations and Supporters Who Make This Publication Possible

The Publisher's Desk

The Year In Retrospect

By Ira Minot, Founder & Publisher, Mental Health News

The New Year 2003 is not for another three months, yet for many in the mental health community, Fall represents the start of another year. Summer has gone and September marks the time to gear up for the new year ahead. With that in mind I thought it fitting to look back on the year 2002—a year marked by tragedy and promise.

The Tragedy

It was Wednesday morning September 11th. I was sitting here at my desk at Mental Health News as I am now, writing. The morning radio show I listen to was on as usual in the background. Suddenly an announcer interrupted the show and said that something was happening in the city..."turn on your television." I did and I watched as smoke and fire poured out of the first tower that had just been hit by a jetliner. Putting my work aside, I sat motionless watching CNN thinking (as many have) that the pilot must have had a heart attack or a seizure to have veered off course into the World Trade Center Tower. Minutes later I watched in horror as the second plane struck the second Tower. I remained at my desk for the rest of the day riveted to the TV watching events unfold, which, in the aftermath, would change the lives of so many...and life as we once knew it to be, would not be the same for America.

So many lives lost, so much confusion and fear, a nation attacked by terror—the likes of which we had only watched with detachment as something that happened elsewhere—not here in our own cities, villages and towns.

Here at Mental Health New, we had just finished delivering the Fall 2001 issue—with the cover story *Understanding and Treating PTSD*. People started calling me on the phone wondering how I was able to get this issue on PTSD out so timely after the 9/11 tragedy? Was it coincidence or was it *meant to be?*

That cover story had been suggested to me back in the Spring of 2001 by Dr. Andrew Levin. Dr. Levin, who is now Medical Director at Westchester Jewish Community Services, had done extensive work in the field of PTSD. He recommended the topic to me during a discussion we had about topics to cover in future issues, and he suggested I contact Dr. Randall Marshall at Columbia who was one of the nations leading authorities on PTSD.

I called Dr. Marshall and interviewed him over the phone. Thru their guidance and expertise in the field, and wonderful caring and interest in the efforts of this newspaper, both Drs. Levin and Marshall succeeded in helping me sculpt much of what went into the PTSD issue.

I was so proud and grateful to have Dr. Marshall's interview on the front page and Dr. Levin's piece entitled, *PTSD As A Normal Adaptation,* in that issue.

As we now find ourselves in the midst of the one-year anniversary of September 11th, we must pause, reflect and review what we know, what we are still learning, and how we can continue to help those who continue to suffer in the aftermath of such a tragedy. In that spirit, I am grateful again to Dr. Marshall for allowing Mental Health News to reprint an updated version of the piece we ran a year ago (see page 16).

Our heartfelt thoughts are with those who mourn and with those whose experience of the tragedy has left an indelible mark on their hearts and minds.

In closing, I wish to send my prayers, thanks and recognition to the hero's of Ground Zero... and to all the organizations and staff who were there then and who continue to provide crisis intervention and groundbreaking PTSD program initiatives in and around the NYC metropolitan area.

As the months passed after Sept. 11th, the mental health community began to refocus on the fiscal battles in Albany where the mental health budget was hanging in the balance. Cost of living raises for mental health workers, Reinvestment Fund cutbacks and the battle for parity in insurance of the mentally ill, were in jeopardy of being sidetracked, leaving many to wonder when our agenda would be met.

Suddenly, our attention was shifted to the heart wrenching realities of the Adult Home scandals revealed in the NY Times. How could we rationalize the abysmal care imposed upon sons and daughters; mothers and fathers—those we have been entrusted to care for and who we have unfortunately forgotten.

Ira Minot

The Promise

There were battles won
and battles lost.

There were scandals
which woke us up.

There is so much work
that still must be done.

But the promise for a
brighter and more effective
mental health landscape
is within our grasp.

Thanks to the dedicated
efforts of the many people
who *are* the fabric of our
mental health community.

At Mental Health News, we are proud to have the representation of the dedicated organizations that fight for the rights of persons with mental illness. Our new column format is enabling us to keep pace with news from NAMI (National Alliance for the Mentally Ill), MHANYS (Mental Health Association in New York State, NYAPRS (New York Association of Psychiatric Rehabilitation Services and NAMH (National Artist for Mental Health).

In addition to the advocacy and consumer issues covered by these columns, we wanted to provide you with expanded coverage of the clinical side of mental health. We created a column called *Working With Medications,* which gives our readers a unique perspective on the how's and why's of medications. Understanding medications can be a daunting and difficult experience for consumers and families, but Dr. Richard H. McCarthy does an incredible job of taking the mystery out of something that affects all of us who struggle with mental illness.

Your response to our new columns has encouraged us to continue building on this successful format. This falls issue brings yet another new column to our readers by the newly elected President of the New York State Psychiatric Association (NYSPA), Dr. Barry Perlman, Chief of Psychiatry at St. Joseph's Hospital in Yonkers, New York. And the excitement keeps building with new plans to cover the mental health scene in the New York metropolitan area in the coming months.

In June, we invited leaders from the NYC mental health community to a luncheon hosted by Dr. Alan Siskind, Executive Vice President of JBFCS. We wanted to learn how to better serve the mental health education needs in the metro NYC area. What we learned, was that there was a tremendous need to bring our mental health education mission to more individuals and families in the five boroughs and city of New York.

The meeting resulted in the formation of a dynamic new committee of leaders from the NYC mental health community eager to help us launch a NYC section of the newspaper which we hope to premier in our next issue. The excitement keeps building.

I knew that Mental Health News could fill the vital need to reach consumers and families in communities near and far. This thought proved out when I was contacted by George Griffith, President of the DMDA of the Finger Lakes—a consumer run support group devoted to providing hope and education to people battling mood disorders.

DMDA of the Finger Lakes, which is located in Elmira, New York, wished to team up with Mental Health News to help bring their group's message to a broader audience in upstate New York. The result is a four page spread in this issue (see pages 23 - 26) which we know will help send a message of hope and connection to individuals and families in the Southern Tier and western regions of New York State.

Through the support and encouragement of our readers, and ever-growing family of friends in communities near and far, Mental Health News continues to cover and respond to the news and events within the sphere of our mental health world.

Thank you for your continued interest and support, and as always, I appreciate you E-mailing me your ideas, suggestions and comments to my mailbox at mhnmail@aol.com.

Best Wishes
Ira H. Minot, CSW

Letters To The Publisher

Some Thoughts on the Vagaries of Employment

By Alan H. Bernstein

Unfortunately, for many, life is littered with shattered dreams. The promise of personal fulfillment is just a middle-class concept that beckons to the professionals among us who consistently achieve a high level of personal satisfaction from their families, work, friends and hobbies. Fortunately, in recent years, the recovery movement has challenged the status quo on this issue as well many others. More and more often people are talking about the possibility of everyone's ability to attain a sense of personal fulfillment. This is a welcome and important change in the thinking about the direction of services and supports for the mentally ill. However, all of the polemics in the world won't change the situation without a key ingredient - work.

My own story includes starting to work at the age ten as a delivery boy for the corner pharmacist. At the age of eleven I graduated to be a newspaper carrier and did that until I was sixteen and a freshman in college. Then I got a real job, earning a significant amount of money as I went to college. In those days working meant clothes, a car and ample spending money. This was not the era of the bankcards, parent funded checking accounts and other frills that seem so usual to so many families today. We can all debate about the wisdom of a plan such as this. "Necessity" of course speaks for itself and tends to minimize dialogue when perhaps it shouldn't.

Shortly after graduating from college, it was a rude awakening for me to emerge from some months of acute psychosis, ECT, insulin and other therapy to realize that I was no longer employed. Without work. Bereft of the independence that I had so carefully developed over the course of my life. I was always the one with the resources. Second only to losing my personal address book, being without a job was most devastating. Even worse was the rejection trying to find work, experienced as humiliation. I had been employed since I was 22.

I was a reasonably competent and reliable employee. Why couldn't I land a job? I had a college education, was presentable and conducted myself well in interviews. I was better looking then than I am now even though some people find that hard to believe! What did I lack? It was impossible for me to understand at the time. Only in hindsight do I have a glimmer of what some of the issues may have been. Now, looking back I can say that one of the glaring issues was a significant lack of career preparation. It was not my value as a worker; it was my career direction or lack of it that repeatedly skewed the situation. The careful thinking through of my options as a young man and an examination of the real possibilities was largely missing. I was a young man without a direction.

Finally, with the help of a friend who I met volunteering on the Lower East Side, I found a job as a teacher, got an apartment, met my first wife, became firmly involved in therapy and began to set a clear direction for myself. Things were looking up considerably as I soon moved into another job, social work school and, eventually, my dreams of running an agency and having a family. Despite the stresses, it's critical to understand the powerful nature of the feelings that are generated by such personal achievement. They offer the ability to help one sustain much hardship, distress and downright unhappiness. They offer a focus to help sort through and cope with the onslaught of feelings that people with mental illness experience. Productive, responsible and gainful activity, is a wonderful tonic for depression, schizophrenia or for life in general.

We can and must embellish on the "love and work" credo that Freud handed down many years ago. Friends, hobbies, community and spiritual needs are all now seen as important parts of a well rounded, mature life. Providers work with consumers to help build a solid, holistic repertoire of activities, social events, entertainment and intellectual stimulation. However, those things may often be the icing. Where's the cake?

Innovative approaches to finding jobs are out there. Helping companies small and large find places where people with disabilities can make a start or continue careers interrupted by illness is now becoming a critical component in the provision of service to people with mentally illness. Reaching out to employers is another way of helping to educate the community about the destructive nature of stigma. Helping consumers manage the complex issues of employment is a major task for which we must educate staff who are already overworked and overburdened. These days a simple discussion of the process of disclosure can fill volumes. People, consumers, families, direct care staff, management and boards all need substantial training. It appears that soon New York State will ask providers to make additional effort to improve and expand vocational services. That's good. What's not good are unfunded mandates that put additional responsibilities on a system that is already overburdened.

The concepts behind psychiatric vocational rehabilitation are sound. People with serious mental illness can recover and function and *pay taxes !* However, career counseling is a critical component. Training for staff and others is needed. Money for outreach and job development needs to be available. Serious work needs to be done with consumers and it must be supported in a serious way by the mental health system if the promise is to be realized. The professional, advocacy and consumer movements need to join forces in order to work with government agencies to make certain that future requirements for psychiatric vocational rehabilitation include ample reimbursement so that this most important job to be done is done well.

Alan H Bernstein, MS, ACSW is an independent consultant serving the New York Mental Health community. He can be reached at 718-237-5744 or by email him at abernstein@albernconsulting.com.

Rising Cost of Health Care Unfair At Any Price

I just started to peruse your Spring 2002 issue which spoke of anger. I got as far as Letters to the Editor when I decided to write this. Yesterday I read in another periodical (Newsweek) about how the private insurance companies will further put consumers up against the wall by making insurance coverage ever more expensive, the employers will pass the costs on to the employees and those with higher salaries will be able to afford better care than those who make less. We will be able to choose from an ever-expanding smorgasboard of insurance offers, such as if you want a "premium" doctor, board certified or specialist, it will cost more and if you choose a "run-of-the-mill" doctor it will cost less.

These choices will cost us more and more until the point where enough consumers are in a corner to begin a revolt against private care. It is frightening and makes me angry. This leads me to comment on the letter "Stigma and September 11th" by G. Slaby.

The place to prevent stigmas of all sorts, and to make consumers aware of the dangers of decreased and expensive future health care in the U.S., is at the level of college students. This is where education and awareness will really work, but it needs to be constant and unrelenting. Just as insurance denials are constant and unrelenting. I know, I work in a hospital in a behavioral health unit. If students ever wanted a cause to demonstrate about then this is it. This is about them, their future children, and their parents, brothers and sisters. Without affordable and equitable health care, more and more of those who are not wealthy, or even upper middle class, will wander the streets with mental illness or die earlier.

This is the future our students face and they should be made aware of it. Their reaction, demonstrations, letters, etc. will fuel a response from the Government. Silence on this issue will almost literally kill or maim many of us.

Helen Blas
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MENTAL HEALTH NEWSDESK

NYC's Health & Mental Health Commissioner Sets Priorities and Vision for the Next Four Years

Office of Public Affairs
New York City Department of Health

Thomas R. Frieden, M.D.

Thomas R. Frieden, MD, MPH has assumed his post as New York City's 41st Health Commissioner and began his tenure as head of the Departments of Health (DOH) and Mental Health, Mental Retardation and Alcoholism Services (DMH). This July DOH and DMH merged, and Dr. Frieden became Commissioner of the new Department of Public Health.

Dr. Frieden returns to the New York City Department of Health where, as Assistant Commissioner and Director of the Tuberculosis Control Program from 1992 - 1996, he led efforts that halted the tuberculosis epidemic. For the past five years, Dr. Frieden worked in India as Medical Officer for the World Health Organization on loan from the U.S. Centers for Disease Control and Prevention (CDC). During his time there, he helped India develop one of the most effective tuberculosis control programs in the world.

"It is a tremendous honor to have been asked by Mayor Michael R. Bloomberg to serve as Commissioner," Dr. Frieden said. "New York City has a wonderful public health tradition. Public health departments can improve the quality and length of life. Through strong tobacco control efforts and by promoting better nutrition and regular exercise, we can control cancer, heart disease, stroke, and diabetes—the leading causes of premature illness and death in New York City. "To make this new era of public health in New York City a successful one, we will need the participation of every individual and community," Dr. Frieden continued. His priorities include plans to:

- Strengthen systems that monitor each community's health status to help identify community needs;
- Decrease tobacco use, an epidemic that currently causes more than 12,000 deaths each year in New York City;
- Work with communities to improve HIV prevention strategies;
- Ensure that high quality, adequate services exist to serve persons with mental illness and developmental disabilities and to free individuals from dependence on alcohol or other drugs;
- Promote the health of children through stronger partnerships with schools, especially in the areas of tobacco use; HIV/AIDS and other sexually transmitted diseases; mental health; alcoholism and other drug use; asthma; violence; and obesity; and
- Ensure New York City remains prepared to confront new and emerging disease threats, including those posed by biological terrorism.

Under Dr. Frieden's leadership, cases of multidrug-resistant tuberculosis declined 80% between 1992 and 1996. Before directing DOH's Tuberculosis Control Program, Dr. Frieden worked at DOH on a wide spectrum of public health issues as CDC Epidemiological Investigation Service (EIS) Officer from 1990 - 1992.

Dr. Frieden said, "The past year has been one of the most difficult in New York City's history. I look forward to working with communities to foster recovery and to further promote and protect the health of all New Yorkers. This is the greatest city in the world and one of the healthiest. Working closely with communities, together, we will make New York City even healthier."

The Departments have combined budgets of $1.3 billion and a staff of more than 6,000 health professionals and allied employees.

Over the course of a distinguished twenty-year career in public health, Dr. Frieden has worked as an epidemiologist, administrator, teacher, researcher, clinician and community organizer. A considerable part of his public health career has been spent in New York City. Dr. Frieden is dedicated to the mission of protecting and promoting the health of all New Yorkers. Foremost among his priorities is the strengthening of systems to accurately monitor each community's health status. With information from these systems, the Department will work with communities to improve health status.

Dr. Frieden believes that certain public health problems require special attention. Because tobacco addiction is the leading cause of preventable illness and death in New York City, the Commissioner is a staunch advocate of expanded tobacco control activities. By reducing tobacco addiction, considerable progress will be made toward decreasing heart and lung diseases, cancer and other illnesses related to smoking.

Other basic health interventions high on Dr. Frieden's agenda include mental health care; prenatal care; cancer screening; and ensuring that more New Yorkers are treated effectively for hypertension. With the HIV epidemic now more than 20 years old and with evidence of the increasing spread of the virus, Dr. Frieden views working closely with affected communities to develop more effective HIV prevention strategies as a top priority. He will also lead city efforts to address new and emerging disease threats, including those posed by biological terrorism.

He considers schools key partners in the prevention of tobacco use, HIV/AIDS, obesity, drug use, alcoholism, violence, and asthma. Dr. Frieden is also an advocate for high quality programs to serve persons with mental illness and those with mental retaradation and developmental disabilities, and to free individuals from dependence on alcohol or other drugs.

A world-renowned expert in tuberculosis control, Dr. Frieden has worked in India for the past five years assisting the government there in its efforts to control tuberculosis. As the Medical Officer for the World Health Organization on loan from the US Centers for Disease Control and Prevention (CDC), he helped India develop one of the world's most effective tuberculosis control programs. With his assistance, the program has treated 1 million patients and has saved close to 200,000 lives.

Prior to his tenure in India, Dr. Frieden was instrumental in stopping the tuberculosis epidemic in New York City. He began his career at the New York City Department of Health in 1990 as a CDC Epidemiologic Intelligence Service (EIS) Officer working on a wide range of health issues. His success in documenting the spread of multidrug-resistant tuberculosis led to his appointment as Director of the Bureau of Tuberculosis Control and Assistant Commissioner. He served in this capacity from 1992 - 1996, during which time New York City cut cases of multidrug-resistant tuberculosis by 80%. The program Dr. Frieden built is still used to address tuberculosis in New York City and is considered an international model for tuberculosis control.

A graduate of Oberlin College, Dr. Frieden received degrees in Medicine and Public Health from Columbia University. He completed specialty training in Internal Medicine at Columbia, and subspecialty training in Infectious Diseases at Yale University. Combining a career of distinguished scholarship with public health action, Dr. Frieden is the author of more than 100 articles. The recipient of numerous awards, Dr. Frieden is fluent in English and Spanish and familiar with French and Hindi.

MENTAL HEALTH NEWSDESK

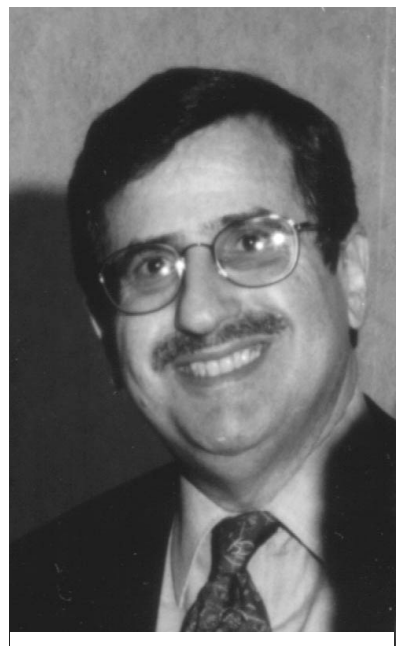
Dr. Barry Perlman Elected President Of The New York State Psychiatric Association

Staff Writer
Mental Health News

Dr. Barry Perlman, Director of Psychiatry at Saint Joseph's Medical Center in Yonkers, was elected president of the New York State Psychiatric Association. The New York State Psychiatric Association (NYSPA) is an organization representing 4,500 psychiatrists in New York State on professional issues as well as advocacy on behalf of persons with mental illness. An Area II affiliate of the American Psychiatric Association, NYSPA's goal is to promote quality mental health care in New York State. Before being elected president of the association, Dr. Perlman was vice president for four years.

A graduate of Yale Medical School, Dr. Perlman was appointed chairman of the New York State Mental Health Services Council by the governor in 1995. He also serves on the New York State Hospital Review and Planning Committee, an advisory committee for the New York State Department of Health. As Director of the Department of Psychiatry of Saint Joseph's Medical Center in Yonkers since 1981, Dr. Perlman oversees Saint Joseph's expansive mental health services, including inpatient and outpatient care, continuing day treatment, counseling services, and substance abuse treatment programs.

According to Dr. Perlman: "NYSPA is committed to advocating on behalf of persons with mental illness and our profession, assuring that psychiatry is being practiced in a scientific and ethical manner, and striving for access to psychiatric care on a fair and equitable basis."



Barry Perlman, M.D.

New Community Effort Premiers in Westchester National Council on Alcoholism & Drug Dependence

Staff Writer
Mental Health News

They are new. They are eager, and they are committed to reaching all people in Westchester County whose lives have been affected by the disease of alcoholism and drug dependence.

Who are these people? They include anyone who has abused alcohol or drugs, as well as anyone who has lived with, worked with, is in a relationship with, or who has a friend who is an alcoholic or drug abuser. The affected population is staggering. Many of these people suffer pain but have no idea why.

The National Council on Alcoholism and Drug Dependence/Westchester's mission is to provide information, education, prevention and referrals. Our goal is to educate the public regarding the disease of alcoholism and chemical dependency and to help eradicate the stigma surrounding this disease.

Their current programs include the Family Information Series, which is four sessions beginning the first Thursday of each month at The White Plains Hospital Center from 7:30 to 9 p.m.. Relapse Prevention Workshops will be held on the second and fourth Saturdays of each month from 10 am to 11:30 a.m., also at The White Plains Hospital Center. They are a member of The Clear Choices Task Force, which is a middle school drug and alcohol prevention program in Westchester County sponsored by our D.A.'s office: educating parents as well as children regarding drug and alcohol use and abuse.

They are available to conduct seminars for medical professionals, clergy, and judges in conjunction with The Coalition for Family Justice. They are also conducting seminars at community service groups. September 13th, 14th, and 15th, they are sponsors of Recovery Weekend. Our Council will assist you and your loved ones in getting the help you need. You may contact Joan Bonsignore, President, at (914) 949-8500, and by e-mail at jsb28@aol.com. Volunteers are needed.

Joan Bonsignore

Volunteer Positions Now Being Filled At Mental Health News Leading To Full-time Paid Positions - See Page 52 For More Details

Our Mental Health Associations
The Heartbeat of the Mental Health Community

Staff Writer
Mental Health News

Mental Health Associations (MHA's) bring together mental health consumers, parents, advocates and service providers for collaboration and action. MHA's provide public education, information and referral, support groups, rehabilitation services, socialization and housing services to those confronting mental health problems and their loved ones. Many also provide family advocate services to parents and children with serious emotional disturbances, mentoring relationships for adults recovering from mental illnesses, and professional education to those working in the mental health field. They serve as local leaders in the support and development of consumer-run initiatives and primary prevention programs. Finally, MHA's strive to influence public policy at the local, state, and national level to assure fair and effective treatment to the millions of Americans suffering from mental disorders.

Mental Health News takes great pride in saluting the Mental Health Association movement in this fall issue, and wishes to recognize the staff and volunteers at local MHA's whose tireless efforts combine to make a difference in the lives of countless individuals and families.

We want to introduce you to some of the many MHA's in our local area here in New York. MHA's are busy organizations so we were unable to cover as many profiles as we had hoped to. Our apologies to those who were unable to meet our deadline for this story, and we pledge to offer them an opportunity to be seen and recognized as often as we can in future issues.

When our lives are disrupted by emotional upset or we find the problems of family or illness becoming too hard to bear, the Mental Health Associations of our communities are there for all of us. These organizations offer a beacon of hope to bring us back to a sense of normalcy in an often abnormal world.

Mental Health News urges all of our readers to get to know and support the local MHA in your area. Become a volunteer and become a partner in caring for the mental health needs in your community. It will be a gift you will cherish for a lifetime.

MHA In Ulster County

Ellen Pendegar, Executive Director MHA in Ulster County

The MHA in Ulster County, Inc. is an intregal part of the mental health system of care in Ulster County. We provide a wide range of services for the community, including but not limited to, mental heatlh education, information & referral, advocacy, and direct services. The MHA direct services include opportunities for adults recovering from mental illness to address issues with housing, school, socialization, and recreation. We collaborate with peer run programs and the treatment services provided by the county and the state programs. The MHA also has a large array of services addressing the needs of children and their families, such as, the Teaching Family Model Residential Program, Family Based Treatment Program, Therapeutic Foster Care, Respite, and many prevention, support and educational programs. For the last 10 years the MHA has expanded its borders beyond Ulster County to include provision of services in the New York Counties of Chenango, Delaware, Otsego, Schenectady, Schoharie, and Sullivan.

The MHA in Ulster County, Inc.'s mission is to create communities that are dedicated to mental health through the full participation of all persons. We pursue this mission in our work with MHANYS and the National MHA. We have a dedicated partnership with them to ensure that mental health remains a primary public health concern on the local, state, and national level. Without the workings of this three-tiered approach progress would be impeded. Together we are a powerful voice to be reckoned with.

MHA of Westchester County

Carolyn S. Hedlund, Ph.D., Executive Director, MHA of Westchester

For more than 50 years The Mental Health Association of Westchester County has been committed to advocacy, community education, and direct service provision on behalf of people with mental health problems. It has grown considerably over the years. Initially it was a small advocacy organization staffed primarily by volunteers. Now it is one of the largest mental health organizations in Westchester County staffed primarily by mental health professionals and paraprofessionals with the assistance of a great many volunteers.

The Mental Health Association of Westchester seeks to help a broad array of people with mental health problems. Its rehabilitation, housing and employment services are available for adults with severe psychiatric disabilities. Its case management services are available to seriously emotionally disturbed children and their families. It provides assessment and treatment for homeless families and children. It provides various forms of assistance for victims of both spouse abuse and child abuse—in the courts, in their homes, and in MHA facilities. It serves older adults in nursing homes and other settings. Its clinics provide outpatient treatment for people of all ages and many different kinds of mental health conditions. It reaches into the schools to help to prevent the development of serious problems.

In the past year, MHA of Westchester has taken on several key tasks in Westchester's response to the psychological consequences of terrorism.

At the same time that MHA has become a major direct service provider, it has continued to be a primary source of public mental health education in Westchester County, and it is widely recognized as the primary voice of mental health advocacy in the County, working at local, state, and national levels. Please take a moment to visit our website at www.mhawestchester.org for more information, including listing of local educational events.

Our Mental Health Associations
The Heartbeat of the Mental Health Community

The Mental Health Association in New Jersey

Carolyn Beauchamp
Executive Director - MHANJ

Serving over 15,000 individuals annually, the Mental Health Association in New Jersey strives to be the premier organization in the state, advocating for children and adults to achieve mental health through education, training, and services. Throughout its 53 year history, the MHANJ has worked to ameliorate the effects of mental illness and promote mental wellness. The Mental Health Association works to turn individual experiences with mental health services into public policy, advocacy and legislative action into order to make the NJ mental health system more responsive to the needs of the its citizens.

As a grassroots organization, it has been a major force behind all of the significant changes within NJ's mental health system. The organization has a long-standing history of creating and implementing initiatives that focus on the needs of consumers of mental health services through the development of program partnerships and advocacy coalitions. MHANJ has played a key role in building broad based coalitions and task forces that have brought about major legislative, policy, and programmatic changes within NJ. "From leading the fight for deinstitutionalization, to modernizing commitment and screening laws, to seeding the family and consumer movements," states Executive Director, Carolyn Beauchamp, "MHANJ has been a systems change agent within our mental health system."

Creation of innovative program models is another major goal of the Association. These programs provide new and innovative ways of approaching existing mental health needs. Consumer Connections, for example, is a national award winning MHANJ program initiated in 1998 to recruit, train, and support consumers of mental health services who are interested in becoming providers of mental health services. With training and technical assistance from Consumer Connections staff, this model is now being instituted in other states.

From the coordination of NJ's annual Depression Screening Campaign to Project Return which focuses on teaching consumers of mental health services the skills they need to promote wellness among their peers, MHANJ's Community Education Department works to promote understanding of mental health and mental illness issues. The Department reflects the organization's agenda of empowering consumers, supporting the development of strong community based services, fighting stigma, educating the public, and integrating consumers into the community.

Since 9/11, the MHANJ has expanded its Information and Referral services to include Project Phoenix which includes a mental health helpline specifically devoted to assisting those who were impacted by this tragedy. Other activities of Project Phoenix include a workbook entitled "Helping School Staff Prepare for the 9/11 Anniversary," which is currently being distributed to all teachers in NJ.

Throughout its history, the Mental Health Association has worked to ensure the rights of mental health consumers and promote mental health among NJ's citizens. It will continue to respond to needs as they emerge. For more information about the Mental Health Association in New Jersey, its programs and publications, visit www.mhanj.org.

MHA of Nassau County

Steve Greenfield, Executive Director
MHA of Nassau County

As the MHA of Nassau County approaches its 50th Year of Service, we are focusing on the recovery process and the hope that it engenders. We are harnessing our residential employment, educational and community support programs to produce positive outcomes for both adults and children. Simultaneously, the mental health community must fight the discrimination and prejudice that limits the opportunities available to people with psychiatric issues.

Support Your MHA!

MHA in Dutchess County

The MHA in Dutchess County plays a multifaceted role in the community. As a major service provider, we are continually re-evaluating the way in which we can best serve the community, and how we can ensure that our services produce hope, inner strength, empowerment, and recovery. As an agency engaged in advocacy, we believe we must serve as a catalyst to help move the system to address the needs of people with serious mental illness and to promote the emotional well being of all children and adults. Also, as 9/11 taught us, we must be ready to act, in coordination with our colleagues at a moment's notice to respond to traumatic events. The challenge for our organization, like many of our fellow affiliates, is to put into action our vision of a responsive, rehabilitative model of mental health services, to maintain our passion in the face of discouragements, and to translate dreams into practice.

Jacki Brownstein, Executive Director
MHA of Dutchess County

Our Mental Health Associations
The Heartbeat of the Mental Health Community

The Mental Health Association Of New York City

The Mental Health Association of New York City has been serving New Yorkers for 32 years. Our core goal is to improve the lives of people with mentall illnesses, and we do that through extensive public education and advocacy and innovative direct services for consumers.

MHA's growing public education efforts dispel stigmatizing myths about mental illness, and we encourage people to get treatment. Our best known educational program is Lifenet, a 24/7, multicultural hotline information and referral service. For more than six years, it has brought tens of thousands of people into the treatment system. Through advocacy we insure that government maintains and expands its commitment to those with mental illnesses. This year, for example, we spoke out forcefully on how to correct the deplorable conditions in adult homes where more than 15,000 New York City consumers live.

Our 20 direct service programs ensure that all consumers get the opportunity to realize their personal goals. Last year alone, MHA assisted 2,700 individuals. We focus on children and adolescents, on maintaining and strengthening families and on reaching out to underserved populations like the elderly, and those with a dual diagnosis of mental and substance abuse illness. Through a variety of peer groups and consumer-run programs, we help to empower people living with mental illness.

Because of the World Trade Center disaster, 2002 was undoubtedly the most extraordinary year in MHA's history. All of us at the agency are grateful that we have been able to contribute to the recovery effort. Lifenet became the communications hub of the mental health emergency recovery program and the doorway to crisis counseling and other mental health services for thousands.

Since 9/11 we have worked hard to get the word out that help is available. Our efforts are directed to groups most in need of assistance and least likely to seek treatment. Our newest initiative, to be launched next month, is a children's 9/11 mental health campaign targeted to tens of thousands of young people affected by our nation's most traumatizing event. Expect to see our multilingual brochures and posters in schools and other places frequented by children and their parents. We are delighted that this program has just been endorsed of Senator Hillary Clinton who has made children and adolescents a major priority.

Giselle Stolper, Executive Director
MHA of New York City

MHA of Rockland County

Days before completing my first year as President of the Mental Health Association of Rockland County Inc. my reflections focus on the accomplishments of this organization. September 11, 2001 taught us that in collaboration and with a commitment to others we can respond to our worst fears and as a community and nation we can be resilient. The Mental Health Association of Rockland County, Inc continued to provide quality services this past year as well as expand services to meet the needs of the county following this tragedy.

The Mental Health Association of Rockland County, Inc. developed a Volunteer Mental Health Corp. made up of therapists and computer specialists to work jointly with other providers in the community. This ongoing initiative is available and will augment existing services.

As the Mental Health community struggles to understand mental health issues in this new day, I am happy to say the Mental Health Association of Rockland County, Inc. will continue to be a leader in both service provision and collaborative efforts within the county.

Karen Oates, Executive Director
MHA of Rockland County

MHA in Putnam County

Our vision for MHA in Putnam is to continue to expand the opportunities we provide for psychiatric rehabilitation for Putnam County residents. Our legally incorporated name is now MHA in Putnam County II, Inc. (after a failed attempt to incorporate and offer services in the late 1960's). The reason behind the dissolution was that no one in Putnam County appeared to have mental health needs back then.

A quarter century later, we're back and show no signs of going out of business! We have more than doubled our operating budget in the past five years and look forward to celebrating our 10th Anniversary in 2003.

"Growth" is the word that best describes our agency and what we offer our clients and the vision of our future!

Megan Nowell, Executive Director
MHA in Putnam County

National Empowerment Center Founders Laurie Ahern and Dr. Daniel Fisher Receive NMHA's Coveted 2002 Clifford Beers Award

By The National MHA
www.nmha.org

Laurie Ahern and Daniel Fisher M.D., Ph.D., founders and co-directors of the National Empowerment Center and pioneers in recovery from mental illness, share their thoughts with The Bell (NMHA's newsletter) about their lives and work as advocates. Ahern and Fisher received the 2002 Clifford W. Beers Award, NMHA's most prestigious award, at NMHA's 2002 Annual Conference in Washington, D.C.

The Bell: *Would you tell us a bit about your experiences with mental illness?*

Laurie: I was diagnosed with schizophrenia when I was in college at age 19. I was hospitalized, frightened and alone. With my diagnosis came a prophecy of doom that my life would be very limited, and that I shouldn't expect much in the way of a career or dreams.

Dan: I was diagnosed with schizophrenia at 24 and also told I would probably have it for the rest of my life. At he time, I was working in the neurochemistry lab at NIMH, and felt like my career was coming to a close just as my illness was beginning.

The Bell: *Yet you both defied your prognoses and recovered to embark on meaningful and successful careers. Tell us about your early work and how going public with your illnesses affected it.*

Laurie: I became a newspaper reporter and editor and didn't disclose my history until later on because of basic necessity. With the stigma that surrounds mental illness, I wouldn't have been hired as a journalist. But once I did make the choice to go public and become an advocate, I knew it meant the end of my newspaper career.

Dan: I decided to become a psychiatrist after my second hospitalization. I wanted to reform the system but was advised not to disclose my history during residency. I did so afterward, and it severely limited my job opportunities--not just my disclosure, but my advocacy on behalf of consumers. In fact, I'm often characterized as "too consumer friendly."

Laurie Ahern and Daniel Fisher, M.D., Ph.D. receive NMHA's 2002 Clifford Beers Award

The Bell: *What specifically led to your careers as advocates?*

Laurie: I was fortunate enough to recover from my illness, but when I looked around me, I saw so many other people who hadn't had the same opportunity. I had people around me who believed I could get better--and that was key. Also, I once covered a story on a state hospital where the big issue was whether to let people go outside because there were schools nearby. It was so poignant to me that I could be one of those people locked up in a hospital trying to get out. When I had the chance to work at the Center, I felt it was my life's calling.

Dan: When I was hospitalized, I kept thinking that if they knew what I really needed, they'd interact with me in a much more positive fashion. I needed hope, I needed to be treated as a human being, I needed tools to recover. And I was outraged at the punishing aspects of treatment. I felt there needed to be a more human and informed approach.

The Bell: *And so 10 years ago you started the National Empowerment Center. How did it get off the ground and what is its goal?*

Dan: We got the Center going through a CMHS grant to start a consumer supporter technical assistance center. Our goal from the beginning has been to get the message out that people can recover. And who knows better what can help or hurt people in recovery than people who have gone through the experience themselves? We want to transform the way mental healthcare is provided in all sectors of society. There needs to be a shift in understanding about recovery.

The Bell: *What is your shared philosophy on recovery?*

Laurie: We believe that mental illness is simply a label for the severe but temporary emotional distress that interrupts a person's role in society. We lose our social roles when we're labeled with mental illness, but we can recapture our dreams and dignity through self-determination and the absence of coercion.

People are empowered to recover when they are entrusted to make decisions about their lives and when they have positive peer support and relationships.

Dan: Our lives echo what most people who recover know to be true: that it is vital to have trusting relationships with people who believe in you and your ability to recover. All these values are embodied in our recovery model called PACE, or Personal Assistance in Community Existence.

The Bell: *How have your ideas about recovery changed over time?*

Laurie: Our ideas have become more clarified. Ten years ago we weren't talking about full recovery as we are now. We also know that people are more than their biology and their chemistry. We're trying harder to focus on the whole person, whole lives and dreams. Mental illness is as much a loss of dreams as a loss of dopamine.

The Bell*: What are your thoughts on plans to cut funding for your and other technical assistance centers next year?*

Dan: We are hopeful that funding will be restored for 2003 and that people see value in peer-support, self-help and promoting recovery with successful outcomes. In the long run, a little bit of funding provides a tremendous amount of support. It doesn't cost a lot of money to give people hope.

Laurie and Dan lecture around the country and give workshops to consumers, ex-patients, practitioners and family members. Their empowerment and recovery manuals have been translated into six languages.

In addition to their advocacy work at the NEC, Laurie Ahern is vice president of the National Association of Rights and Protection Advocacy. Daniel Fisher, M.D., Ph.D., works as staff psychiatrist at Eastern Middlesex Outpatient Center in Wakefield, Mass.

For more information, contact
The National Empowerment Center
at 800-Power-2-U (769-3728)
and please visit their website at:
www.power2u.org

The Clifford Beers Story
The Origins Of Modern Mental Health Policy

By Michael B. Friedman, CSW

"...the afternoon of May 6, 1908 ... a little knot of people sat down together in a residence in New Haven, Connecticut, upon the invitation of Clifford Whittingham Beers—a young man with a remarkable history—to organize the Connecticut Society for Mental Hygiene, the first ...association of its kind and the beginning of the organized mental health movement in America."

With these words Nina Ridenour begins her excellent history of mental health policy in the United States in the first half of the 20th century. It is a high and well-deserved tribute to Clifford Beers, the founder of what has become the Mental Health Association movement. At the age of 32, five years after he had emerged from three harrowing years of psychiatric hospitalization in three different hospitals, Beers took the first step towards realizing a grand vision he developed while he was in a hospital. It was a vision that arose from his personal experience of abuse at the hands of poorly paid and poorly trained hospital "attendants" and from his witnessing the abuse of so many other patients. He imagined an advocacy organization that would spread from local to international levels—an organization that would (1) fight to improve care and treatment of people in mental hospitals, (2) work to correct the misimpression that one cannot recover from mental illness, and (3) help to prevent mental disability and the need for hospitalization.

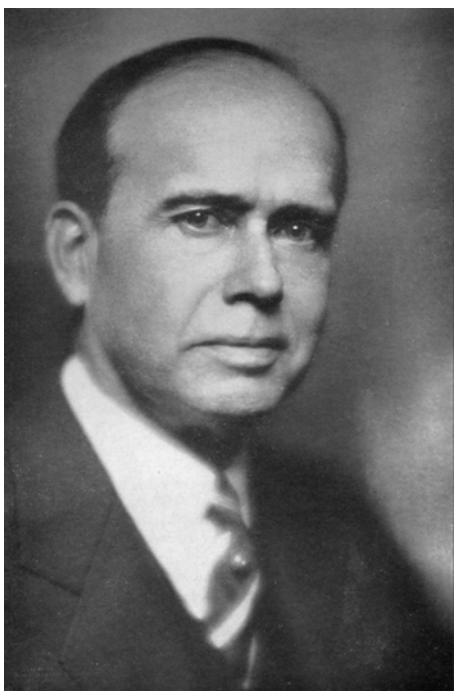
Within a year of founding the Connecticut Society for Mental Hygiene, Beers founded The National Committee for Mental Hygiene and began groundbreaking work that would change the face of mental health in the first half of the 20th century.

Beers' success in developing a national, and ultimately an international movement, began with his autobiography, *A Mind That Found Itself*. He hoped that it would have an impact on the scale of U*ncle Tom's Cabin.* In it he traced the course of his illness. He was a graduate of Yale University at the beginning of a promising career in business when he developed an obsessive fear of mental collapse subsequent to the death of a brother from epilepsy. His despair became so great that he attempted suicide. This led to the terrible years he spent in private, voluntary, and state hospitals in Connecticut and eventually to his recovery and his determination to reform the treatment of people with mental illnesses.

Although there had been other exposés before Beers', none had the impact that Beers' account did. Norman Dain, Beers' biographer, comments, "...other exposés...described treatment in asylums as cruel and inhumane, but most went beyond credulity, so that they were not effective propaganda...". Beers' autobiography has the ring of truth and reason. While exposing abuses, he revealed a great deal about his inner suffering and confusion and about his provocative behavior when he was in the hospital. He condemns the abusive behavior of attendants and lack of supervision exerted by the physicians who should have helped to protect him and other patients who could not comply with dehumanizing hospital routines, but he also acknowledged his own illness and showed considerable respect for the physicians' knowledge and abilities. The balanced voice and substance of *A Mind That Found Itself* unquestionably contributes to its power. Robert Coles has suggested that it is also the artistic quality of the writing that makes it so effective. In the Preface to the 1980 edition, he says that most exposés "prompt compassion...and maybe a kind of clinical understanding, but not the larger response that a work of art commands—a broadened moral sensibility."

A Mind That Found Itself is, unquestionably, morally compelling. Most people who read it feel horrified by the suffering it reveals and are moved to help to humanize our society's actions towards people with serious mental illnesses.

From the beginning Beers was able to attract very prominent supporters. The first was William James, the most important psychologist of his day and one of the founders of American philosophical pragmatism. James helped to open many doors for Beers prior to the publication of the autobiography, including to his publisher and to a number of people who had the resources to



Clifford Whittingham Beers

help to found a movement. In addition, Beers won prepublication interest from Adolph Meyer, one of the most prominent psychiatrists of the era. While Meyer—who ran a psychiatric hospital—was disturbed by some of Beers' most troubling allegations about hospitals, he too believed that hospitals needed substantial reform and recognized that Beers had the potential to generate the kind of public support that was needed to bring reform about. He and Beers formed a partnership which gave the National Committee on Mental Hygiene its initial directions.

Beers combined a number of leadership characteristics that were essential to the success of the National Committee on Mental Hygiene and of the state and local societies that it spawned. He had a clear, powerful vision. He had remarkable ability to communicate in writing and face-to-face. He had unending determination to realize his vision even at considerable personal cost. (He ran up a significant personal debt to get the National Committee going.) He had the flexibility to compromise when he had to in order to forge and preserve alliances, but he also had the courage to stick to his own views when he thought it was critical. He had sharp business acumen. And he understood that an enterprise of the magnitude that he imagined could not be the work of one man. From the start his goal was to build a unified advocacy community. He knew that he needed the moral and financial commitment of prominent lay people and that he also needed the support of the most highly regarded mental health professionals—particularly physicians. The laypeople and mental health professionals who joined Beers in the development and expansion of the mental health movement were a veritable who's who of America.

When The National Committee on Mental Hygiene began its work, most of what we take for granted now in the mental health system in the United States not only did not exist; it was yet to be imagined. Beers and the National Committee played a major role in formulating what would become the core of mental health policy in the 20th century. This included building a database that would inform the development of mental health policy. The National Committee was the first to compile lists of mental institutions and psychiatrists. Until the Census Bureau took over the function of counting people with mental illnesses in institutions and related data gathering, the National Committee put out the only annual statistical report about mental illness. Through this work, it became clear that data gathering was hampered by lack of shared nomenclature; and the National Committee played a leadership role in the development of the first official diagnostic language. It was also the first to successfully call attention to the lack of trained personnel to deliver mental health services and organized the first systematic training efforts with support from the Commonwealth Fund and the Rockefeller Foundation. It created a Division of Psychiatric Education, which, in collaboration with the American Psychiatric Association developed psychiatric training curricula and created the American Board of Psychiatry and Neurology to provide certification for psychiatrists. It also collaborated on the development of the field of psychiatric social work.

The National Committee is probably best known for the work it did to bring about major changes in legislation and in funding for mental health services. Early on it collected and analyzed mental health laws. Most importantly it conducted numerous surveys of the conditions in institutions for people

see *Beers Story* on page 45

Let's Meet NMHA CEO, Michael Faenza

Under the direction and leadership of CEO, Michael Faenza, the NMHA continues its history of playing a pivotal role in shaping mental health policy and programs throughout the United States.

After more than 15 years of experience providing direct service to children and adults with mental disorders, Mr. Faenza has spent the past decade focusing on legislative advocacy and improving society's commitment to helping people with mental illness.

A social worker by training, Faenza brings a public health perspective to issues of individual and community mental health. He has held clinical and management positions in public sector mental health services, child protective services, juvenile justice, and vocational rehabilitation.

Faenza holds a Bachelors of Arts degree in Sociology from Indiana University and a Masters of Science in Social Work degree from the University of Texas in Arlington. He currently serves on the National Assembly of Health and Human Service Organizations Board of Directors and the National Health Council Board of Directors. He is a former member of the Planning Board for the Surgeon General's Report on Mental Health and is currently a member of the United Way of America's Leadership 18. Faenza has received the Excellence in National Executive Leadership Award from the National Assembly in 1999. In 2001, he received the APA Speaker's Award in recognition of his enormous and crucial contributions to the care and well-being of people with mental illness.

Mental Health News was honored to have an opportunity to ask Mr. Faenza about NMHA and his vision for the future.

Michael Faenza

What is the role of NMHA?

NMHA's role is to help American society understand and act rationally and compassionately toward people with mental disorders and those at risk for developing mental health problems. A key part of that effort lies in two dynamics of the NMHA movement. The first is NMHA's commitment to empower and support community advocacy, and the second is seeing mental health and substance abuse as public health issues. NMHA's commitment to making change at the state and community levels is supported through the public education initiatives and systems advocacy work of mental health association (MHA) affiliates across the country. This public health orientation guides NMHA and its affiliates in our work in prevention, health promotion and consumer-centered services for all children and adults who are at risk for, or currently experiencing, mental health disorders. NMHA's vision of social justice is one of inclusiveness and equality.

What has NMHA done to improve mental healthcare in America?

As a national nonprofit enterprise, I believe the MHA affiliate infrastructure is America's best single bet to drastically change social policy and service systems for consumers, families and vulnerable communities. I think the negative impact of privatization in public mental health systems over the last few years would have been much worse if it were not for MHAs bringing consumer interests to the table in sophisticated ways. I also believe that the growing acceptance of mental disorders as a huge public health issue is the result of NMHA and its affiliate network's public education efforts around mental health, treatment and recovery. NMHA has put a public policy spotlight on the unmet mental health needs of children and adolescents, we have also highlighted the very sad state of youth and adults with mental health and substance abuse disorders caught in our juvenile and criminal justice systems.

How do local MHA's serve the mental health needs of the community?

I think of NMHA as a national movement of consumer-centered, community-based advocacy organizations for social justice. The biggest contribution over our 93 year history is the development and strengthening of 340 MHAs, located in state capitals and communities all over the United States. Legislative and service systems advocacy, community planning for evidenced-based prevention and treatment practices, and public education are central missions for all MHAs. MHAs provide effective information on all mental health issues, offer referral services, and advocate for consumers and potential consumers with mental illnesses and substance abuse disorders. Bringing diverse citizens and interests together to work with and for consumer and family interests is the hallmark of NMHA and its affiliates' collaborative efforts, and, as a result, contributes greatly to the larger mental health community that is often combative over scarce resources and political capital.

What should consumers and families know about NMHA?

Most important, NMHA is the organization that is for everyone who needs help or support with the symptoms and social challenges associated with mental disorders. We think that the only way to gain the political power needed to make real cultural and policy changes regarding mental health and substance abuse issues is to walk the walk of public health and inclusiveness. As long as Americans see themselves as individuals on one shore and the "people with mental illnesses" on the other, mental health consumers, and the rather paltry political strength of mental health and substance abuse treatment advocacy, will continue to fail in making the kinds of changes in access and quality of services we talk about. National and state public policy is enabling a fragmented approach to mental health that is shamefully insufficient for the majority of children and adults with mental health and addictive disorders in the United States.

What accomplishments during your administration are you personally most proud of?

I am proud of the consumer, family and community stakeholder interests within the MHA affiliate network that are working so effectively for rationale and compassionate public policy and community responses to mental health needs. During my eight years here, the state and local MHA affiliates have become the central focus of NMHA programs that target advocacy and public education goals. It is often difficult for Washington-based organizations to be relevant to real communities in real time, and I think we are learning how to do this in a way that is unprecedented in the mental health movement. I think NMHA's most important contribution is that we have built the strength and visibility of a social movement that says all people may benefit from education, health maintenance, and mental health and substance abuse treatment at some point during their lives. Mental health is not for "those people"; it is an aspect of life on the planet that has huge implications for each and every individual and community.

What goals would you like to see come to fruition during the next several years?

I would like to see pronounced changes in the way federal and state governments approach mental health and substance abuse needs across the spectrum of community life. The fact that the health insurance industry currently discriminates against mental health and substance abuse needs is outrageous. I think that the lack of attention and investment in children's mental health is shameful and needs change dramatically. The fact that approximately 40 million Americans lack health coverage and that the healthcare industry is under economic stress only promotes the continuing neglect of mental health and substance abuse needs. But these issues need national and state leadership we have not yet had. The fact that there are serious disparities in care among different racial and income groups needs to be acknowledged and corrected through moral leadership. The fact that 16 percent of adults and anywhere between 50 to 75 percent of juveniles behind bars have a mental health or co-occurring substance abuse disorder indicates a crisis in mental health and substance abuse services that future generations will find hard to understand.

Visit NMHA on the net at www.nmha.org

NMHA College Initiative: Finding Hope and Help

For many young adults, the college years are the best times of their lives. But too often these critical years of adjustment are undermined by depression, anxiety, substance abuse and eating disorders, sometimes leading to suicide. Researchers are finding that many mental illnesses may be traced to trauma whose damage surfaces in times of stress and change, such as the college years. Some of the threats to college students' mental well-being are highlighted below.

Depression affects more than 19 million American adults annually, including college students. At colleges nationwide, large percentages of college students are feeling overwhelmed, sad, hopeless and so depressed that they are unable to function. According to a recent national college health survey, 10% of college students have been diagnosed with depression and including 13% of college women.

Anxiety disorders affect over 19 million American adults every year, and anxiety levels among college students have been rising since the 1950s. In 2000, almost seven percent of college students reported experiencing anxiety disorders within the previous year. Women are five times as likely to have anxiety disorders.

Eating disorders affect 5-10 million women and 1 million men, with the highest rates occurring in college-aged women.

Suicide was the eighth leading cause of death for all Americans, the third leading cause of death for those aged 15-24, and the second leading killer in the college population in 1998.

According to the Federal Centers for Disease Control and Prevention (CDC), 7.8% of men and 12.3% of women ages 18-24 report frequent mental distress – a key indicator for depression and other mental disorders.

College students are feeling more overwhelmed and stressed than fifteen years ago, according to a recent UCLA survey of college freshman. More than 30% of college freshman report feeling overwhelmed a great deal of the time. About 38% of college women report feeling frequently overwhelmed.

In partnership with the American College Counseling Association, the American College Health Association, the American College Personnel Association, The BACCHUS and GAMMA Peer Education Network, and the National Panhellenic Conference, NMHA is working to educate the college population about the signs, symptoms, and prevalence of depression and co-occurring disorders, and encourage individuals to seek treatment if needed.

Adjustment to Life's Changes

It can be a difficult time. Suddenly, perhaps for the first time in your life, you're moving away from everything familiar to you - family, friends, home, community - and beginning to make your way as a young adult entirely surrounded by strangers, in a new setting. You may feel that everything is on the line: your ability to succeed at college-level work, to build adult relationships, and to adapt to a lot of change all at once.
According to a recent UCLA study, more than 30% of college freshmen reported feeling overwhelmed a great deal of the time during the beginning of college, and Johns Hopkins University reported that more than 40% of a recent freshman class sought help from the student counseling center. So understand that if you're feeling pressure and stress, you're not alone.

Helping Yourself

Many college students have minor problems adjusting to their new environment. Here are a few ideas that can help you manage your feelings of pressure and stress:

• Better plan your use of time. Make time every day to prioritize your work. Prioritizing can give you a sense of control over what you must do, and a sense that you can do it.

• Plan your work and sleep schedules. Too many students defer doing important class work until late at night, work through much of the night, and start each new day exhausted. Constant fatigue can be a critical trigger for depression. Seven or eight hours of sleep a night is important to your well-being.

• Join an extracurricular activity. Sports, theater, Greek life, the student newspaper - whatever interests you - can bring opportunities to meet people interested in the same things you are, and it provides a welcome change from class work.

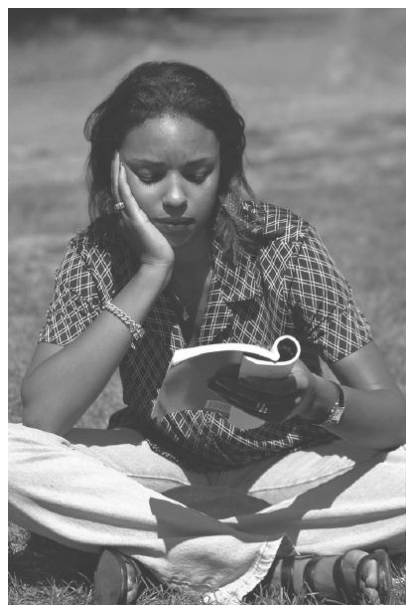
• Make a friend. Sometimes this may be a roommate or someone you meet in class or in the cafeteria. Friendships can help make a strange place feel more friendly and comfortable.

• Try relaxation methods. These include meditation, deep breathing, warm baths, long walks, exercise - whatever you enjoy that lessens your feelings of stress or discomfort.

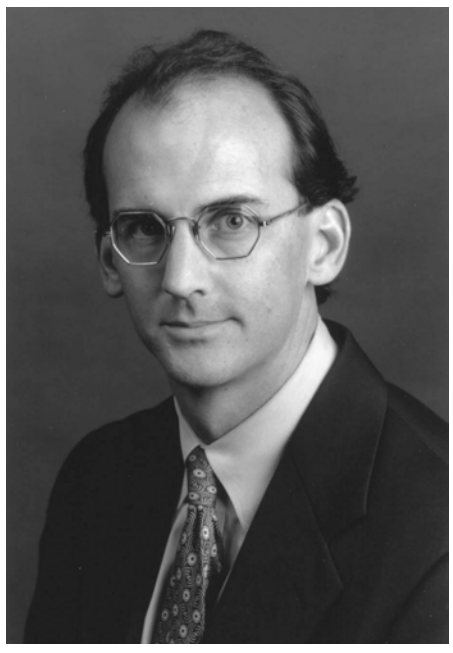
• Take time for yourself each day. Make this special time - even if it's only 15 minutes by yourself - a period where you think about your feelings and dreams. Focusing on yourself can be energizing and gives a feeling of purposefulness and control over your life.

Getting Help

Sometimes however, multitude of the changes and adjustments can trigger depression. If the above techniques do not appear to be working, don't hesitate to seek professional help. If your feelings of constant stress become feelings of sadness that go on for weeks and months, you may be experiencing more than just difficulty adjusting to life's changes. Seek assistance from the university counseling service, student health center, your doctor, or a mental health professional. It can be a difficult time. Suddenly, perhaps for the first time in your life, you're moving away from everything familiar to you - family, friends, home, community - and beginning to make your way as a young adult entirely surrounded by strangers, in a new setting. You may feel that everything is on the line: your ability to succeed at college-level work, to build adult relationships, and to adapt to a lot of change all at once.



Another Look At PTSD
The One Year Anniversary of September 11th



Randall Marshall, M.D.

Mental Health News is honored to present our readers with an interview with one of the nations leading experts on Posttraumatic Stress Disorders (PTSD), Dr. Randall Marshall. Dr. Marshall is Associate Professor of Clinical Psychiatry and Director of Trauma Studies at the New York State Psychiatric Institute, Columbia University College of Physicians and Surgeons—America's oldest psychiatric research institution.

Mental Health News wishes to thank Dr. Marshall for helping us understand the nature and treatment of Posttraumatic Stress Disorders in an updated version of our original interview which appeared in last year's Fall issue, which was released just days before the tragedy of September 11th. Dr. Marshall begins the interview with an updated prologue:

When Ira Minot, Founder and Publisher of Mental Health News and I first spoke last year, before 9/11, I could never have envisioned the direction our work has taken in trying to help our community recover while continuing our research efforts. For example, we have formed a partnership of 4 trauma research centers directed by myself, Marylene Cloitre, Rachel Yehuda, and Spencer Eth, to provide state-of-the-art trauma treatment and to provide free educational seminars to the mental health community. Thus far there has been strong demand for our seminars, and any clinician interested can call (212) 254-0333 extension 510 to participate.

One of the first efforts was to educate our own staff in order to expand rapidly our treatment and teaching capacity. Many trauma experts strongly suspected from the very beginning that, even in the most sophisticated mental health community in the country, there were not enough expertly trained clinicians to treat all the new-onset PTSD and depression we expected to see post-9/11. The research is simply too new. Surveys after the fact have proven our intuition to be correct—the first survey 5-8 weeks after 9/11 found there were 67,000 new-onset instances of PTSD in Manhattan below 110th street. Fortunately funding became available through charitable institutions such as the New York Times Foundation to move at a speed that would have been impossible through the usual funding channels. The scope of the mental health response is unprecedented after a terrorist attack of this severity, and we hope that, in addition to providing necessary treatment, there will be an ongoing interest in *learning* from our experience so that a knowledge base can be developed for future efforts all around the world. We are currently exploring ways to obtain funding for the second year of our efforts, and hope to continue as long as there is a need.

Q: You were quoted last year at the APA convention in Atlanta as to the scope of suffering and disability due to symptoms of PTSD here in the United States.

A: Yes, Nearly eight percent of individuals in the U.S. -- 20 million people -- will have full-blown PTSD in their lifetime, and as many as 20 million more people may suffer from disability and distress related to PTSD symptoms even though they do not have the full disorder. The tragedy is that many of these people do not get the help they need because the problem is not identified and they don't receive appropriate treatment."

Q: When was posttraumatic stress disorder first described in literature?

A: Going back centuries, PTSD had been recognized in both medical and literary writings, but it was only recently officially recognized in the DSM III as Posttraumatic Stress Disorder in 1980. Before that it was often referred to in descriptions of war trauma, but also there's a quite interesting 19th century literature in relation to accidents. For example, there was something-called *railway spine syndrome*, which was thought (much like shell shock) to be a neurological disorder caused by the impact of the many cataclysmic train wrecks of the time.

What the DSM does is identify core features. This was a critical advance in the field, but it is important to realize that PTSD as a clinical syndrome is much broader. Comorbidity, based on DSM assessments, is extremely high. The DSM breaks down the description of PTSD into Diagnostic Features and Associated Features, but clinically it isn't as important to separate the two, as all clinical issues need to be addressed. Problems with depression, aggressive outbursts, relationships, and substance abuse are very common.

PTSD by definition is a triad of symptom clusters that are known to go together. They can be summarized as re-experiencing the trauma in the form of dreams or unbidden images or perhaps just frequent thoughts about the trauma. Flashbacks are rarer, and are a kind of dissociative re-experiencing.

The second cluster is *avoidance* and *emotional numbing*.

Avoidance can be both internal and external. The individual tries to avoid thinking about the trauma by pushing thoughts out of his or her mind. But the patient might also avoid situations, which are reminders of the trauma. The emotional numbing I refer to specifically describes numbing of positive emotion. So it's not just feeling nothing at all. With PTSD numbing, people mostly feel negative affect like anxiety, fear, depression and rage—but lose the capacity for feelings of love or tenderness or pleasure.

Q: Is emotional numbing an automatic response or are people in this situation struggling to consciously block these upsetting feelings and recollections of the trauma they experienced?

A: That's a very important question. Some formulations would say that it's a defense, that it's a shutting down of all emotions because they become overwhelming—but I think that there is reason to think that in some cases it may be a direct consequence of the disorder—something like a burnout of normal emotional capacity because of the overwhelming dominance of fear and anxiety.

Q: Are the rates of PTSD the same for men and women?

A: PTSD on the whole is twice as common in women as in men. Although it's not clear why that is, part of the explanation is that women are more likely to experience the most severe trauma—namely, sexual abuse or assault. Rape is one of the most severe trauma, and results in PTSD 50-70 percent of the time. And the vast majority of rape victims are women.

Then the last cluster of symptoms include *signs of autonomic arousal*, of which insomnia is often one of the most severe—but also irritability, jittery-ness and a heightened startle response.

Q: Is the startle response similar to panic attacks?

A: No, it's not like a panic attack because it is in response to some kind of stimulus – usually sudden. It is a biologically based reaction that's actually been very well studied. And sometimes even when most of the other symptoms go away, the patient will retain their startle response for years later, which can be annoying at the very least. Recent research from Shalev's group shows that the startle response develops within 1 month in individuals who are developing PTSD.

So in review of the full syndrome, we are seeing the following: (1) Re-experiencing, (2) hyper arousal, and (3) Avoidance or Numbing. However, our recent study (due in the American Journal of Psychiatry in September 2001) is consistent with other studies from Murray Stein, Daniel Weiss, Charles Marmar and others, suggesting that *sub-threshold PTSD* also carries considerable disability.

We studied about 9,000 people who came to National Anxiety Disorders Screening Day in 1997—and found that PTSD symptoms were linearly related to comorbidity, suicidality, and functional impairment, suggesting in fact that a dimensional model rather than a categorical model might make more sense. So if you had three symptoms you were worse off then if you had two symptoms—and two symptoms were worse than one.

Q: Can you explain what you mean by subthreshold PTSD?

A: A typical sub-threshold patient might have re-experiencing and hyperarousal but no longer be avoiding. In psychotherapy for example, you can help a motivated patient overcome avoidance. Often the other symptoms will also be reduced through treatment, but sometimes they won't. So that would be an example of sub-threshold PTSD.

Another typical example might be a patient who has re-experiencing and hyperarousal, but is drinking alcohol as a strategy of avoidance. It's not specifically described in the DSM as a manifestation of avoidance, but that's a fairly common scenario.

Q: Can you walk us through a typical unfolding of events for a person who experiences a trauma and then develops PTSD?

A: First let me say that there is a distinction between trauma and stress, which is very important because the psychiatric and the human consequences are quite different.

A Criterion A trauma (DSM terminology) involves a threat to the physical integrity of the self or others that has to be experienced, witnessed, or more rarely, heard about. The sexual abuse of children is the only recognized exception to this. That is, even though there may be no overt threat of physican harm (as is often the case), the abuse is age inappropriate and coercive because of the power imbalance between the adult and child. In this kind of situation the abuse can still lead to posttraumatic stress disorder.

continued on the next page

Another Look At PTSD
The One Year Anniversary of September 11th

continued from previous page

The kind of typical traumas that we see are related to the violence and coercion that is very common in this country, namely: domestic violence, sexual assault, rape, childhood physical or sexual abuse, automobile accidents, industrial accidents, or witnessing someone being shot or stabbed.

Combat trauma still seems to be most strongly associated with PTSD among the general public, although 9/11 has probably changed that somewhat. The vast majority of people with PTSD in this country have PTSD related to other kinds of trauma.

The longitudinal course of PTSD is something I should comment on. Let's say a woman is in a serious automobile accident. Car accidents are the most common Criterion A Trauma in the US. About 1 in 10 that are in a serious car accident will get PTSD.

A normative reaction after a severe trauma can look somewhat like PTSD, meaning that the individual may have a heightened startle response, be generally anxious, have problems sleeping, and may re-experience the event especially when there are cues in the environment. For example, she might hear the screech of tires and suddenly get an image of the car accident from the week before. The next time she gets in the car she might feel extremely anxious and be generally more vigilant, more cautious – not just about cars, but about everything. This happens because there's a heightened, generalized awareness of potential danger in the environment after trauma. Considered from an evolutionary point of view, it might enhance the chances of survival when a more dangerous environment has been entered. Over time these reactions may fade away so that the images become less frequent and less intense. The individual is able to drive again without being anxious or without even thinking about the accident and the startle may fade away over a period of days or weeks. The trauma becomes a normal memory, which is accessed from time to time but does not possess the immediacy of the experience. It may have influenced an adjustment of behavior and assumptions about the world—for example, more caution when entering poorly marked intersections.

That would be a spontaneous recovery, and most people do recover spontaneously after serious trauma. We are fairly resilient as a species and we're normally equipped to have adverse experiences and learn from them, and are not debilitated by them in the normal course of events.

In contrast, somebody who develops PTSD will actually be getting worse instead of better - also, from the very beginning, the people who are going to get PTSD tend to have a more severe reaction and that's fairly clear - so that's sort of a clinical marker. If somebody is having an especially severe acute reaction to trauma, they are probably at risk.

Some of the other risk factors are known to be: previous exposure to trauma, having a psychiatric disorder, having a family history of psychiatric disorder, lack of social supports and the response of one's support system To the person being traumatized. There's a pretty clear indication of genetic vulnerability as well, although with all the various biologic systems at work in PTSD, it is hard to say how the vulnerability is specifically manifested in the body. One possible example involves the differences in how the HPA axis functions from person to person. There are a couple of studies now that show that, if people have low cortisol in the acute aftermath, they are more at risk for developing PTSD.

Q: What is cortisol?

A: Cortisol is a stress hormone produced by the HPA axis (the Hypothalamic/Pituitary/Adrenal axis). Rachel Yahuda and others showed through a series of studies that at least a significant sub group of PTSD patients have low-normal cortisol at baseline as well as a more rapid decline in cortisol under stress or in the laboratory. This was a big surprise, because from the physiology most of us learned in medical school or graduate school, one would have thought cortisol should be in the high range. And the question there was: is this associated with PTSD or is it a pre-existing vulnerability? It looks like it's actually a marker for the people who are more likely to get PTSD— it was about 8% predictive in one recent study of stress hormones immediately after trauma. It isn't a lab test for PTSD, though, because the predictive value is too low and the range overlaps significantly with the normal range. It does suggest however that there is something different in these persons stress responses. It is also fascinating that the HPA axis functions differently across individuals—also an important finding in this research.

I think at this point there is good evidence to say that there is some kind of a biological vulnerability, and that it probably is not a single discrete vulnerability. It is probably intrinsic to several of the biological systems that respond to threat and danger. One theory is that the threat response system fails to shut off, sort of like an alarm that goes off and keeps going off. There are a number of inhibitory mechanisms in the body, and in the brain, that are meant to shut down these biological systems, because they can be very destructive if they remain activated over an extended period.

These studies point to the theoretical rationale for the use of medications. It has been known for a while that psychotherapy can be very effective for PTSD and there are several psychotherapeutic approaches that work. What they have in common is that they are very supportive, provide education about the nature of the traumatic response, attempt to reduce feelings of guilt, shame, and failure surrounding the trauma, and focus on describing the traumatic experience in great detail. I think that it is actually the most dramatic and satisfying of treatments to conduct because you can see a remarkable degree of improvement in a relatively short time period. We have been using the treatment developed by Edna Foa and colleagues in our clinic for several years now and find it consistently effective across a wide range of trauma.

Q: Has stigma played a role in the evolution of our understanding and treatment of PTSD?

I think that explains why we didn't see it in the official nosology until 1980. There's always been a stigma surrounding PTSD in the military. Often soldiers with PTSD were labeled as treasonous and executed, or discharged in a shameful way, or put in military prisons. We see the same stigma in the medical literature. There's a bias toward assuming that people with PTSD are always malingering, or are motivated by secondary gain. There is actually a syndrome in the early 20th century literature called "compensation neurosis." In the first DSM, the assumption was that if a patient hadn't recovered from the trauma, he probably had a personality disorder or some other kind of vulnerability to begin with. The notion used to be that "normal people are more resilient." Although vulnerability factors do exist as we discussed, they are not moral failings. We have to abandon these simplistic and prejudicial assumptions as a society and as a profession. We hope that all the public education efforts after 9/11, such as Project Liberty, have made progress in this direction.

Q: Some of the literature suggests that people with a history of severe trauma and severe PTSD have been misdiagnosed and incorrectly treated as having schizophrenia or bipolar disorders.

A: This is a very important point. PTSD is under-diagnosed. The few studies in the literature found that trauma histories that relate to PTSD are missed as often as 90% of the time, even in mental health clinics.

Why might this be? Patients are sometimes very ashamed or upset by discussing trauma, and the evaluators often do not know how to bring it up. Clinicians can be very uncomfortable asking about a history of sexual abuse or of rape or of the loss of a loved one. We are trained to help and so our instincts are to avoid topics that might be upsetting to the patient. But also, we avoid topics upsetting to us. We are getting better about it though. In New York State for instance, there is a requirement that there be an assessment of traumatic life events whenever a patient is admitted. The way to get the diagnosis of PTSD and assess for other possible consequences of traumatic experiences is to ask about specific traumatic events. If you don't do that then you're likely to miss it.

Q: Is the inquiry process even more difficult when you are dealing with children?

A: Yes. The manifestations of PTSD differ substantially in younger children, the process of evaluation is more subtle and inferential, and there are often serious social and legal consequences of a trauma history is elicited.

Q: What are some of the other diagnostic issues?

A: Subthreshold PTSD is an important issue. If a patient presents just one aspect of PTSD—such as an inability to sleep, irritability, and a heightened startle response—if you don't ask about recent life events you may not find out, for example, that this began after her spouse became violent at home, and that most of the other PTSD symptoms were present in the past but have since subsided.

If there is severe dissociation sometimes it's misdiagnosed as psychosis. I have seen that on inpatient units where a patient with very severe PTSD and dissociation was mislabeled as schizophrenic and of course given the wrong treatment. Traditional anti-psychotic medications will make these symptoms worse instead of better. We have heard about patients who have sadly been on inpatient units for years and never diagnosed or treated properly.

Q: If we want to offer hope to our readers—what can we say?

A: The overall message is that PTSD is very treatable and it appears that, unlike depression, patients who get better seem to stay better. In fact several psychotherapy studies have shown that patients continue to improve after termination. I believe that in most cases, treatment facilitates a natural healing process, which allows patients to go on continuing to recover without our help.

A trauma focused therapy (and there are several that have been developed) should always be considered; otherwise you may collude with the patient's avoidance. In order to get to that point, you often have to provide a lot of education to patients as to why it's a good

see *PTSD* on page 49

FEGS' Project Liberty Blankets NYC With Outreach: Diversity And Cultural Relevance Key In Reaching New Yorkers Post Sept 11th

By Ellen Stoller, Assistant VP Community Services, Training and Consumer Affairs F.E.G.S.

FEGS, the largest Health and Human Service agency of its kind, has reached thousands of New Yorkers by hiring staff indigenous to various communities for its' Project Liberty services.

In Jamaica, Queens, Oneychi A. goes to the homes of undocumented immigrants identified by church and community leaders. They are afraid to come to a clinic or a public session because they are undocumented. But they open their homes to Oneychi, who is Ethiopian and a neighbor, because he understands the experience of coming to America for freedom and since Sept 11th being afraid all over again. They have told him of their children's plight, being tormented in the schoolyard by other children, and being told to go back to their country. One man from Egypt has been ostracized at work because his co-workers assume he is Muslim; he is not, he is Christian, but it doesn't matter. Nobody will talk to him or eat with him.

Cultural competence and cultural sensitivity have long been talked about. But reaching people in the wake of a mental health emergency, in a very diverse city, requires these issues be addressed more fully. In order to find people who may be suffering silently, FEGS moved its operations out into the community. Our cadre of newly hired staff have connections to community centers, schools, synagogues, churches, businesses and store owners. They offer Project Liberty services, public education sessions, and group and individual crisis counseling in Spanish, French, Hebrew, Yiddish, Swahili, Russian, Creole, Mandarin and Cantonese. Breaking down the barriers to traditional mental health services requires that we combine community organization and public health models with mental health services. It requires flexibility and a redefinition of our role as helpers and requires listening to the community in new ways and finding out how the community communicates.

Judy L., a resident of Battery Park City knows the ways to approach her community. You can't put flyers up in buildings, but you can get on their website and be listed in the Broadsheet. Judy is an experienced clinical social worker but, as a resident, she has an access that an agency doesn't easily come by.

Julie A. has devoted her professional attention to the Gay, Lesbian, Bi-Sexual and Transgendered community. As a disenfranchised group, they need to have their special needs addressed by professionals who know where they are coming from.

Shira K., an Orthodox Jewish young woman is too young to know but listens carefully to the stories she hears from Holocaust survivors in Far Rockaway.

Rabbi Yehoshuah K., an Orthodox Jew, understands the feeling of the young boys he talks to at a Yeshiva in Brooklyn. They are angry and afraid.

Rimma K., who was a journalist in Russia, talks on Russian/Yiddish radio and gives information about Project Liberty and how to get services.

Lydmulia L. grew up in Chernobyl. She understands what it is like to live in a traumatized community.

Responding to the needs of New Yorkers in the aftermath of September 11th has taken mental health service to the streets...disguised in some ways, but has perhaps broken down some of the stigma. Although FEGS is providing outreach in many neighborhoods in many languages and to peoples from many cultures there are common themes post Sept. 11th: Love of family, love of community, love of New York.

Trauma Center Poised To Respond To 9/11

By Robert Abramovitz
Paula Panzer and Caroline Peacock

No one could have been fully prepared for the catastrophic attacks on the World Trade Center on September 11th. However, since 1995 with the inception of the Saul Z. Cohen Chair in Child and Family Mental Health, JBFCS had given priority to enhanced trauma services. This reflects its longstanding commitment to populations exposed to child abuse, sexual abuse and domestic violence. The three Cohen Chair recipients: Bessel van der Kolk, M.D. (1996-1998), Sandra Bloom, M.D., (1998-2001) and the current Chair, Claude Chemtob, Ph.D. have increased our knowledge and sophistication about treating traumatized populations, which has promoted significant growth of new programs.

The September 11th disaster gave the entire nation a deep understanding of what it means to live with uncertainty and chronic danger. It also highlighted three major, post-traumatic recovery themes: the need to re-establish safety, adaptive coping, and self-care. Since September 11th the need to simultaneously address both current and past threats has informed the expanded work of the Center for Trauma Program Innovation (CTPI). From the first moments after the attack, we have seen forceful evidence demonstrating how prior trauma exposure interacts with current exposure and complicates the recovery process.

Within our outpatient mental health clinics, we have seen how profoundly the WTC attack affected the large Russian émigré population we serve. The re-awakening of old traumas, such as war, anti-Semitic discrimination and abuse in their country of origin lead to intense current distress. Similarly, JBFCS' domestic violence programs all routinely address how fear of unpredictable violence affects already traumatized individuals. This work teaches us about the destabilizing impact of adapting to such a chronically threatening environment.

The recent Board of Education Needs Assessment revealed that sixty four percent (64%) of public school children living outside the ground zero area report significant exposure to high levels of interpersonal and community violence. This includes 15% having been badly hurt themselves; 39% having seen a killing or injury; 29% who had a close friend killed and 27% who had a family member killed. Prior exposure increased the chances of having PTSD by 65%. The likelihood of suffering from PTSD also varied with ethno-cultural factors with Hispanic children experiencing higher rates of mental health problems.

The evidence that cumulative trauma exposure increases the risk of having a disorder underscores the importance of knowing a person 's full exposure history and symptom picture. Thus, the CTPI emphasizes attention to systematic assessment as an essential part of providing structured trauma treatments.

Dr. van der Kolk, a renowned expert on post-traumatic stress disorder, devoted his two years as chair to helping the agency build trauma competence for its staff. Many new pilot programs were launched with his guidance. In order to sustain this work, the Center for Trauma Program Innovation (CTPI) was created in 1998. With Dr. Abramovitz's leadership the CTPI enlisted a core group of clinicians who continued the systematic introduction of trauma expertise into JBFCS programs by focusing on the recognition and treatment of traumatic stress disorders and secondary trauma experienced by staff treating trauma victims.

Our next Cohen Chair, Dr. Bloom brought her Sanctuaryâ model, to our residential programs that treat potentially violent adolescents exposed to multiple traumatic life events. Sanctuaryâ stresses the creation of a safe community and phase-oriented therapy. It has now been successfully introduced on 8 of 16 units within the three Westchester residences, and also in our three Family Violence shelters. JBFCS and the Center for the Study of Social Work Practice received an NIMH grant to evaluate the Sanctuary residential program (see page 5 for more on Sanctuary).

Fortunately, the newest Cohen Chair, Dr. Claude Chemtob, an internationally known expert on Disaster Mental Health began his tenure just before September 11th. Since then he has been an eloquent and dynamic source of help, enabling the agency to launch both a sophisticated public health response to

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Anxiety and Depression – Common and Treatable

By Carla Quail, CSW, Clinic Manager, MHA of Westchester

It is estimated by the Surgeon General's Report (1999) that one in five adults experience some type of mental disorder each year. Of these adults, five percent suffer from a serious mental illness such as schizophrenia, major depression or bipolar disorder. According to MHA of Westchester's website, clinical depression impacts 10% of adults each year. In addition, Freedom From Fear, an educational website about depression and anxiety, reported that recent national surveys indicated 25% of the population have reported symptoms of anxiety severe enough to meet the criteria for a diagnosis at some point in their lives. These disorders can debilitate individuals by interfering in their ability to work, have relationships or even care for themselves. Individuals who suffer with an anxiety and/or depressive disorder are the most frequently seen by mental health professionals.

Recent scientific advances and improvements in behavioral and biological treatments have made mental disorders as treatable today as general medical conditions. According to the National Advisory Mental Health Council (1993), the majority of Americans receiving behavioral healthcare benefit from treatment including those with serious mental illnesses. Regrettably, less than one third of adults and half of children with a diagnosable mental disorder receive treatment in any given year.

There are many different types of disorders that fall into the diagnostic category of Anxiety Disorders. Phobias, panic disorder, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress disorder and separation anxiety disorder all fall under the category of anxiety disorders. The common denominator of all the disorders is fear. Everyone experiences anxiety in response to the stresses of everyday life. Someone suffering from an anxiety disorder experiences anxiety in powerful and unpredictable ways that are beyond their control. These symptoms interfere with everyday life, for example, someone may be unable to shop for groceries, drive over bridges, socialize, or even leave the house.

Anxiety disorders do respond to treatment. A combination of medication and psychotherapy is most effective. Behavioral and cognitive-behavioral therapies are two psychotherapies that have been proven effective. Behavioral therapy focuses on changing specific actions and uses techniques to stop unwanted behaviors. Cognitive-behavioral therapy teaches people to identify, understand and change the ways they think.

Depression, like anxiety, is an illness that can interfere with someone's ability to function and perform everyday tasks. This is more than the usual experience of sadness in response to life events or losses. Clinical depression is persistent and requires treatment. The person with clinical depression cannot "snap out of it" or "shake it off". Symptoms of depression include sad mood most of the day, nearly every day, loss of interest or pleasure in activities that were once enjoyed, change in appetite or weight, disruption of sleep pattern – not enough or too much sleep, physical slowing or agitation, energy loss, feelings of worthlessness or inappropriate guilt, difficulty thinking or concentrating and recurrent thoughts of death or suicide. Major depression, dysthymic disorder and bipolar disorder are the three most common types of depressive disorders.

Recommended treatment for depression also includes medication and psychotherapy. Exercise is also proving to be an important component in the treatment of depression. Some studies indicate that regular exercise is as effective as anti-depressants in treating clinical depression.

As in all mental illnesses, family plays an important role in a successful treatment outcome. Family includes anyone who has a significant and active role in the client's life. Family can support the client through treatment and provide the clinician with valuable information to further help the client. Families also require support for themselves. Often it is the family that has struggled to help the client with his/her symptoms for many months or even years before the client has made the decision to come into treatment. As is the case with many mental illnesses, people struggling with these symptoms often refuse to seek help due to social stigma and misunderstanding. Sufferers may be ashamed of their symptoms and may be unaware that their symptoms could be alleviated with treatment. The National Alliance for the Mentally Ill (NAMI) provides family members with a forum for support and education as well as advocacy.

The Mental Health Association of Westchester provides cognitive behavioral treatment and medication management for the spectrum of anxiety and depressive disorders. Individual and group psychotherapy are available through MHA's clinical programs. The Northern Westchester Guidance Clinic in Mt. Kisco and The Sterling Center in Elmsford and White Plains both offer specialized trauma services with clinicians trained in Eye Movement Desensitization and Reprocessing (EMDR). EMDR is a successful and innovative treatment intervention used for individuals suffering with an anxiety disorder.

If you or someone you know is experiencing anxiety and/or depressive symptoms and would like to speak with a mental health professional, please call MHA of Westchester at (914) 345-5900 ext 240.

For more information about anxiety & depression and other diagnoses, treatment and links to other relevant sites for visit us at www.mhawestchester.org.

Zen Answers To Mental Health Questions

By Brenda Shoshanna, Ph.D.

Dr. Brenda Shoshanna

Zen takes a different approach to the problems which plague many of us. If we take a few moments to consider and try this alternative way of dealing with suffering, we may discover something of great value, readily available for all to enjoy and benefit from.

Question: I am the victim of mood swings, and although these are somewhat regulated by medication, I hesitate making plans with others, not knowing how I will feel that day.

Answer: From the Zen point of view mood swings are natural. They are part of the inevitable fluctuations and change all must endure in life. In some cases these mood swings may be more intense or frequent, causing greater suffering and insecurity. However, the first point to realize is that all individuals are subjected to change and also to suffering. You need not separate yourself from society, thinking your situation is the worst of all.

Secondly, in general, it is most helpful not to focus upon one's moods, but upon the present moment. The practice of Zazen (Zen meditation) helps us take charge of our focus. During this practice we take attention away from the many thoughts and feelings which alternate within us, and place our attention upon our breath, or upon the present moment. When we take our attention away from our thoughts and feelings, (pleasant or unpleasant) they become less important and naturally subside. Attention gives power and energy. It is up to you what you will give your attention to. Give your power and energy to the present moment, to where you are now and what needs doing.

Rather than worry about what your mood is, or what it will become, do what needs to be done. Clean your room, sweep the floor, take a shower, plant new flowers, pay bills. Put your attention right here, on your activity. Let your mood swings simply fade into the background.

As we do what needs to be done, and do not allow our moods to distract us, we gain a sense of strength and security. We then become senior to these mood swings and they no longer have the power to rule our lives. If we continue in a regular practice of Zazen, not only does our concentration deepen, but one day we may become vividly aware of what these mood swings are truly made up of. At that time they vanish on their own.

Question: No matter who I am with, or what I am doing, I fight with a sense of loneliness all the time.

Answer: Do not fight with your loneliness. Whatever we fight with or resist grows more intense, and can turn into an obsession or preoccupation. Rather than fight with loneliness, make friends with it. Realize that loneliness arises because we are disconnected from ourselves. We have rejected a part of ourselves, and as a result feel incomplete and lonely. There may be a part of ourselves which we have never given expression to, that feels unheard and unwanted. Rather than turn away from loneliness, when we turn to it and welcome it, we are turning to the part of ourselves that needs special attention. We are listening to a cry from within.

During Zen meditation, we sit without moving and allow all that arises into our awareness. We do not reject any part of it. We make friends with all that we consist of and then we return to the breath or to the present moment, over and over again. As we do this, all parts of ourselves become heard and integrated. There is a much greater sense of wholeness, and by paying attention to all that we are, we do not feel so alone.

Rather than view loneliness as a problem, why not view it as a treasure, an opportunity you are giving yourself to truly know who you are and make friends with all parts of yourself.

Question: No matter how hard I try to find love, I am always rejected. However, I cannot understand what exactly is wrong with me.

Answer: There is nothing wrong with you, except that you believe that something is wrong with you - that somehow you do not fit the bill. When we believe we are lacking or inadequate, not basically loveable, we project that feeling and receive those results. The first step here is to realize that you have accepted a belief which is making it difficult for you to love and be loved by others. (This is only a belief, not a fact). When in relationship with others you then behave in a way to get what you feel you deserve. This, unfortunately, leads to your becoming preoccupied with yourself and with the impression you're creating. This not only causes tension but prevents you from enjoying the moments you have with the other person, no matter how they work out.

Turn this all around. Don't be so worried about how others feel about you. Don't think of what will happen between you in the future. Instead, spend your time finding wonderful, loveable things about the person you're with. See the best in others. Really listen to what they have to say. Drop your own agendas. Take your attention off yourself and put it on them. Be there for them. Give to others what you wish to receive from them. Not only will this take your anxiety away, you will enjoy yourself thoroughly. When you function in this manner, rather than worrying about how things will work out, you will find that each encounter you have is meaningful and satisfying all on its own. In order to find the right person, we must first be the right person ourselves.

"Open your hands if you want them to be filled."

Zen Saying

Dr. Brenda Shoshanna, psychologist, long time Zen practitioner and workshop leader is the author of Zen Miracles (Finding Peace In An Insane World), Wiley, 2002. She offers talks, workshops on Zen and Psychology and psychotherapy.

Visit her website at www.Brendashoshanna.com and to contact Dr. Shoshanna directly send your E-mails to: Topspeaker@Yahoo.com.

The Help We Sometimes Need Is Just Around The Corner
Your Mental Health Community Offers Vital Programs & Services

DMDA of the Finger Lakes

A Special Supplement By
The Depressive and Manic Depressive Association: Elmira, New York

Chapter President's Welcome:

George Griffith

We are excited and proud to bring you our DMDA newsletter in cooperation with Mental Health News. We hope you will enjoy reading the informative articles and local news from our region of New York State.

The mission of DMDA-Finger Lakes, Inc., is to provide personal support and information to people with clinical depression and manic depression, and to educate their families, friends and the public about the nature of the stigma, and management of these treatable diseases.

We wish to thank Mental Health News and our growing family of friends and supporters who have helped make this effort possible. This support has enabled us to broaden our reach through Mental Health News, as we continue to provide the Southern Tier of New York State with an open forum of depression support.

Tips For Dealing With Mood Disorders

Here are some tips that we hope you will find helpful in your efforts to cope with mood disorders.

1) You have a brain/body disorder—it is NOT your fault; if you were suffering from any other "physical illness" would you blame yourself?

2) Your chance of improvement or recovery will increase if you obtain the correct diagnosis and, thence, treatment. If you have been seeing the same professional(s) for a long time without significant relief—seek a consultation with a new doctor—even if this new person ends up agreeing with the previous diagnosis and treatment plan. Confidence in the treatment you are receiving enhances your likely outcome.

3) Do not take too seriously the suggestions for alternative treatments, which are based on anecdotal data. (e.g.: Your friend Joe says he took vitamin "Q" and nutrient "X" and his depression went away.) In the absence of scrupulous scientific studies, such statements cannot be considered to be valid. People improve from all sorts of medical conditions without any intervention; the placebo effect also can cause people to go into remission.

4) Compliance: No treatment regimen can be effective if the person refuses to follow the regimen as directed by his/her doctor. There are people who refuse to take their lithium or antidepressant, complaining "it's not natural." Why so many mood disordered concentrate on the word natural is interesting—after all cyanide and arsenic are natural! In fact, lithium is "natural," appearing on the periodic table of elements. Some persons take their meds but not as directed—rather only when they feel like it. The efficacy of most drugs depends on blood levels, which should be relatively constant. Taking medications intermittently, can defeat the intended results.

5) Stigma: The reaction of society to your disorder. Responses to all "mental illnesses" used to be absolutely horrible! Now, there has been some improvement, due to some education of the public, via television, magazines, and public people "coming out of the closet." (e.g. authors William Styron, Art Buchwald, actors Margot Kidder, Dick Cavett, and Washington Post publisher Katherine Graham (who also went public when her husband Philip committed suicide due to manic depression…) and the list goes on! Special credit is due to Dr. Kay Jamison, who is preeminent in the field of mood disorders. In her memoir, she juxtaposes her important scientific work with an exploration of her having lived with manic-depressive illness for over thirty years.)

Knowledge Defeats Stigma
Ambiguity Scares
Facts Remove Fears

By David S. Chowes, Professor of Psychology at Baruch College/The City University of New York; Advisory Board Member of NAFDI; Board Member of the National Depressive and Manic-Depressive Association (NDMDA) Reprinted from NAFDI News Volume 29 Fall 2000

Understanding and Treating Cyclothymia

Cyclothymia is a chronic bipolar disorder consisting of short periods of mild depression and short periods of hypomania (lasting a few days to a few weeks), separated by short periods of normal mood. Individuals with cyclothymia (thymia: from the Greek word for the mind) are never free of symptoms of either depression or hypomania for more than two months at a time. In 1990 the classification of cyclothymia was changed in the DSM-IV from Personality Disorder to Mood Disorder.

Though the above description portrays cyclothymia as a mild disorder, it is so only relative to the severity of Bipolar I and Bipolar II disorders. Cyclothymia can completely disrupt the life of an individual and create personal chaos. In their continual oscillation of mood, one never knows from one day to the next what to expect.

Incidence of Cyclothymia

Equally common in men and women, cyclothymia affects 0.4 to 1.0 percent of the population. Most commonly the disorder begins in the teens or early twenties. Eventually approximately 30 percent of individuals with cyclothymia experience a full-blown manic episode or major depression, and their diagnosis is changed to Bipolar I or II.

Causes

Genetic factors appear to be causative in cyclothymia as they do in the Bipolar Disorders.

Many of those affected have a family history of major depression, bipolar disorder, suicide or alcohol/drug dependence.

Symptoms

- Zig-zagging from periods of elation to doom.

- Unable to maintain enthusiasm for new projects due to mood changes.

- Personal relationship problems due to influence of moods causing a constant "pulling close and pushing away" of emotions.

- Abrupt changes in person-ality from cheerful, confident and energetic to sad, blue or "mean."

- Sleep difficulties are prominent, with affected persons sleeping little during hypomania, and "unable to get out of bed" during depression.

Self-medication with alcohol or illegal drugs is common.

In a word cyclothymia seems to sabotage a person's opportunity for a stable life.

According to DSM-IV a diagnosis of cyclothymia is based on the following:

1. Individual has had many periods of both hypomania and depression for a period of at least two years.

2. Individual has experienced no periods of normal mood lasting longer than two months.

3. Individual has experienced no major depression, manic or mixed episode during the first two years of symptoms.

4. Symptoms are not attributable to either Schizophrenia or Psychotic Disorder.

5. Symptoms are not due to effects of medication, illicit drugs or medical condition.

6. Individual experiences significant distress or impairment in daily living.

Treatment of Cyclothymia

In some cases individuals may prefer no treatment or supportive psychotherapy alone. Couples or family therapy is often sought to help with the problems in relationships brought on by the disorder.

In addition, lithium, a mood stabilizer used commonly in the treatment of Bipolar Disorder, has been proven to help a substantial number of people with Cyclothymia.

New lithium Application

New studies have found that lithium "significantly increases total gray matter volume in the human brain of patients with manic-depressive illness." According to Husseini Manji MD, Chief of the Laboratory of Molecular Pathophysiology at the National Institute of Health, lithium has neuro-protective qualities that may prevent stroke, Alzheimer's and similar diseases, and one day may be taken in small doses by those who do not require this common salt to treat their bipolar symptoms.

Reprinted from DMDA-Finger Lakes June/July 2001; Vol. 5 No. 3. All material presented is in cooperation with NDMDA fact compilation from the National Institute of Health—2001.

Mood Disorders of Depressive Illness

Mood Disorder(s):

Depression

The core symptom of depression is usually sadness, which may be accompanied by crying spells. Sometimes people experience a loss of hope or have feelings of worthlessness. There may be a loss of interest in things or an inability to enjoy things one would normally enjoy, such as work, hobbies, or sex. Some people experience difficulty concentrating or have slowed thought processes. Energy level may be low with prominent feelings of fatigue. Depressed individuals may feel either sluggish or slowed down or, in contrast, quite agitated and unable to keep still. Other symptoms of depression may include significant increase or decrease in appetite, and increased sleep length or thoughts of death and suicidal ideation may accompany depressed mood.

Euthymia
"good mood" or tranquility

Euthymia can include a range of feelings such as happiness, anger, boredom, or sadness, but mood is not especially high, irritable, or depressed. Interest and energy levels permit effective functioning in work, leisure, and social activities as needed or desired. Clear thinking and the ability to concentrate on necessary tasks are usually characteristic of euthymia. Sleep is restful and is usually in the range of 6-10 hours. Appetite and weight may vary but do not change dramatically. One's self-esteem may vary some but is neither unrealistically high nor characterized by excessive guilt or self-reproach.

Hypomania and Mania

Mood can be either unusually good, high, or euphoric. But one might also be irritable which might be experienced as a "bad mood"(dysphoric). There may be a wealth of ideas, or increased creativity. High energy levels are common in hypomania, and some people may engage in many activities simultaneously or may find it difficult to sit still. One may feel more sociable or outgoing than usual; one may also speak rapidly, or more than usual.

Thinking may be speeded up. Self-esteem tends to be unusually high. Often there is a significant decrease in the need to sleep and one awakens feeling energetic. An increased interest in sex or impulsive/compulsive behavior may be present as well. *The main difference between hypomania and mania is that with mania there is impairment in social or occupational functioning.*

National Institute of Health (NIH)

Accepting Crisis As A Transitory Life Event

By George Griffith
Chapter President

If I were to ask for a first definition for the word "crisis," I am quite sure most would be amused with what a dictionary gives for its first definition. A quick review of "crisis" is to find it commonly defined in Webster's as: "1--(a) the turning point for better or worse in an acute disease, (or fever), (b) "…attack of pain, distress, or disordered function, (c) an emotionally significant event or radical change of status in a person's life. [Perhaps it is in this definition where we feel that crisis best suits our needs. In fact, the Random House dictionary does just that.] I have to wonder just where our language and vernacular have overlapped. The word "crisis" is just one such instance. The meanings of "catastrophe," "duress," and "fear" have supplanted my preference of "crisis" first and foremost meaning.

The object lesson here is not to play word games, but rather that we provide for what is the best understanding of how to proceed for accepting that crisis is a life event. Often when I'm confronted with group members whose 'belief systems' run contrary to their own betterment, I have to look at how deeply ingrained these patterns of belief are. There is an endemic quality to many of us with Mood Disorder, which is peculiar, when we are of a belief(s) that runs contrary to 'turning our lives around'. Yet, to persons with Mood Disorder(s), whether it's a radical change, attack of pain, or a turning point of an acute disease "crisis" can be an unacceptable life event. While an individual is fighting for his life (once a commitment to do so is instilled), atypical symptoms along with confusion, frustration, and so on give way to a lessening of commitment. Trying to support someone in his fight to overcome Mood Disorder, we are confronted with the person's lack of understanding that "crisis" is never going to become part of their past.

When the word "crisis" is brought to its least common denominator: "a turning point" in which things could be on an upswing, or "radical change" that someone might find themselves in a position to break through to the 'other side'; that being to the side of non-distortion, or a reality base norm. Then we have prompted this person to accept one more facet of their progress, rather than a set back that "crisis" has become to be known. Lastly, I believe that an individual has to believe they may actually experience a "crisis." This was my "turning point." I've always felt better in my treatment for manic-depression knowing that symptoms are always going to be coming into my life; they are also always going to leave, and that's critical.

Seeing The Plus Side Of Our Limitations

By: Sher Fridmann
DMDA-Finger Lakes

It has been ten years since I had my first really important introduction to the subject of limitations. I was hospitalized for clinical depression and was taking part in group therapy. I had been assigned a psychiatrist at the hospital and saw him on a weekly basis. There wasn't a lot that I learned about myself during my stay, but one thing seems to stand out as a bright light in an otherwise pretty dim experience. It was my luck to get some insight into the meaning of personal limitations. It was a fairly crude insight as I think back on it, but it somehow planted a seed that led me to a good understanding of limitations over the years that followed.

I suppose that like many people who've experienced major depression, there were a lot of things I didn't like about myself. And those dislikes went back to well before the time my depression was diagnosed as such. What the depression does is to somehow validate these dislikes in the form of a whole host of feelings of inadequacy and helplessness. These in turn are accompanied by the inevitable thoughts that one has a set of inadequacies amounting to severe disability. And almost needless to say, this disability becomes a very real part of one's life.

The pathway back to "normalcy" can be very tortuous, complex and long, and is one that is different for every individual. But one piece of that process that I think is common to all of us recovering from depression is the gradual realization that our feelings of inadequacy are *not any* indication that we are inadequate as a person. Yes, we may be severely disabled by the incredible number of limitations that come with our disorder, but these limitations do not define us as a person. They are reversible for the most part, and will gradually lessen---they may even worsen at times---until we reach the point at which we can say that we have our disability under control, that we are as "cured" as we ever will be.

But there is more good news… the limitations that we are left with after we fully recover---and if we relapse, after we recover again---still do not define us as a person unless we choose to allow them to do so. And that is because limitations are not shortcomings or weaknesses but rather are "normal" limits to the abilities and talents we all have as human beings. They are not signs of weakness any more than it would be a sign of strength for someone to claim that they have no limitations at all. And they are not shortcomings any more than the inability to bowl a perfect 300 game or to write the great American novel are shortcomings. All of us, with or without a history of depressive illness, are "stuck" with certain limitations…but they are very much a part of what makes us unique. And what is even more exciting, our very efforts to live our lives to the full extent of our capabilities will possibly reveal coping skills and talents we never could have imagined.

Mr. Fridmann is a Charter Member. He also serves as an officer and heads our Tuesday evening meeting.

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An 'Experts' Survival Story of Mood Disorder

We found the following very interesting because a person with bipolar disorder, and not a clinician, wrote it. Also, this shows that there is hope for people who suffer from depressive illnesses. Unfortunately, it is too long to publish in one month's issue. We hope you, too, will find it of interest and enlightening.

Dimitri Mihalas, a distinguished professor of astronomy at the University of Illinois and a member of the National Academy of Sciences, is considered a pioneer in attempting to increase public awareness about mood disorders and therefore decreasing the stigma associated with them.

These words began the pullout supplement featured in the September 2000 issue of DMDA of the Finger Lakes newsletter, Vol. 3 No. 6. When former editor, Tina Brown, brought this idea to me, I was astonished. Little did I know how formative a role Dr. Mihalas would be for this chapter. The very words penned by Tina were used to revise our Mission Statement, ..."public awareness...of the stigma associated with depressive illness." In this present time where mission statements don't hold nearly the importance as a corporate bottom line, it is necessary to remind ourselves why more people don't know or appreciate the breath and depth of depressive illness. There is a need for more brave souls like Dimitri Mihalas needs to be taken. And it is this chapter's responsibility to move forward with that mission.

I want to introduce our readers to Mihalas' publication and indicate to you, that this 'primer' is as important today as it was two years ago, when we first corresponded with Dr. Mihalas. The balance of this document will be published in our next supplement, which will appear in Mental Health News's winter edition. I felt it important to bring to Mental Health News an article which represents a great deal about the philosophy of DMDA of the Finger Lakes, and also a bit of the perspective Mihalas' writings lends to the understanding of mood disorders, which we have adopted as our own at DMDA of the Finger Lakes.

George Griffith
Chapter President

A PRIMER ON DEPRESSION AND BIPOLAR DISORDER

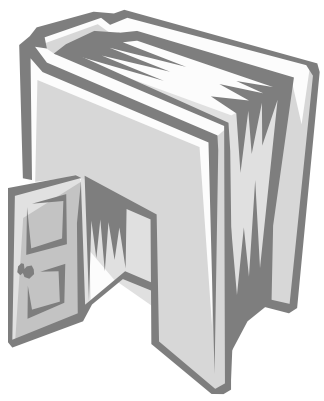
By Dimitri Milialas (1999)

First, I should say that I am not a doctor, psychiatrist, psychologist, or social worker. Likewise I am not qualified as a research worker in this field. Therefore, you should not take what I write as medical advice; always consult with your physician before you undertake any new treat-ment regimen or alter an old one. I am only a layman in the field. Nevertheless I am an "expert" because I have suffered with bipolar disorder for 43 years. I have also gotten to know a large number of other CMI (clinical mentally ill) people, mostly with bipolar disorder. We all know the illness "inside-out." And we all have had experiences we can share with others to guide them in their own struggles with mental illness, whether first-hand, or in helping a friend or relative.

A. Why This Pamphlet?

Perhaps the most common reaction people have to mental illness, in general, or to depression/bipolar disorder, in particular, is to ask, "Why in the world would anyone want to discuss such an unpleasant subject?" This, perhaps, along with an (unspoken) intimation that the subject is also in rather bad taste, the answer to this question is long and complicated; indeed it is the subject of the entire pamphlet. Yet there are a few basic points that need to be made from the outset. First, mental illness is of varying degrees of severity and effects many people. The estimates differ a good deal from one source to another, partly because the criteria used in different surveys differ from one another. But it is clear that something like 3% of the population of the United States (i.e. roughly 7.5 million people) suffer from, chronic depression or bipolar disorder. A similar number suffer from chronic schizophrenia. And another 1% or so suffer from various other mental disorders (e.g. obsessive-compulsive disorder, dementia...). These are the people who are chronically mentally ill (CMI), the ones who must (and whose families must) struggle with the illness day-by-day, year-by-year perhaps for a lifetime. Isolated episodes of serious depression are far more common. It is conservatively estimated that something like 25% of the U.S population will have at least one bout of depression serious enough to merit medical attention during their life-time.

Second. depression and bipolar disorder can be extremely unpleasant. It can blight a person's existence for years. In its more severe forms it can incapacitate a person, as completely as any serious physical disability. Often employment becomes impossible, which implies severe economic and social hardships, or, both for the individual and his/her family. In its most extreme form, depression can lead to suicide, destroying one's life as surely as cancer.



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Psychiatric Issues with Chronically Ill Children
A Dialogue with Pediatricians

By Joseph Damore, M.D.
Four Winds Hospital
Medical Director, Deerfield
Child Inpatient Unit

It is estimated that between 10 and 20 million children and teenagers in the United States suffer from some type of chronic physical illness or dysfunction. By definition, chronic connotes a condition or impairment that is expected to last for an extended period of time, and requires substantial medical attention, extensive and repeated hospitalization, or in-home health services. Chronic conditions are often described in terms of their duration, usually longer than 3 months, or by severity, that is, the effect of the disorder on a child's physical, educational, emotional, or social functioning. Examples of typical chronic conditions in children include the following: asthma, diabetes, seizure disorders, neuromuscular disease, acquired immunodeficiency syndrome, cancer, solid tumors, chronic hematologic disorders (especially leukemia, lymphoma, sickle cell anemia, the thalassemias and hemophilia,) juvenile rheumatoid arthritis, cystic fibrosis, and congenital heart disease. This list can be further extended if we consider the effect that these illnesses have on children when they are experienced by a parent or a sibling. In addition, it should be noted that conditions such as blindness, deafness, mental retardation, and cerebral palsy often fail to make the list in a discussion of the psychiatric issues of chronic illnesses in children. Truth be told, the impact of these disorders on the psychological well-being of children is so profound as to require their own article. For the purposes of this discussion, we will limit our scope to those illnesses associated with the potential for long-term sequelae, and in most cases, death.

Joe Damore, M.D.

It is the life-threatening quality of these illnesses that tends to drive the psychological reactions which are seen in affected children and their families. Thus the specter of the death of a child or parent so affected often becomes an elephant in the room about which discussions are never shared…and this has certainly been experienced both in my private and professional life.

Estimates vary about the incidence of psychiatric disorders in children and adolescents who are affected by chronic illness. It has long been held that children with chronic physical illness or impairment are at an increased risk for psychiatric and psychosocial morbidity. While some evidence suggests that the rate of psychiatric co-morbidity in children may be as high as twice that of their healthy counterparts, other research suggests that the psychiatric impact of such conditions is small. In my own experience, as the Director of Pediatric Consultation Liaison Psychiatry at Memorial Sloan Kettering Cancer Center, our service conducted 74 new consultations in a one year period, and the treatment of patients with chronic cancer illness accounted for more than 420 visits to the psychiatry service in that year alone. Furthermore, reports have also demonstrated that these conditions create significant disturbances in the quality of life in a least 10% of such children, and often disrupt relationships between family members. Chronic physical conditions have also been demonstrated to be a major risk factor for grade repetition, and for the placement of children in special education programs. Though discrepancies about the impact of these illnesses are reported in the literature, such statistics which are obtained in a naturalistic clinical setting are difficult to ignore. Thus, the psychological impact of chronic illness on children and their families is a particularly valuable thing for pediatricians to be aware of. Timely intervention can alleviate substantial psychological suffering.

Normal Reponses to Chronic Illness:

Prior to the isolation of insulin by Banting and Best, the diagnosis of diabetes mellitus was uniformly fatal. Once commercially prepared insulin become available, however, the prognosis of diabetes was upgraded from fatal to that of chronic. Similarly, in 1964, the five year survival rate of children with acute lymphocytic leukemia was 5%. By the early 1980's, this had increased to 75%, and currently the five year survival rate is reported to be better than 90%. As a result of advances in medical technology, many childhood illnesses that were rapidly fatal can now be managed and do not necessarily result in a child's death. Though the death of an affected child may be forestalled or even prevented, the diagnosis of these conditions are often accompanied by shock and disbelief. The uncertainty associated with treatment and follow-up normally create ripples of fear and sadness. I often refer to these emotions as the normal responses to chronic illness, and I divide them into two phases: diagnostic and chronic.

Recently, Four Winds welcomed area Pediatricians, the gate-keepers to early childhood care, to a well-attended dinner presentation on Psychiatric Issues in Chronically Ill Children. A portion of that presentation is reprinted here by permission.

see *A Dialogue* on page 30

Four Winds Hospital and Foundation
Fall 2002 Community Educational Events Calendar

OCTOBER 2002

Grand Rounds
Friday, October 4th • 9:30 - 11:00 am
"Smart Kids with School Problems: Things to Know and Ways to Help"

Priscilla L. Vail, M.A.T., Learning Specialist, Consultant, Author, Bedford, NY

Each of us has an intellectual fingerprint: unique and permanent. Recognizing how and why smart kids can have school problems enhances the academic climate for everyone. Drawing on current research, clinical experience and common sense, we will explore things to know and ways to help.

Fee: $20.00 payable to the Four Winds Foundation, a non-profit organization

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536
Registration Required: Please call 1-800-546-1754 ext. 2413

Community Service
Thursday, October 10th • 1:00 - 4:00 pm
"National Depression Screening Day"

Take advantage of this free program designed to educate the public about depression. The screening process will include a written "self-test", a consultation with a mental health professional, and an educational presentation (screening is modified for children).

For information, or to schedule a confidential appointment, please call 1-800-546-1754, ext. 2413. Free of charge – Open to the Public

Community Event
Friday, October 11 * 9:30 – 11:00 am
"They Cage the Animals at Night"

Jennings Michael Burch, Author, Survivor

An ex-NYC police officer, Mr. Burch was abused, abandoned and homeless for much of his young life when left in the care of the social services system. His story, soon to be released as a major motion picture, will revitalize your commitment and the impact that you can make by listening to, and working with, children.

Fee: $20.00 payable to The Four Winds Foundation, a non-profit organization
Location: The Northern Westchester Center for the Arts
272 North Bedford Road
Mount Kisco, NY 10549
Visit www.nwcaonline.org for directions
Registration Required: Please call 1-800-546-1754 ext. 2413

A Special Event
Friday, October 18th * 9:30 - 11:00 am
"The ABC Program: Bullying Part II"

Joel D. Haber, Ph.D., Clinical Psychologist, Co-Owner and Clinical Director of Prime Care Behavioral Health, White Plains, NY

Returning by request, Dr. Haber will present Part II of the problem of bullying in the school setting. Learn to understand the bully and why they do what they do. How can the silent majority of children, those neither victimized nor bullying help to stop the problem? Dr. Haber's ABC Program, ***A Better Community***, offers tools for resolution.

Fee: $20.00 payable to the Four Winds Foundation, a non-profit organization

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536
Registration Required: Please call 1-800-546-1754 ext. 2413

Special Training
Thursday, October 24th • 2:00 - 4:30 pm
"Child Abuse Identification and Reporting"

Joanna Landau, Ph.D., Psychiatric Nurse Practitioner, Adult Service, Four Winds Hospital

This course is required by all licensed professionals involved in reporting child abuse and neglect. A State Education Department certificate of completion will be given at the end of the class.

Fee: $40.00 payable to the Four Winds Foundation, a non-profit organization

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536
Registration Required: Please call 1-800-546-1754 ext. 2413

NOVEMBER 2002

Grand Rounds
Friday, November 8th • 9:30 - 11:00 am
"Adolescents and Adoption"

Gary Silverstein, CSW-R, Executive Director of The Therapy Center and
Brian Gerety, CSW, Clinical Director of The Therapy Center, Mount Kisco, NY

Parents of an adopted child wonder whether, when and how to tell their child that he or she is adopted, and if that child will face special problems or challenges. As if the adolescent years, by definition, aren't difficult enough, you will gain further insight into the sometimes confusing world of an adolescent facing life as an adopted child. How does the adoptive parent respond to questions? What might be expected from the child – curiosity, anger, confusion? This informative discussion will deal the joys and frustrations of adolescents and issues of adoption.

Fee: $10.00 payable to Four Winds Hospital

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536

Registration Required: Please call 1-800-546-1754 ext. 2413

Grand Rounds
Friday, November 22nd • 9:30 - 11:00 am
"Mood Disorders in Children: Diagnosis and Treatment"

Joseph P. Damore, M.D., Medical Director of the Deerfield Child Program, Four Winds Hospital and Assistant Professor of Psychiatry (Courtesy), Weill Medical College of Cornell University

In addition to discussing clinical criteria for making a differential diagnosis of mood disorders in children, Dr. Damore will acquaint the audience with related current thinking on medication and psychotherapeutic treatment, and will address when it is necessary to seek an evaluation.

Fee: $10.00 payable to Four Winds Hospital

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536
Registration Required: Please call 1-800-546-1754 ext. 2413
1.5 CME Credits Available
Through Mid-Hudson Continuing Medical Education

DECEMBER 2002

Grand Rounds
Friday, December 6th • 9:30 - 11:00 am
"Treating the Culturally Different: Diversity in Mental Health Treatment of Latinos"

Ofelia Rodriguez-Srednicki, Ph.D., Professor, Montclair State University
and Private Practice, Upper Montclair, NJ

Cultural issues and treatment approaches that are specifically defined as beneficial to Latino families and adolescents in particular will be highlighted. Treating the resistant, and determining treatment readiness will be discussed.

Fee: $10.00 payable to Four Winds Hospital

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536
Registration Required: Please call 1-800-546-1754 ext. 2413
1.5 CME Credits Available
Through Mid-Hudson Continuing Medical Education

Due to limited seating, registration is limited to the first 120 paid registrants. For those requiring special services, please call no later than two weeks prior to the conference date so that the appropriate arrangements can be made.

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- **Full Day Program**
- **Intensive Family Treatment**
- **On-site school**
- **5 days a week (9:00 am - 3:00 pm)**

Adolescent Partial Hospitalization Program

- **Ages 13-17**
- **Treatment alternative to inpatient care**
- **24 hour crisis intervention**
- **Full Day Program**
- **Intensive Family Treatment**
- **On-site school**
- **5 days a week (9:00 am - 3:00 pm)**

Adult Partial Hospitalization Program

- **Ages 18 years of age and older**
- **Treatment alternative to inpatient care**
- **24 hour crisis intervention**
- **Flexible full or half-day scheduling**
- **Specialized treatment tracks**
- **Individual case management**
- **5 days a week (9:00 am - 3:00 pm)**

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- **Individual and Family Counseling**
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- **Interventions**
- **Dual Diagnosis Track**
- **Acupuncture for Detoxification**
- **Womens Groups**
- **New York State Department of Motor Vehicles Mandatory Drinking Driving Program (DDP) Assessments**

Adult Ambulatory Detoxification Program

A medically supervised 24 hour, 7 day a week program in which all substances can be detoxed. 23-hour crisis bed available

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***A Dialogue* from page 27**

Diagnostic Phase:

The feelings that children associate with the diagnosis of a chronic, potentially life-threatening illness, are clearly evident in this description. Other feelings children report during and immediately following the diagnosis of chronic illness include terror, pain, embarrassment, and shame. For many families, the diagnosis becomes a partition between the worlds of health and illness. It is during this time that the family finds itself consumed with often painful procedures and scary tests. Children and their parents are forced to cope with the uncertainty of illness which threatens the need for consistency and the safety that it implies. Caregivers who work with the population benefit these families most by utilizing a candid and reassuring approach while presenting realistic hope.

The initial shock of such a diagnosis may last days to weeks, and responses to such bad news are idiosyncratic, and cover a broad spectrum of emotions. Tears, anger, bargaining, blaming, and shame may all be encountered during this time. Because each family demonstrates different levels of resilience, predicting when emotions may cool is often difficult. Physicians working with this population must be aware of, and respectful of, this range of emotions and allow children and parents to grieve in their own way. There is no right or wrong way to mourn. If the need to mourn is understood and the process is given time and support, most children and families progress to the next level of coping without significant psychological sequelae.

Chronic Phase:

For most children and their families, the initial shock of diagnosis will at some time wear off and give way to a period of improved family functioning. During this time, the family re-equilibrates – that is, develops a routine for coping with the illness – a routine involving trips to the clinic, follow-up testing, as well as at-home monitoring, procedures and daily management. At this time, the child's response to diagnosis tends to be fluid. Different emotions ebb and flow at different times. In addition, anticipatory grief – that is, grief associated with the potential for loss – begins at the time of diagnosis, and similarly waxes and wanes throughout the illness experience. It is during the chronic phase that most health care providers see the various coping strategies employed by families…and it needs to be re-emphasized that there is no right or wrong way to cope with such an illness. Some families opt for a 'business as usual' approach, attempting to maintain activities enjoyed prior to diagnosis as much as possible. Denial of the severity of the illness and its consequences is often encountered in families who follow this approach.

Other families attempt to cope with an illness through cognitive mastery. Attempts at mastery are associated with both factual and distorted information regarding treatment and prognosis. One has only to cruise the internet to see what is available to patients who wish to obtain medical literature, and as very little of the information on the internet is peer reviewed, the majority of patients have difficulty separating the wheat from the chaff.

It is not unusual during this phase to find that children, and occasionally parents, view the illness as punishment for previous bad acts. Children demonstrate the concept of immanent justice quite readily – that is, the notion that punishment for bad acts is unavoidable. Because they attempt to make sense out of the seemingly senseless experience of chronic illness, they conceptualize their plight as punishment for some wrongdoing. Such conceptualization can sometimes lead to the development of an over compliant or oppositional child. Working with these children involves challenging their misconceptions and facilitating an understanding of illness as nobody's fault. Continuing to treat a child as normal during this time is a formidable task for parents, especially regarding discipline. There is a tendency for parents to indulge children who are chronically ill, and to set few limits. It has been my experience that when discipline becomes lax, the child's anxiety increases. The child tends to interpret the relaxation of discipline as a comment about the severity of their illness. They think "Mom and Dad are being extra nice to me. I must be really, really sick." Maintaining pre-illness limits sends a critical message to the child that the illness may be abnormal, but the child as a person, is as normal as they ever were, and that the expectations are the same as for any normal child.

Abnormal Reponses to Chronic Illness:

As time passes, most children return to a level of function that closely resembles their life before the illness. In many cases, however, the emotional demands of illness and its treatment overwhelm the psychological defenses of children and their families. In these situations, significant psychiatric disorders are noted most often. The clinician should expect that during this time, an adjustment disorder, a mood disorder, an anxiety disorder, or an exacerbation of a pre-existing psychiatric disorder, will most commonly be seen. Almost invariably, adjustment disorders are diagnosed during the diagnostic phase. Mood disorders are most often diagnosed in the chronic phase. Anxiety disorders appear to be diagnosed equally in both the diagnostic and chronic phase.

Adjustment Disorder:

One of the most common psychiatric diagnoses encountered in the diagnostic phase is that of adjustment disorder. By definition, this disorder refers to the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stress or stressors. The symptoms of an adjustment disorder must develop within three months of the stressor, such as diagnosis of a chronic illness. The clinical significance of the reaction is indicated either by marked distress in excess of what would be expected, given the nature of the stressor, or by a significant impairment in social or academic functioning. Though the DSM-IV stipulates that such disorders dissipate within six months of the ending of the stressor, the symptoms may persist for longer than six months if they occur in response to a chronic stressor, such as a chronic illness. There are several subtypes of adjustment disorder, and these are specified in terms of their predominant symptomatology.

Reports of the prevalence rate of adjustment disorder ranges from 25 to 65%. Treatment of an adjustment disorder works best when it is implemented quickly. The goals of such intervention are to decrease the stress experienced by the child, and to firm up the coping mechanisms of both the child and the family. In addition, counseling aimed at helping parents understand their child's experience can empower the entire family. Unfortunately, the constraints of clinical practice often make labor-intensive therapeutic contact unreasonable for most pediatricians. When features of an adjustment disorder arise, especially if they are severe, it is appropriate to arrange referral to a child mental health specialist. Usually a referral to a child psychiatrist is the best first step. It needs to be understood, however, that such referral is often met with stiff resistance from parents who want to avoid the stigma associated with such a referral. The pediatrician does the family a great service by integrating the child psychiatrist into the health care team. In these situations, the best outcomes are obtained when it is explained to the parents that the input of the child psychiatrist is vital to the overall well-being of the child. The psychiatric treatment of adjustment disorder tends to be time-limited…usually weekly sessions conducted over 3 to 6 months, and medications are rarely prescribed.

Mood Disorders:

In a one year period at Memorial Sloan Kettering, approximately one-third of patients referred from the Pediatric Heme-Onc service met criteria for mood disorder. Usually, the diagnosis was either major depression or a mood disorder with symptoms arising from the illness itself or the medical treatment. The course of mood disorder in chronically ill children has not been studied, and the progression seems quite variable. In one study, depressive symptoms in chronically medically ill children tended to correlate well with psychosocial life events, such as the number of hospitalizations. Depressive symptoms, however, appear to be unrelated to the course of the illness. In addition, adaptive style has been reported to influence the medical and psychological outcome of ill children, and may account for the variance in depression over that explained by the severity of the illness. As a pediatric intern, I used to overhear routinely conversations from the Heme-Onc service or Endocrinology service that "Of course the patient is depressed. He or she has cancer or diabetes." I often found these statements suspect because it had been my experience that the majority of patients with either cancer or diabetes that I had seen did not appear to me to be clinically depressed…and research with medically ill populations has borne this observation out. Therefore, when patients have cancer and depression, or diabetes and depression, they have two illnesses…and the depression is eminently treatable and curable…whereas the chronic illness may not be…and treatment of the depression results in a substantial improvement of the quality of life of these patients. A careful interview is necessary to determine the presence of major depressive symptoms. In children and adolescents with chronic illness, the diagnosis may be particularly difficult to make because symptoms of the illness such as weight loss may mimic the symptoms of major depression. Symptoms that are common in both the chronic illness and depression should count toward the diagnosis of major depression unless the symptoms can be attributed directly to the chronic illness. For example, weight loss, secondary to ulcerative colitis, should not be counted toward major depression.

Mood Disorder Secondary to a General Medical Condition:

In this situation, the mood disturbance is considered directly attributable to the physical condition. The mood can be depressed, elevated, or irritable. For example, certain malignancies such as carcinoma of the pancreas and illnesses such as lupus are known for the mood changes they produce as part of their symptomatology.

The recognition of mood disorders in physically ill children and adolescents is the first step toward proper treatment. Pediatricians should be diligent in their inquiry about changes in sleep, interest, concentration, appetite, and energy level. It should also be noted that guilty ruminations – that is, the presence of self-recriminating statements – I'm a bad boy, bad things happen to me because I'm bad, God is punishing me for something – tend to be associated with the presence of a mood disorder, and are not typically seen in either an adjustment disorder or normal coping.

In addition, it is vital to remember that mood disorders carry with them an increased risk of suicide. Parents and physicians alike often worry that frank discussions about suicide will "put ideas in the patient's head." This does not appear at all true. In fact, such frank discussion often allows a child or teenager to express feelings that he or she thought were taboo.

Most mood disorders in chronically ill children will respond well to a combination of antidepressant medication, particularly SSRI's such as Paxil and Zoloft, and psychotherapy. Because dosing of these medications and monitoring of clinical conditions in therapy can be complicated, especially in this population, a referral makes very good clinical sense.

Anxiety Disorders:

At Memorial Sloan Kettering, the most commonly encountered anxiety disorder is 'anxiety disorder not otherwise specified.' This category includes disorders with prominent features of anxiety and avoidance that do not meet criteria for either a specific mood disorder like major depression, or a specific anxiety disorder like panic disorder. Children with an anxiety disorder may present in a number of different ways. They may become fearful of previously tolerable experiences such as going to see their doctor. They may develop fears of separation from their parents, especially when active treatment ends and they must return to school. Finally, it is quite common for a child with an anxiety disorder to manifest the problem somatically. The youngster may demonstrate panic attacks with associated tachycardia, shortness of breath, choking nausea, vomiting, and de-realization. Other children and adolescents may demonstrate fatigue, teariness, or insomnia…and it is helpful to ask the parents about the activities of daily living and about school, because often changes in behavior at home and in school are the first signs of an anxiety disorder.

As with mood disorders, the diagnosis of anxiety disorders is the first step towards proper treatment…and once such a disorder is suspected, a timely referral to a child psychiatrist is warranted. It is the relationship with the child psychiatrist that seems to assist the patient in the daily struggle with the illness, while medication can often be used to rapidly and successfully treat most anxiety disorders. Interestingly, SSRI antidepressants have been used for this indication and are well-tolerated. Though the course of anxiety disorders in children and teenagers with chronic illness varies, it has been my experience that exacerbation of anxiety correlates with exacerbation of illness.

Exacerbation of a Pre-existing Psychosocial Disorder:

In general, a child or adolescent with a pre-existing psychological disorder such as attention deficit or oppositional defiant disorder may create a management problem for a treatment team when a chronic illness develops. In the same way, chronic illness can, and often does, exacerbate long-term parent-child relational problems. When such disorders are known at the outset of chronic illness, the clinician does well to ensure that treatment for the psychological disorders continues during the diagnosis and treatment of chronic illness. Proper medication of ADHD and proper family therapy for oppositional defiant disorder can go a long way toward making chronic illnesses more manageable for patients, families, and pediatricians.

References: Damore, J.P., "The Child With Chronic Illness," in Primary Care Pediatrics, Hernandez C., Singleton J., Aronzon, D., (eds.) Philadelphia, (2001) p. 617-621.

NewYork-Presbyterian Hospital The Westchester Division

Fall 2002 Programs for the Community

SEPTEMBER

Wednesday, Sept. 25:
Financial Planning for Families with Disabled Loved Ones
Anthony J. Enea, Esq., Charles J. Newman
Center Building, Conf. Room A, 6:30-8:00 pm

OCTOBER

Wednesday, Oct. 9
Community Mental Health Resources Fair: Self-Help Groups
Center Building Auditorium, 1:00-3:00 pm

Thursday, Oct. 10
Depression Screening Day
Center Building, Conf. Room C, 10:00 am- 4:00 pm

Thursday, Oct. 17
12-Step Programs: How They Work
Barbara Mazer-Turtenwald, BS, CASAC
Center Building, Conf. Room A, 6:30-8:00 pm

NOVEMBER

Wednesday, Nov. 6
Women's Issues in Psychiatry
Lisette Rodriguez, MSN, RN, Isabel Frankel Rachlin, CSW-R
Center Building, Conf. Room A, 6:30-8:00 pm

Wednesday, Nov. 20
Creating Wellness: Key Concepts for Living with a Mental Illness
Beth Harris, APRN, BC
Center Building, Conf. Room A, 6:30-8:00 pm

DECEMBER

Tuesday, Dec. 3
How to Recognize Posttraumatic Stress Disorder And What to Do About It
JoAnn Difede, PhD
Center Building, Conf. Room A, 6:30-8:00 pm

Wednesday, Dec. 4
The Role of Spirituality in Healing
Barbara Yeager, Hospital Chaplain
Center Building, Conf. Room A, 6:30-8:00 pm

These programs are presented at no cost as a community service. For further information and directions, call

914-997-5779

Asset-Based Community Development and Person-Centered Planning: Some Old Ideas with New Applications

By DeMecia Wooten-Irizarry, MPA, Vice-President for Corporate Community Relations

Benjamin R. Sher, MA, CSW, Director of Training and Staff Development

Institute for Community Living, Inc.

Imagine sitting down for your annual performance evaluation with your supervisor and s/he hands you a sheet with a list of performance goals on it. Imagine then that your supervisor tells you that these will be the goals you will be expected to work on during the next performance year. S/he tells you that failure to work on these goals will mean a poor performance rating next year.

Service planning for persons with mental illness in traditional community-based settings is not very different from the scenario described above. Though a little extreme, the imaginary performance evaluation conference often models how treatment plans goals and objectives are written when a consumer lives in a residential mental health setting, attends a traditional day treatment program, or goes to an outpatient mental health clinic.

Person-Centered Planning, a vision of planning long used in the developmental and mobility disabilities field, is beginning to emerge as a practice model in traditional mental health settings. Defined as "an entire family of approaches to organizing and guiding individual and community change in collaboration with individuals with disabilities, their families, and their friends," (American Association for Mental Retardation website, www.aamr.org), person-centered planning (PCP) shifts the focus away from giving consumers their service plans with goals already listed on them. Instead, it starts where the consumer is at, allowing them to tell their story so that their wishes, dreams, and hopes (and nightmares) can truly unfold into a plan for work. A concurrent process to PCP, Asset-Based Community Development (ABCD), helps a person in the planning process unite with and utilize a community's strengths in networks, vocational and educational opportunities, support, and other areas to shape their goals and make them happen. This article addresses how one community mental health agency is using these program-planning tools.

The Institute for Community Living, Inc., (ICL) a not-for-profit community based organization established in 1986 to provide rehabilitative and residential services to persons with mental illness and developmental disabilities in New York City, has begun the journey towards PCP and ABCD. Established early on as an agency dedicated to consumer empowerment and advocacy, ICL was developed to offer residential alternatives for people with disabilities who were long institutionalized or underserved in large congregate settings. The agency has grown to serve over 1,000 consumers a day; offering such diverse services as day treatment, assertive community treatment, case management, vocational services, specialized medical support, a clubhouse, outpatient mental health, family support, school-based services, juvenile justice diversion, and specialized housing opportunities, such as housing for persons with mental illness and their children.

ICL's organizational philosophy has been to maximize the independence of the people it serves. Therefore, Person-Centered Planning was a natural step towards maintaining this vision. In 2000, ICL obtained a three-year Commission on Accreditation of Rehabilitative Facilities (CARF) accreditation for its community housing and integrated behavioral healthcare programs. CARF, a national accrediting body similar to JACHO, establishes a grounding treatment recommendation in the person-centered approach. Because ICL had always believed in community integration and inclusion for its programs and its members, the drive towards this national standard was a natural evolution for the agency. At the same time, ICL had developed and implemented a "good neighbor" policy over many years. These two philosophies, together, formed the basis for its venture into "Inclusive Community Building."

According to Northwestern University's Institute for Policy Research, the presence and availability of community-based services are vital for achieving community integration. Often, such services can only be established and successfully operated with the aid of substantial community organizational effort. This is particularly true when the nature of the population served, despite their eligibility for community services and capacity to benefit from such services, arouses prejudice in the community.

The Bazelon Law Center for Mental Health determined that housing for individuals who are mentally disabled are among the nation's top 10 most controversial facilities. These individuals are often stigmatized and ridiculed in their new communities. This stigmatization is demonstrated by a community's unwillingness to live, socialize or work with; rent to, or employ people with mental disorders.

Over the past 15 years, "Community Building" strategies have been developed to deal with the concerns of individuals who have been excluded and considered to be on the margins of our society. Community Building is the process of supporting individuals to make and sustain connections with others in the community. "Inclusive Community Building" is the process by which the assets and resources of a community are identified and strategies developed to link disabled individuals to these assets and resources as well as to their neighbors.

Noteworthy among current community building

continued next page

Asset-Based Community Development and Person-Centered Planning: Some Old Ideas with New Applications

from previous page

approaches is the Detroit Initiative for Inclusive Communities and a Washington DC effort by the Community Partnership for the Prevention of Homelessness on behalf of its homeless clients. It has been successful over a five-year period in developing partnerships among private agencies and federal and municipal governments that cultivate relationships between families and neighbors so that persons struggling to overcome homelessness can be constructively reintegrated into their communities.

ICL began to work toward implementing an "Inclusive Community Building Project" (ICBP). This ICBP is comprehensively designed to ensure that the experiences and struggles of people with mental illness and developmentally disabilities become part of, and are used to strengthen, the community. Part of this process is to utilize the Assets Based Community Develop (ACBD) process. This is the process by which the assets and resources of a community are comprehensively identified and strategies developed to link individuals with disabilities to these resources. While there has been recognition in the mental health field that community building is a necessary component of any attempt to support people outside institutional settings, community-building methods have rarely been applied upon behalf of those with serious mental illness. Awareness regarding the existence of such approaches is just dawning in New York City.

ICL also began strategically planning to employ community-building concepts used by the "Community Partnership," such as "person-centered planning, circles of support, making connections to associations, and neighborhood mentoring.

An interesting issue arose in the seeding of this work at ICL. In the spring of 2002, with agency training on Person-Centered Planning, ICL administrators realized two tracks of development were occurring on our strengths approach to systems of care. In his presentation to ICL, Jack Pearpoint, an internationally renowned speaker on person-centered planning and the President of Inclusion Associates in Ontario, Canada, clarified that ABCD was but one part of PCP. His training helped ICL understand that in order for a person to achieve their dreams in a person-centered approach, a community must be involved. Person-Centered Planning is team-facilitated (2001) and occurs with community, or circles, as they are described in the PCP literature.

Thus, ICL has begun to form its own circle as we implement person-centered planning. Comprised of a diverse membership, our strategic planning "circle" now involves direct care professionals in mental health, vocational services, and developmental disabilities; administrators working in training outcomes and quality management; planners, and will soon involve consumers. Recognizing that helping people to achieve their dreams is cautious and careful work, ICL is utilizing a pilot approach to the introduction of PCP/ABCD. The agency has identified our program on the Upper West Side of Manhattan as a viable "launching pad" for this work. Opened in 1995, the Broadway CR/SRO is home to 72 formerly homeless consumers with serious mental illness. Recognition of the rich resources available in this community, coupled with the fact that the program has a strong community advisory board, planning is in process to begin PCP and ABCD at the facility.

Now considered by the New York State Office of Mental Health to be long-term transitional housing, work has begun at the Broadway CR/SRO to help consumers maximize their skills to move on to more independent living should they choose to do so. Many of the program's members have lived at the facility a long time and are grappling with using traditional mental health supports to move to their own apartments. Given the success of person-centered planning in similar situations, members of the Broadway program will be offered opportunities to design their treatment plans based on principles and applications of person-centered planning. Implementation of this process will take time. Evaluation of this method will enable ICL to assess development of person-centered planning throughout its systems of care. The Institute for Community Living is committed to maintaining our mission of consumer empowerment, and PCP and ABCD helps the agency do just that!

For more information on Person-Centered Planning, A Little Book About Person-Centered Planning is available at Inclusion Press, (416) 658-5363, or on the net at www.inclusion.com. For more information on Asset-Based Community Development, Building Communities from the Inside Out: a Path toward Finding and Mobilizing a Communities Assets is available from acta@one.org or contact the Asset Based Community Development Institute at Northwestern University (847) 491-9916.

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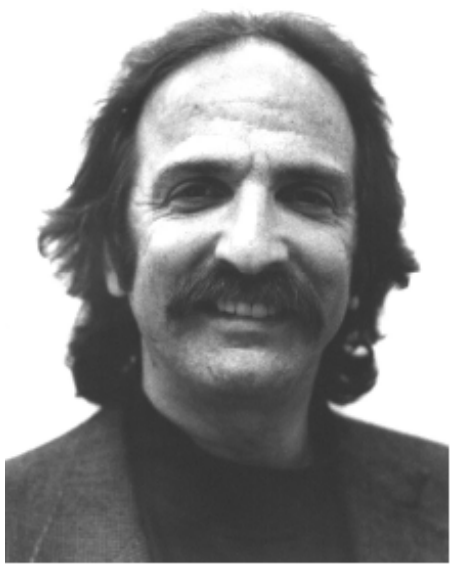
THE NYAPRS ADVOCACY WATCH

By Harvey Rosenthal
Executive Director, NYAPRS,
New York Association of Psychiatric Rehabilitation Services



Harvey Rosenthal

Testimony on
Quality of Care in Adult Homes
Before the New York State Assembly
June 6, 2002
Delivered By Harvey Rosenthal
NYAPRS Executive Director

Thank you, Chairmen Luster, Gottfried, Englebright and Klein and Assemblywoman Pheffer for this opportunity to speak to you today on the crisis facing thousands of New Yorkers with psychiatric disabilities who have been inappropriately housed and deplorably served in adult home settings across the state.

I speak today on behalf of a coalition of prominent mental health, social policy and legal rights groups, the NYS Coalition for Adult Home Reform, which has joined together this year to press for prompt real solutions to New York's adult home crisis. I also represent my own organization, NYAPRS, which brings together thousands of New Yorkers from across the state, individuals who use and/or provide mental health services and others who similarly work together to improve services and social conditions for New Yorkers with psychiatric disabilities by promoting their recovery, rehabilitation and rights.

Just about 30 years ago, upwards of 90,000 New Yorkers lived in 30+ state psychiatric hospitals, warehoused, many would say, in all too often dehumanizing settings, many living marginal lives robbed of their dignity, hope and opportunities for recovery and a productive and meaningful life.

With the advent of the policies of deinsitutionalization, New York State provided the funding, services and supports and the public commitment necessary to provide a portion of these individuals with the community housing, treatment, rehabilitation and support that have allowed tens of thousands to experience the dream of a life in recovery in the community.

But we are here today to talk about the forgotten ones, the tens of thousands more who have been denied the proper care and support they required and deserved from New York State and who, as a result, have been stranded in the shadows to live on the streets as homeless people, endured the criminalization of mental illness that has resulted in 16,000 of our loved ones swelling the ranks of our state prison population and left 15,000 of us to make up a large percentage of those forced to endure deplorable, dangerous and demeaning conditions in our adult homes.

Many have or will talk to you today about a variety of measures necessary to fix the scandalous conditions in our adult homes. Before I join them, I do need to strongly emphasize a central conclusion reached by all of my fellow advocates: New Yorkers with psychiatric disabilities simply do not belong in 300 bed institutional adult home settings!

Even if the homes were better run, by operators who were focused on properly caring for those they served rather than viewing them as opportunities to make big profits, by properly trained direct care staff who were school and supervised in providing appropriate, respectful and recovery-focused supports and services, even if the homes were better cooled and heated and properly kept up and offered decent food, even if residents received better medical and mental health care, we strongly agree with the Supreme Court's Olmstead decision that people with disabilities should be offered, by the states in which they live, the proper array of housing and support to allow them to live in the least restrictive settings of their choice, in their home communities.

So I want to lead off with a primary recommendation. Only a few years ago, when all the headlines were focused on the tragic death of Kendra Webdale, the New York Times and the NYS Commission on Quality of Care for the Mentally Disabled helped us understand that Andrew Goldstein was also a victim, a victim of our inadequate community mental health system that failed to properly provide him with the consistent housing and support he had responded to and deserved.

The following year, Governor Pataki and the state legislature responded with a $200 million package of NYS Office of Mental Health New Initiatives aimed at shoring up the care system for those who were currently engaged in seeking help and support. The impact of that initiative is just beginning to be felt in New York, with the deployment of an array of new case management services and the creation of new housing beds to help those on pre-existing waiting lists get the support they deserve from New York State.

None of these dollars will help those in the adult homes however (especially since adult home residents are deemed ineligible to receive supported housing services by OMH), and so, we are calling on the Governor and the legislature again to heed yet a new call prompted from the New York Times, a call once more amplified by stark new findings from the Commission of Quality of Care, and to respond to this call with a major new funding and programmatic initiative aimed specifically at each of the 15,000 New Yorkers who reside in adult homes, offering them the community housing and state-of-the-art mental health services and support we have long denied them.

New York State owes each of these individuals nothing less than the best care we can offer them, after decades of moving them from the backwards of state hospitals and disgracefully abandoning them to the inhumane squalor of the streets, the prisons and the adult homes.

There has been much talk today about wanting to respect the choice of adult home residents to remain in adult homes or to go to less desirable settings like street shelters. But we believe that all too many adult home residents with psychiatric disabilities have been afforded the opportunity to make fully informed choices from a reasonable array of true desirable choices; after years of dehumanizing treatment and institutionalized learned helplessness, we believe that far too many are operating out of ignorance as to their rights and fear they should not gamble on a better life. And very few have been offered better choices, like supported housing, because they are denied access to those beds, which are far too few in number anyway.

The New York State Office of Mental Health is the agency of primary responsibility for these individuals...they are 'our people', people who not too long ago lived in OMH's state hospitals and now deserve all of the best care that OMH and its community mental health provider networks can offer.

Accordingly, the Governor should propose and the Legislature should approve a major new funding initiative that provides adult home residents with a broad and appropriate array of community housing opportunities, from supported housing apartments to small community residential programs and a full array of recovery-centered services, including the latest advances in self-help, rehabilitation and employment services.

Since it takes years to roll these programs out fully, we must not delay: funds must be found now to make this initiative a prompt reality!

And New York State can take one measure now to help pool available but unused federal funds with state and local dollars to help get a part of this job done: we must end the discriminatory Medicaid neutrality spending cap that has arbitrarily and unfairly limited the growth of necessary community mental health services across the state and would be a major asset to a relief package aimed at helping adult home residents to make safe and proper transitions into the community.

But we must focus just as strongly on conditions in the adult homes today and look to prevent any further deaths and injuries, abuse and neglect, inhumane or inadequate levels of care. For the moment, that chief responsibility lies within the Department of Health, which has performed abysmally in its responsibilities to oversee the homes and the care they provide.

In recent weeks, the Governor and DOH have made a number of proposals which represent some basic first steps in addressing conditions within the homes.

DOH and OMH have increased the number of inspectors assigned to oversee downstate homes. We need more of them, more of them to inspect upstate homes as well and increases in CQC staffing to allow a stronger watchdog role for them here as well.

The Governor has proposed higher fines on errant operators and practices. We support those as well as no downward negotiation of the fines to ensure they are taken seriously and produce change.

The Governor has proposed legislation to stop the flow of referrals to adult homes from an array of healthcare, OMRDD and correctional facilities. We must also stop all discharges to the streets and to other than appropriate well-supported community placements.

The legislation includes a provision to allow DOH to promptly remove a seriously negligent operator and replace them with a temporary receiver: we strongly support that and urge that the state do so immediately at Seaport Manor.

The state has sent engineers in to examine what it would take to ensure proper heating and cooling conditions within the homes and is looking at Dormitory Authority funds and other means to support this. We must ensure that not only a few pubic spaces, but all of the hallways and resident bedrooms also are refitted to assure proper temperatures.

DOH has proposed requirements that all homes have at least one nurse on staff to assure proper disbursement of medications. We strongly support this measure, and object to the disgraceful series of obstacles adult home operators have put in the way of relief through their regular series of temporary restraining orders preventing measures like these from being implemented.

DOH has promised to publicly post adult home statement of deficiencies on their website, a good measure we have yet to see implemented.

I also want to reiterate several recommendations our coalition proposed in April, measures necessary to bring immediate relief to the adult home residents:

The state should allocate a $1.6 million fund to deploy teams of lay advocates, legal advocates and peer counselors who can be up and in the homes virtually immediately to ensure that resident rights are protected, resident councils are encouraged to play stronger roles, illegal practices are exposed and addressed and that residents in the most impacted homes receive the personal support of a trained peer bridger, to help them understand their capacity for recovery and receive the personal and group support necessary that has already helped hundreds successfully transition from state hospitals into home communities across New York. These 3 initiatives can strongly help bolster practical efforts to ensure that the lives of adult home residents improve this summer and beyond.

The state should commit, at the very least, an additional $8 million towards increasing the personal needs allowances and creating small clothing allowances for home residents.

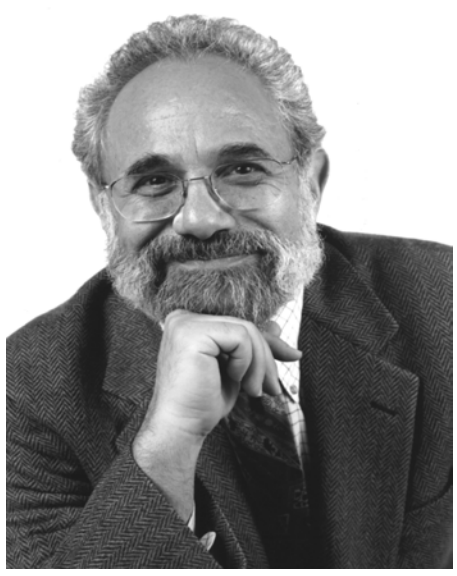
There is plenty of blame to go around in examining why we have so miserably failed New Yorkers with psychiatric disabilities who reside in the adult homes. Recent statements by the Governor and DOH, the formation of a stakeholder workgroup, past and recent statements by the Assembly and your two public hearings are all important steps in trying to address this horrific scandal. But we have talked in New York about the adult home scandal for decades and talk has done less than little to help its victims.

We must ensure that all of these statements, workgroups and hearings result in real substantial systemic change. Our coalition is committed to working with the Executive and the legislature in assuring that swift and permanent action is taken. I want to close where I began by strongly urging that only a major new OMH housing and community services initiative will see that permanent action is indeed taken to address this terrible crisis. Thank you for the opportunity to share these remarks.

Point of View

Think About The Next 25 Years: Advice For The President's Commission On Mental Health

By Michael B. Friedman, CSW



Michael B. Friedman

President Bush recently announced the formation of a Commission on Mental Health to develop recommendations for changes in mental health policy in the United States—a remarkable event if only because major Federal Commissions on Mental Health are so rare. In the second half of the 20th century, there were only two of them. The first was created by The Mental Health Study Act of 1955. That Commission issued a report in 1960 which became the basis of The Community Mental Health Act of 1963. It triggered massive deinstitutionalization of State mental hospitals and contributed to the development of mental health services in the community. The second Commission was established by President Carter in 1977 and produced recommendations that led to the passage of the Mental Health Systems Act at the very end of his administration. Although the Reagan administration never implemented the Systems Act, its central idea—that the mental health system is a fragmented non-system that must be reorganized—has been a driving force in mental health policy for the past twenty-five years.

There are a number of lessons the current Commission should learn from the prior two experiences.

First, the Commissions have been convened a quarter century apart. This Commission, therefore, needs to project mental health policy for the next twenty-five years.

Second, however thorough and complex their reports are, Presidential Commissions end up being known for, and driving, a very few simple ideas. The first Commission drove the transformation of the public mental health system from an institutional system to a community system. The second President's Commission contributed to the expansion of the community support program and lent credence to the belief that reorganization could solve our problems.

Third, there is a very sharp divide between idea and implementation. The initial phases of deinstitutionalization were tragic for a great many people with serious mental illnesses and their families. Nearly forty years have passed since the Community Mental Health Centers Act was passed. Many people are faring better now, but we still do not have a fully adequate community mental health system. Unlike deinstitutionalization, the ideas behind the Mental Health Systems Act have not had tragic consequences. In fact some of the efforts that have emerged—such as case management—have been helpful to people with mental illnesses and their families; and the management of mental health has improved. But many of the most brilliant ideas about systems change have either foundered on the rocks of reality, led to remarkable but unduplicable model programs, or been turned into humdrum bureaucracy.

History, then, suggests that The President's Commission on Mental Health needs to think about the needs of the next quarter century and seek a few clear, central ideas that can be the basis of changes in practice that take into account the pitfalls of implementing great ideas.

Here is one suggestion. The Commission should *focus first on the mental health needs of people* rather than on the needs of the "system." Who will need mental health services over the next twenty-five years? What kinds of services will they need? What research should be sponsored to determine service need and effectiveness? Who will provide services? Only after answering these questions should the Commission ask how to organize and finance mental health?

Who are the people who need mental health services in the foreseeable future?

Post-Deinstitutionalization Populations: Clearly there are a number of populations who still are not adequately served after years of deinstitutionalization. One critical population consists of *people with severe and recurrent mental illnesses who live on the edge in the community and tend to reject traditional mental health services.* The other critical population consists of people who have been "transinstitu-tionalized." Of primary concern are *people in adult homes and those in jails and prisons.* Just over the historical horizon are those who have been transferred to nursing homes with inadequate mental health services.

Children and Adolescents: Promises to address the mental health needs of children and adolescents go back at least a quarter of a century. There have been some accomplishments, but nothing that approaches fulfilling the promise to *develop an adequate community-based mental health system for kids.* It is time to keep that promise while keeping in mind the fundamental lesson of the deinstitutionalization of adults. *Don't take down the institutional elements of care without developing adequate alternatives first.*

It is also critical to be clear that the goal is to *help kids with serious emotional disturbances wherever they are*, not just those who turn up in formal mental health settings. There are more kids with mental health needs in child welfare, education, and juvenile justice than are served by formal mental health providers. Public mental health authorities have done far too little to help these children.

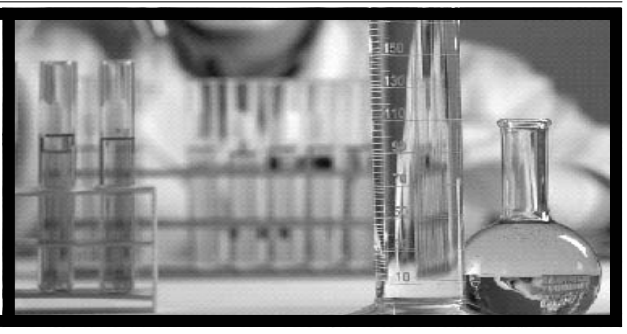
Changes in Demography: Over the next twenty-five years there will be vast demographic shifts in the United States. There will be tremendous *growth of older adults* (who will be more likely to seek mental health services than the current generation of older adults), and there will be tremendous *growth of minority populations* (who together may constitute a majority of the American population.) Mental health services for aging Americans living in diverse settings will be a critical challenge during the next quarter century. And the development of cultural competence must go beyond politically correct lip-service if this nation is to be able to meet the mental health needs of a majority of its citizens in the future.

It may well be that if the President's Commission devotes its attention to all of the populations I have noted, its work will become too complex and diffuse. Perhaps it should set sharper priorities. But it is surely critical that the Commission *anticipate the needs of diverse populations over the next twenty-five years*, and those findings—rather than findings about organization and finance—should drive its deliberations.

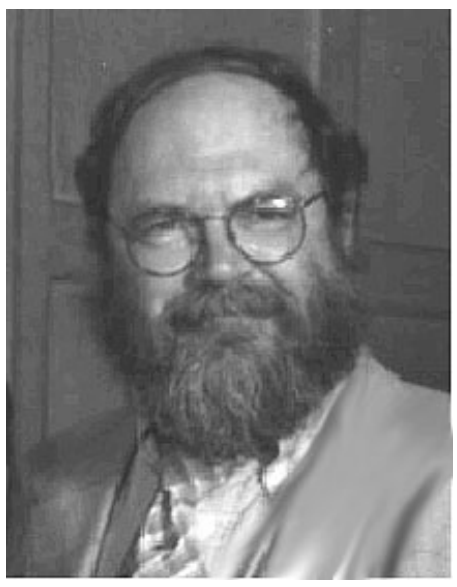
Michael B. Friedman is the Public Policy Consultant for The Mental Health Associations of New York City and of Westchester County. The opinions expressed here are his own and are not necessarily shared by the Associations.

WORKING WITH MEDICATIONS

How Do Doctors Choose Medications? Part 1.



By Richard H. McCarthy M.D., C.M., Ph.D. ComprehensiveNeuroScience White Plains, New York



Dr. Richard H. McCarthy

The last column discussed the process by which medications are discovered and brought to market. These methods of discovery and development directly and inevitably result in medications that are have both significant benefits and significant limitations. Put otherwise, what medications do well and what they do poorly are both the result of how we look for and find them. This process has resulted in the development of a large number of medications that differ in how well they work, how easy or complicated they are to use, and how many adverse effects they have. Today's column will address some of the factors that go into a doctor's decision about which medication to use to ameliorate a patient's problem. Sometimes there are dozens of medications from which the doctor could choose. Why is one prescribed and not another? While it may seem obvious, such decisions will require an examination of many factors: those related to the patient, the medication, the symptoms and illnesses being treated, the doctor and finally factors related to the system of care where treatment is provided. The first two of these will be discussed today and the remaining in future columns.

1. Factors related to the patient:

In every interaction between a doctor and a patient several things will be occurring simultaneously. The patient will be trying to explain his needs and the doctor will be trying to understand them. Concurrently, the doctor will be evaluating the patient's reliability, truthfulness and commitment to treatment as the patient is evaluating the doctor's competency, suitability and concern. This is hardly an exhaustive list, but the single most important factor in determining the choice of medication is the patient's description of his difficulties. The way patients think about problems will often determine how they present information to their physicians. Often, a new patient will arrive with a clear sense of what is wrong and an even clearer sense of what the appropriate medication treatment ought to be. Sometimes the patient is right about both the diagnosis and treatment, but not always. For example, a patient could describe himself as depressed but on further examination reveal that he is depressed because he is hearing voices all the time. Prescribing an antidepressant to this patient might gratify his initial desires for a specific medication but would be inappropriate and potentially harmful. Simply accepting the patient's diagnosis and medication request is a mistake.

There is no way to avoid a detailed psychiatric history and mental status exam, even though patients sometimes experience them as intrusive, annoying and irrelevant. The mental status exam is a formal method of evaluation that all psychiatrists employ. It is the psychiatric equivalent of a physical exam and is useful in confirming the presence or absence of a symptom complex. As important as the mental status exam is, it is not as important as the patient's history. The history, including a family history, will gather a good deal of information about the illness. To simplify things for our purposes, however, information about an illness' s onset and development over time, as well as factors that make symptoms worse or help symptoms improve, would be the most important. A history of the patient's past experience with medication is crucial. It is very important to know what medications did and did not help and why. It is not enough to know just what medication was taken, I is also essential to know what dose was taken and for how long each medication was used. Almost all psychiatric medications need to be taken at a certain dose level for a certain period of time, sometimes for weeks, before we can determine whether they have worked or not. Medication trials of only a day or two, or trials using only a low dose of a medication might at best give us some information about possible susceptibility to adverse effects. However, such trials tell us nothing about whether the medication did, or even could, help. Sometimes the history suggests that medication did not help when, in fact, the patient wasn't really taking the medication at all. Just because a doctor prescribed a medication does not mean that a patient actually took it. Obviously this is useful to know and usually the only person who knows this is the patient.

A similar problem exists when patients covertly use street drugs or alcohol and fail to mention this. Medications can't work if people don't take them or if people are doing things that make symptoms worse faster than they can be treated. As a result, any assessment of medication for a given patient will often depend upon the physician's assessment of the patient's truthfulness and reliability. If a physician does not believe that a patient is reliable, then he is likely to opt for safer and, potentially, less effective medications. Similarly, if a physician believes that a patient will not consistently take medication then doctors typically choose medications that are less subject to patient manipulation. As a result many psychotic patients receive injections, which they often do not like and are less effective than other oral medication alternatives.

As patients are deemed to be more reliable, the options that a physician can entertain increase. In a good therapeutic relationship doctors will elicit a good deal of information about the patient's preferences. Such a discussion will focus on which adverse effects a patient most wishes to avoid and which adverse effects are the least bothersome. Adverse effects and their impact on medication use can easily be overlooked by physicians but are of major importance to patients who must live with them. Moreover, many of our medications for treating a given illness or symptom do not differ at all in their ability to treat symptoms but only in their adverse effect profile, and sometimes very significantly. If the patient really wants to avoid sedation then it is sometimes possible to choose the medication where sedation is not an adverse effect. Similarly, if the patient has significant insomnia, a sedating medication taken at night might be a very good choice.

It is not really necessary for the doctor and patient to agree on why the patient is taking medication. It is necessary for them to agree to be clear and honest with each other. Some patients take antipsychotic medications because they feel better, sleep better or are more relaxed when they do, not because they experience a difference in hallucinations or delusions. Here, the doctor is prescribing a medication for one reason and the patient is taking it for another.

There are differences in the way medications are handled by the body. We know that age, sex, race/ethnicity, can all influence how the body will metabolize some drugs. Medications sometimes need to be adjusted in relation to each of these factors. This is a relatively new idea for psychiatry which for a long time has operated under a "one size fits all" approach to medications. As anyone who has bought "one size fits all" clothing knows, one size usually fits nobody well and everybody poorly. Nevertheless, the biggest influence on medication metabolism and blood levels is not any of this, but is something that is under the patient and not the doctor's control. That is, the use of concurrent medication, both prescribed and over-the-counter, smoking, alcohol and drug use. These factors, more than any other, will have an enormous influence on medication response, how much medication is needed, and how well the medication used will work.

2. Factors related to the condition:

It is undeniable that some medications are better for some illnesses than others. There is an enormous body of scientific literature that supports the use of some medications in one condition and warns against the use of the very same agents in another condition. This makes sense if we believe that medications are useful in treating biological and chemical dysfunction in the brain. This, of course, is the operating hypothesis of psychopharmacology. So, an important step in arriving at a choice in medications will be the decision about which illness a person has. We would prefer to treat depression with an antidepressant, and psychosis with an antipsychotic. This sounds almost ridiculously simple and, if it were this straightforward, then you wouldn't need to be very bright to be a psychiatrist. Without commenting about how bright psychiatrists actually are, things just are not as straightforward as they might appear. Actually, our medications do not treat illnesses, per se; rather they treat the symptoms of illnesses. It is true that *Depression*, the illness, is characterized by an overabundance of depressed feelings, i.e., depression, the symptom. However, *Depression*, the illness, is not the only place where depression, the symptom, is found. Psychiatric symptoms are not illness specific, although there was a time when we thought that they were. So, psychosis can be found in depression, mania, substance abuse and not just in schizophrenia. Anxiety is found in almost every psychiatric disorder, and depression is a frequent correlate of substance abuse, psychosis and anxiety disorders.

Just to make things even more complicated; these medications treat more than the illnesses or symptoms that they are named after. So, if we were to assume that antidepressants only treat depression, or antimanics only treated mania, or that mood stabilizers only stabilize the mood, or that antianxiety agents only treated anxiety, we would be mistaken. Just as symptoms are not illness specific neither are medications. Sometimes medications that are typically used in one illness are very useful in another. For example, antipsychotics can also be helpful in treating people who have some kinds of anxiety or in people with some kinds of thinking problems. Likewise, antipsychotics could be a terrible choice for the treatment of some other kinds of anxiety or thinking problems. In a similar manner a low dose of some antipsychotic medications can sometimes lead to an improved response to antidepressant medication; while in other cases antipsychotic medications can make some depression symptoms worse. Lithium, typically considered to be an antimanic agent or mood stabilizer, can sometimes be used to improve the function of either antipsychotic or antidepressant medication. Finally, there are many patients with schizophrenia who experience terrible feelings of depression. To withhold medications that might treat the symptoms of depression because the patient does not have the illness of depression is a mistake. In other cases, patients with schizophrenia may be harmed by antidepressant medications. We need a more thoughtful view of illness and treatment.

Medication by the numbers is not good treatment. It is simply a robotic approach, largely removed from the patient. The choice regarding which medications to use or not use will have more to do with the doctor and the patient's sense of what has helped, how much it has helped, and what more needs to be done. The diagnosis is a good place to start when making treatment choices, but it is not everything. The goal of medication treatment is not to simply apply the "right" drug to the "right" patient for the "right" diagnosis, as if we were trying to get the right answer on some test. Rather, the purpose is to help a particular patient optimize his functioning with a minimum of adverse effects, using whatever medications are found to be helpful to safely reach this end.

The MHA Connection

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By Joseph A. Glazer
President & CEO, MHANYS

Joseph A. Glazer

Parity: If Not Now...When?

Once again, the New York State Legislature concluded another session, more than five in a row now, without passing laws to eliminate discrimination in health insurance (known as Parity), or laws that would allow people to hold their health insurer accountable when they harm someone through the denial of necessary services.

Nowhere can this shortcoming be better seen than in the the suicide rates of children and adolescents. One out of every 150,000 children under the age of 14 commits suicide each year. About 99 others unsuccessfully attempt it. New York has approximately 3.5 million children under the age of 14. Statistically speaking, our state can expect 23 children under the age of 14 to take their own lives this year, and about 2300 others to try.

On Sunday, June 16, 2002, the Binghamton Press & Sun Bulletin Newspaper ran a front-page story about Kaylyn Mitchell, a beautiful eight year-old girl who has professed a desire to kill herself several times. Her family has spent the days and weeks since Memorial Day in May fighting with their health insurance carrier, trying to get Kaylyn the treatment she needed. Waging an uphill battle, they were driven onward by the stories they had heard of an 8 year-old Syracuse boy who took his own life in early May.

During emergency hospitalization at Binghamton General Hospital and Four Winds Syracuse over Memorial Day weekend, Kaylyn was diagnosed with bipolar disorder. She was discharged after a week of hospitalization, with no concrete treatment plan and a growing litany of refusals to provide on-going coverage and specialists from the health insurer. Only after intervention by the newspaper has the insurance company agreed to pay for a child psychiatrist and additional visits to a psychologist.

Families of other children across New York State face a similar dilemma every day -- some relinquish custody of their children, placing them in foster care so they can get full coverage for their health care needs. Others mortgage their homes to pay, out-of-pocket, for the care their children need. And some put up a losing battle against childhood suicide.

Earlier this year, a boy in Brooklyn and another in Syracuse took their own lives. Many others have attempted it.

Often at the center of this systemic collapse is the family's health insurance company. Sometimes, the child's needs exceed the policy limits, a battle that we fight under the lexicon of mental health parity. At other times, the insurance company refuses to pay for needed services, knowing that a court cannot force them to pay for the injuries caused by that denial of services. The undertaking to change this comes in the form of HMO liability.

Simply put, Parity will fix the health insurance policy and HMO liability will allow policyholders to force their HMO to meet their needs.

Each year, the New York State Assembly passes both comprehensive parity and HMO accountability legislation. Unfortunately, those bills get no further, as the measures fail to obtain passage in the state Senate. Even now, our state fails to follow our nation's leader, as both Parity and HMO accountability became law in Texas while George W. Bush was Governor.

Nothing is more heart wrenching in any community than the death of a young child. For the 23 young children who will likely take their own lives in our state this year, we can anticipate deep sorrow and community-wide grief and sympathy. As our elected officials turn out to offer their condolences to the families, will they tell them they have the power to turn these lives around, but rather choose not to act?

This year is an election year for every state legislator, as well as the governor. As the elections approach, candidates will be trying to get your support. You might want to tell them they can earn your support by passing parity and HMO accountability legislaiton.

Parity is not a question of why not, but when—there is too much at stake.

Mental Health News Joins & Supports The Effort To Eliminate Discrimination in Health Insurance

The NYSPA Report

By Dr. Barry Perlman, President of the New York State Psychiatric Association

Barry Perlman, M.D.

I begin this first column on behalf of the New York State Psychiatric Association NYSPA) by expressing admiration for and gratitude to Ira Minot, founder and publisher of Mental Health News. His recovery serves as an inspiration to many of us, psychiatrists, psychologists, social workers, and many others who have chosen careers of working with and offering treatment for persons with mental illness.

NYSPA is the statewide professional medical organization representing the practice of psychiatry in New York. NYSPA, representing over 4,300 psychiatrists in this state, advocates on behalf of persons with mental illness and our profession. NYSPA's diverse membership encompasses psychiatrist-physicians who work in the public sector, private practice, research, forensics, and administrative roles. Our members work with children, adults and seniors.

Our society serves as the New York State affiliate of the 30,000 member American Psychiatric Association (APA), an organization which traces its roots back more than 150 years into America's history. The insignia of the APA bears the image of Benjamin Rush, M.D., a member of the Continental Congress in 1776 and a signer of the Declaration of Independence. Dr. Rush was the authors of "The Diseases of the Mind" and was recognized for his keen clinical observations, his therapeutic common sense, and his concern and devotion for the poor.

I mention Dr. Rush because in some ways his broad array of concerns serves as an example of the wide array of issues which command the attention of the APA. With the goal of assuring scientifically based practice, the APA remains a leader nationally through the publication of its diagnosis based treatment practice guidelines for the treatment of mental illnesses and its diagnostic manual, The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV). DSM IV is the "gold standard" for psychiatric diagnosis and provides the basis for the scientific treatment of mental disorders. Only by improving diagnostic specificity will psychiatrists be able to better target their treatment of psychiatric disorders. The process of defining and treating are both dynamic and are continuously being scrutinized and updated based on evolving psychiatric research. With the advent of improved treatments and therapeutics, the goal of improved access to care has become ever more important, and the APA has lead the national coalition of organizations concerned with federal issues related to mental illness. In recent years, a major focus of that effort has been directed at passing national parity legislation in order to assure equitable and fair treatment for persons with mental illness within the context of global healthcare concerns.

NYSPA, through its local district branches, strives to assure that the profession of psychiatry is ethically practiced in New York State. The ethical practice of psychiatry is based on the APA's specially annotated code of medical ethics concerned with the practice of psychiatry. Our local district branches receive complaints from patients, the public, and other professionals and work to evaluate and resolve them. When necessary, our disciplinary procedures include expulsion for the most serious offenses and reporting to the state and federal authorities to assure that practitioners cannot simply relocate and avoid the consequences of their misconduct.

NYSPA has continued to advocate for appropriate access to important, scientifically based treatment such as electroconvulsive treatment (ECT). ECT, recognized as a potent and important treatment for a number of serious mental disorders, has been under attack by those ideologically opposed to its therapeutic use. NYSPA members believe that just as patients should have access to the most sophisticated psychotropic medications, they should also have access to well regarded alternative treatments. NYSPA is also participating on a NYS Health Department task force on use of generic drugs in the Medicaid program to assure that Medicaid patients are not compelled to receive generic medications when the clinical data indicates that the generic drug is not medically equivalent.

NYSPA has presented testimony at hearings on many subjects of concern at the state and local level. Most recently, NYSPA presented testimony regarding the scandal in the treatment of persons with serious mental illness in the adult homes in New York City and urged increased resources and services for persons with serious mental illness living in adult homes. Since the recent growth in the managed care industry, NYSPA was among the first voices raising questions about inappropriate intrusions into the doctor-patient relationship, and we participated in the development of the first legislation in New York to regulate the managed care industry. Each year, NYSPA comments on the New York State budget and has consistently championed expanded funding for community based services for persons with mental illness.

What do we stand for? NYSPA is committed to advocating on behalf of persons with mental illness and our profession, assuring that psychiatry is being practiced in a scientific and ethical manner, and striving for access to psychiatric care on a fair and equitable basis.

Readers wishing to contact NYSPA may write to: New York State Psychiatric Association, 100 Quentin Roosevelt Blvd., Garden City, NY, 11530.

NAMI Corner

Providing support to families and friends of individuals with mental illness and working to improve the quality of life for individuals with mental illness. Helpline: 1 800-950-3228 (NY Only) - www.naminys.org - Families Helping Families

By J. David Seay, J.D.
Executive Director
NAMI-NYS

J. David Seay, J.D.

From the NAMI-NYS corner, perhaps the biggest thing on our minds right now is our coming 2002 Educational Conference and 20th Anniversary Celebration, ***Twenty Years of Families Helping Families.*** The events will be held October 25-27 in White Plains, New York at the Crowne Plaza Hotel, and promise to be a first-rate conference and a very special event—a milestone—in the life of NAMI-NYS.

During the conference we will be joined by John and Alicia Nash, whose courageous lives were portrayed in the award-winning motion picture *"A Beautiful Mind."* They will be on hand Saturday evening to accept special awards at our dinner celebration. The keynote address will be given by Dr. Frederick Goodwin from George Washington University and Medical Center, and perhaps best known to millions as host of National Public Radio's popular weekly program "The Infinite Mind." His topic will be "Research Advances and the Erosion of Stigma: 20 Years of Progress in Mental Health." Dr. John Strauss from Yale will speak at the Saturday lunch, where his topic will be, "A Broad Look at Improvement in Severe Mental Disorders," in which he will share his views on improvements in both treatment and recovery. Both the President, Jim McNulty, and Executive Director, Rick Birkel, of NAMI, will be there.

On Saturday a full dozen workshops will impart valuable practical advice on new strides in research, treatments and medications, as well as finding out how to get supported housing, understanding legal issues, navigating the state mental health system, learning more about family psychoeducation and child and adolescent mental health issues. The ever-popular Medical Roundtable and "Ask the Doctor" sessions will again be featured, as will the Friday program *Advances in Criminal Justice*. We will also conduct our annual meeting and elect new directors. All in all, this is going to be an event you will *not* want to miss.

Register early to secure your place. The registration fee for the full three days is $140 for members and $185 for non-members. Partial rates are also available for Friday only ($45 members, $60 non-members, and includes the luncheon), Saturday only ($85 members, $120 non-members, and includes both lunch and dinner) and Saturday and Sunday only ($105 members, $140 non-members, and includes Saturday lunch and dinner and Sunday breakfast). The Crowne Plaza is holding a block of rooms at the special NAMI-NYS rate of $117 per room per night (single or double occupancy), but reservations must be made by October 7th to obtain this rate.

The full program and all of the details are included in the conference brochure. If you have not already received a conference brochure, you may order one by calling the NAMI-NYS office at (800) 950-FACT (toll free in New York) or (518) 462-2000.

NAMI-NYS is extremely fortunate to have, and is most indebted to, our Educational Conference Planning Committee, who have put this exciting conference and celebration together. Chaired by George and Emma Shaw, the Committee includes Sherry Grenz, Co-Chair, and members Ione Christian, Judy Beyer, Betts Custer, Ruth Levell, Anand Pandya, MD, Muriel Shepherd and Charlotte Silverberg. NAMI-NYS President Michael Silverberg serves on the Committee *ex officio* and has, like all of the Committee members, been active over the past several months in planning ***Twenty Years of Families Helping Families***.

The summer months at NAMI-NYS gave us time to take stock of the past legislative season and count our wins and losses. Through the tireless leadership of our Board of Directors and Government Affairs Committee, NAMI-NYS advanced a broad and bold legislative agenda this year and fought hard to persuade our elected officials to adopt measures to improve the lives of all those affected by serious mental illness, our loved ones and our family members. Among the big wins this year was the "Medicaid Buy-In," which allows disabled persons to go back to work and not lose their Medicaid coverage as a result. Although this important change will not go into effect until April 1, 2003, it represents a significant improvement in public policy for persons disabled by serious mental illness but who have recovered to the point that they can begin to work again.

Another big win this past season was cost of living adjustments (COLAS) and Medicaid fee hikes for community mental health workers employed by local not-for-profit organizations. Although their salaries are still far too low, the increases, which will become effective in December, will help ease their burden somewhat and hopefully begin to address the crisis-level personnel turn-over rates among these valuable individuals. The mental health workforce is a fragile and inestimably important public asset that must be preserved and defended; many of our loved ones' lives literally depend on it.

Also this year, through a carefully orchestrated effort by many groups individually and working in coalitions, the Community Mental Health Re-Investment Act was re-enacted for another four years. This law, which had expired last September 30th, captures the savings from the down-sizing of the state's psychiatric system and keeps those funds within the overall mental health system by making a significant portion of them available at the county level. The new version of the law allows for more flexibility on how the funds can be directed at the local level while at the same time continuing this important re-capturing mechanism. However, NAMI-NYS has made loud and clear our growing concern over the dwindling number of state psychiatric center beds available for persons who continue to need them. In supporting the re-investment re-enactment, NAMI-NYS re-designed its call for a moratorium on bed closures into a demand for a thorough and serious mental health planning process with "teeth." I am happy to report that the new law calls for a strengthened planning and reporting process by the Office of Mental Health. Also, Assemblyman Martin Luster, Chair of the Assembly's Mental Health Committee, was successful in getting Assembly passage of his bill (A. 11616) to create an independent Inter-Office Coordinating Council within the New York State Department of Mental Hygiene to oversee development and implementation of a long-term plan for mental health and other disabilities addressed by that department. NAMI-NYS will carefully monitor both planning requirements to see if they will address our expressed concerns for a safety net system of psychiatric beds and other resources.

NAMI-NYS supported our friends and colleagues in the social work profession in supporting a bill that would at long last license social workers in New York. While most of the public may be unaware that social workers in New York have never been licensed, indeed New York has remained one of the few states which have not sought to license this important profession in an effort to protect the public's safety. I am pleased to report that with our support, and the active role of the National Association of Social Workers' New York Chapter, this legislation passed both houses of New York's legislature this year. And finally, on the more or less positive side of things, light has been shed once again on the adult homes scandal, with new legislation, investigations and more reforms called for by NAMI-NYS and many others. We suspect that this story is far from over.

And as I said, we lost some battles, too. We need to continue to do everything humanly possible to get more funding for and more housing for persons with serious and persistent mental illness. Some prior housing cuts were restored in this year's budget process, but much more needs to be done to provide more supported housing and community residences in the months and years ahead. We also lost the mental health parity battle again this year, but boy, did we come "oh-so-close" this time. A well-oiled Fair Insurance Today coalition, with NAMI-NYS actively involved, launched what was described by one legislative staff member as one of the best planned and implemented lobbying efforts in Albany she had seen in years. Close, but no cigar, as they say; yet we will regroup for next year's victory.

NAMI-NYS stalwarts will again gird for battle in the legislature's next session where our battle cry will be loud and clear: help persons with serious and persistent mental illnesses with housing, mental health parity legislation – at both the state and national levels, job training and supported employment, more Assertive Community Treatment (ACT) teams, adult home reform, serious and nonpartisan planning for mental health care resources, more funding for mental health research and more humane treatment of persons with mental illness in our prisons and jails. NAMI-NYS will not rest until the housing, care and treatment of persons with serious and persistent mental illness is at least on a par with the housing, care and treatment of persons with mental retardation and developmental disabilities. Why, we implore Governor Pataki and the New York State Legislature, is that too much to ask?

The Art of Healing / A Column By The National Artists for Mental Health

Franklin Marquit, CEO and Founder, NAMH, Inc.
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Franklin Marquit

How To Coordinate an Art Show

Why an Art Show?

An art show is an inviting way to introduce the public to the talents and abilities of the mental health community while inspiring public awareness. We have discovered that to keep public interest high, you need to coordinate events that are subtle in their objective to educate. People don't like to be lectured on social issues and will more often than not lose interest in a presentation that talks down to them about what they should and shouldn't believe about mental illness. An art show gives them an opportunity to make discoveries on their own, and with a well-timed speaker session that utilizes consumers a questions and answer period, attendees will be in a much more comfortable position to absorb the presentation. It is also important to remember that art is a celebration of the spirit and the presentation should be positive.

Getting Started

Whether you plan to hold a formal exhibition or a small showcase, an art show is a major undertaking and should not be attempted by one person alone. The first thing you need to do is begin enlisting help for your project. It is important that all participants be involved at the onset, and that tasks be assigned so that work does not overlap. You should have group meetings weekly to assess progress.

The following are specific tasks to be addressed for your project. Please keep in mind that these tasks are representative of a formal NAMH art exhibition, which requires our most extensive task list. Your list may be smaller or larger depending on the size of your art show.

Recruiting Your Team

If you can't find potential team members directly through affiliations you have with mental health groups or organizations, you can do it indirectly by having people you know refer other people to you. This might entail creating a flyer or other type of notice announcing that you are looking for people interested in your project. Be sure to clearly outline the project and what is expected of the people who sign on. Don't forget to include your name and a number where you can be reached.

Your Team and Your Event

Your first meeting is one of the most important you'll have with your group. This is where you discuss your goals and objectives, especially what type of event you want to present, who your target audience will be, where the artwork will come from, where the show will be held, the costs, and who will foot the bill. Keep in mind your two important resources: Human Services and the Arts. Look into both areas, even if they are independent of each other to seek out the resources you need to accomplish your goal.

This is also the time to formulate your game plan. It is not necessary to have a full working task schedule outlined at this stage, but you should have a draft of the plan, outlining important tasks that can be further developed as you go along.

Where the Show will be Held

When determining prospective sites for your event, you should consider the following: location, accessibility, room layout and cost. Cost of an exhibition site can range from 'free of charge' to "I'm sorry…how much did you say?" depending on what you are looking for. If you dig deep enough though, there are sure to be several sites available for little or no charge within the mental health system or community arts programs in your area. However, you still need to take into consideration the layout, location and accessibility to the public. Potential resources: your local arts council, community recreational program, city, county or state museums, high schools or colleges, local, county or state mental health organizations. Remember that if someone can't help you, they may know someone who can. Always ask.

Getting Artwork for the Show

You may already have access to an inventory of artwork; but if you are truly starting from scratch, you'll need to do some investigating. One possible avenue is to call hospitals or psychiatric centers that have art programs and ask if any artwork is stored away or forgotten or, more tragically, is thrown out. Most of these facilities are simply not equipped to handle an art inventory. You may be able to save some of these creative efforts.

Another way is to hold expressive arts workshops. It's a good idea to have someone lead the group, if only as a source of inspiration. A brief introduction of the healing powers of expressive arts presented by a consumer artist is usually enough to get the group motivated. These sessions are easy and fun to run; all you need are supplies and a location.

You can also create a flyer advertising a call for artwork which you can post or leave in piles at local mental health service organizations, your library, local bookstores, art supply stores, etc. Remember to get permission from the manager of the business where you plan to post or distribute your flyer.

Who Will Foot the Bill?

This is, by design, your most important question. Even if you are successful in getting a free location and supplies donated, etc., you'll probably have to deal with costs somewhere. (e.g. paper for flyers, copy costs). Again, your budget will depend on the size of your art show. You should have a general idea of what you want to accomplish; then see if you can secure a budget to make it happen. If you find that you can't get the amount of funding you need, set your sights a bit lower and allow your event to meet your budget requirements.

Receiving, Logging Procedures

You will need to decide which method(s) to use for receiving artwork (e.g. by mail, a drop-off location, etc., a final date for submission and your criteria for acceptance of artwork. (e.g. medium used, framed, matted, etc.) Each piece of artwork must be logged with the artist's name, address, phone number and include title and medium used. You can use a binder for this purpose. Make sure this information is also secured on the back of the piece. Artwork should be stored in a clean, dry place (away from water pipes, etc.) You will also need to consider how artwork is to be returned to artist; whether it will be picked up or mailed back. If it is to be mailed back, there will be a shipping fee to consider and the artist needs to be made aware of this.

Artist Contract/Release

You will need permission from the artists to exhibit their work. This is a signed statement and can include the criteria for the exhibition, last date for submission and how artwork is to be returned (as well as who is responsible for shipping costs). These contracts can be kept in your log book. It is also important to state whether or not you can be held responsible if a piece of art work is damaged or stolen (this does happen). If this art show is to be judged, this information should also be included, (prizes, honorable mentions, etc.) and cite who will be judging the event.

It is important to develop a theme for your art show and a log, if possible, which will be included on your flyer and promotional material. Take advantage of any and all avenues of free publicity for your event, i.e., local newspapers will usually accept a small article and also many have a free weekly listing. You can also list your event in mental health and art organization newsletters. Check out your local cable television network, as they often advertise community events free of charge. Invitations to key people or organizations in your target area are also a good idea.

Getting the Art Show Together

You will need to decide if you want to hold a reception, formal (with speakers) or informal and the time frame. If you decide to use speakers, they need to be contacted either by phone or letter. When you speak to a prospective speaker on the phone, you should always follow up the conversation with a letter. The letter should include all information about the event and the approximate time allotted for her/his presentation. A reception can include coffee, tea, soft drinks and cookies or more elaborate, depending on your budget and space. Invite the local newspaper or television station to cover the event, as well as the editor(s) of mental health and art organizations newsletters. Arrange for transportation for all staff and volunteers, as well as judges, and coordinate tasks (e.g. seating speakers and guests, handling refreshments, informational and/or sales tables). The master of ceremonies will open and close the program and don't forget to thank volunteers, staff, speakers, sponsors and artists. Remember that your judges will need to view your exhibition before it begins, so provide ample time.

Hanging the Art Show

Generally, artwork is best displayed at eye level, but this depends on the amount of work and your wall space. You can use easels and pedestals (for sculptures or pottery). If you have never hung artwork, you may want to ask a gallery owner or employee for assistance. You can do this by just visiting galleries in your area and asking questions and/or taking notes. The main objective is to hang pieces together that compliment rather than clash, so that you get a natural flow and the viewer is drawn in to get a closer look. Make allowances for the flow of traffic and do not obstruct it with easels, pedestals, etc. As a rule, artwork should remain on the wall until the end of the show, even if it is sold. These pieces should be marked "sold." Each piece of artwork on exhibition should have a number corresponding with an informational sheet for your guests which include the artist's name (if you have permission to use the name otherwise anonymous), title of piece and medium used. This informational sheet can be expanded into a more formal art show program, if your budget allows, with information about the exhibition, speakers, sponsors, etc.

The Art Show

During the course of the show, you should arrange for staff or volunteers to remain on the location to ensure that the exhibition remains safe and protected. This is also important for sales. If you have space in a formal gallery, they will have employees to do this; but it is always recommended to have someone on hand who will be able to answer questions about the artwork and your mission.

So, you've successfully created your own art show and congratulations! However, we're not finished. You'll need to send formal "thank you" letters to your volunteers, judges, speakers and sponsors. It's also a good idea to write an article for your local newspaper and the newsletters where you listed your event and let them know of your success. We'd like to hear about it, as well. We know what a hard job it is to hold this kind of an event, but we also know how important it is. We look forward to hearing from you.

In Our Own Words: "First Person Singular"

Dear Readers:

Very often, Mental Health News receives personal journals from consumers who describe their struggles and triumphs in coping with mental illness. I feel it is incumbent to the mission of the newspaper to share these stories with our readers.

It is hoped that these personal diaries will provide a window of opportunity to learn from the heartfelt experience of a person's feelings about their illness. Friends, family, clinicians, providers and fellow consumers, may find these diaries compelling, inspirational and useful in better understanding the experience of loved ones and by knowing that others are going through similar struggles. Our personal relationships are often clouded by judgmental and stigmatizing evaluations of a loved one who is entangled in an emotional quagmire. Let's not forget that mental illness is nobody's fault and is not a sign of weakness in people.

Rather then condemn, let us support and encourage the heroic efforts of the person who is often doing their best to cope with a difficult situation.

Ira H. Minot, Founder & Publisher
Mental Health News

Growing Up With Depression And Not Knowing It

By Jane E. McCarty

I can remember as far back as fourth grade feeling different than the rest of the kids in my class. I was very serious, and I felt like an adult at the age of nine. I remember having mornings where it was tough to get out of bed…too many days. But I didn't know any better. This was life…to me. I didn't know anything else. Little did I know about this illness called "depression." And because I overcompensated, I appeared to be fine.

When I got to sixth, seventh, and eighth grades, I continued to have the same struggles. But no one knew. Luckily, I found something to hold on to. I was on the C.Y.O. basketball team. I excelled in the sport as I did in most sports. It was the one thing that helped me to get out of bed many mornings. If I had a game, I could get motivated to get out of bed (even though it was still difficult), because I knew I had a game. I was the star of the team, so this would boost me out of my depression…momentarily. I would get attention from the boys from my class. It was my dose of "medication" for the day. I appeared to be just fine. I was the star of the team!

But there were days I would just feel lousy, and I would be teary-eyed. My teacher, a nun, asked me if I was o.k., asked me if there were family problems at home. What did I know about family problems in seventh grade? It was "normal" to me…it was all I knew.

Although I was a solid B+ student, I found it difficult to concentrate and focus. I often day-dreamed. I thought about basketball and the game after school and the boy I liked who I hoped would show up. I found it difficult to concentrate and retain anything I read but managed to get passing grades. But it was such a struggle. But no one else knew. I hid it well. My older sister and brother always took home "A's" on their report cards. I felt dumb with my "B's." In retrospect, I wonder if I had not suffered from depression (or had the proper treatment), would I have been able to be an "A" student as well. I struggled just to get my "B's." My friends always thought I was smart. Little did I know that I would carry not only the depression with me, the inability to concentrate and read and retain, but also the inferior feeling I had about my intelligence the rest of my life. But I hid it well. Everyone else thought I was smart.

I continued on into high school with the "all-American girl façade." I was Captain of the Majorettes and excelled on the first female basketball team. I ran with the boy's track team and grabbed every opportunity to work out with them when I could. I continued to be that "B" student. I always had a tough time reading, concentrating, and retaining…which affected all my studies. Thank God I had excellent eye-hand coordination which gave me A's in all my typing classes. I was also creative and was able to draw attractive maps for my history/geography classes and posters for the football team and band.

I had lots of friends. I had a boyfriend or two. I led the band. But I was suffering from depression. And no one knew. Not even me. I hid it well. But I knew something was wrong. It was so tough for me to get through the day. But I overcompensated and everything appeared to be fine. My best friends knew I struggled…but they didn't know why. We didn't know what this thing called "depression" was. I am grateful for mental education now.

In sophomore year, I tried to hurt myself…not kill myself, just hurt myself. I think I felt so much emotional pain that if I matched it with physical pain, it would cancel each other out and all go away. Physical pain was and is always easier to handle. I didn't succeed in hurting myself nor did I get the help I needed for various reasons because most of the time I looked fine. So, it was all brushed under the rug soon thereafter.

I continued to struggle with my grades. What made it more difficult was that my older brother and sister were honor students. The teachers I had (who had previously had my brother and sister) expected the same performance from me. And I couldn't meet the challenge. The added pressure compounded the problem. I felt dumber because of my mere "B" grades. None of the teachers ever noticed my depression; who knew about depression back then? In retrospect, I often wonder how I would have done academically had I been treated properly back then.

Of course, while I excelled in extra-curricular activities, my "B's" were not enough to entertain the thought of college. Nor did my parents have the money. But my 120 wpm typing won me a scholarship to a top secretarial school. But I didn't really want to do that; but no other choices were available.

I was lucky I had a wonderful group of supportive friends. None of us used alcohol or drugs. Somehow we knew that drugs and alcohol would only have complicated our lives. I sometimes wonder why I wasn't the "drug addict" in the family, drowning the pain I felt for so many years. I have a huge threshhold for pain. I guess that's good…..or not.

At age 19, after graduating from Katharine Gibbs with honors and working in Manhattan, I went to my first therapist. First I was diagnosed with dysthymia, and my medical doctor determined I had low blood sugar. My therapist got me to go to college full-time at a local community college. My first semester, while on antidepressants, I got all "A's." It felt good. I later on earned my B.A.

In a future issue, I will continue with my story about future struggles and victories…and when in my early 40's, I am finally diagnosed bipolar II. But at this time, I share this story with all parents, educators, and friends who might suspect or not suspect their child, student, or friend might be suffering from depression. Watch them closely; get them the help they need. Because many of us who struggle with depression, hide it well. We appear to look just fine. As the old slogan says, "If I only knew then what I know now."

In The Mental Health News Spotlight

Beautiful Mind & Leadership Excellence Awarded At Coalition 30th Anniversary Reception

The Coalition for Voluntary Mental Health Agencies presented the 18th Annual Mental Health Awards at a ceremony and reception in New York City on June 18,2002. Honorees were Barbara Cook, renowned concert and cabaret star, Sylvia Nasar, author of the book, "A Beautiful Mind," Dr. John Forbes Nash Jr., mathematician and Nobel Prize winner, Joyce M. Pilsner, executive director, Riverdale Mental Health Association, and Mike Wallace, CBS-TV reporter and host of "60 Minutes." Presenters were Dr. Alan Siskind, President of The Coalition, and Executive Vice President of the Jewish Board of Family and Children's Services, Mike Wallace, broadcast journalist, Thelma Dye Executive Director, Northside Center for Child Development (Harlem) and Philip Saperia, Executive Director of The Coalition.

"The Coalition presents the Mental Health Awards to individuals and organizations for their commitment to improving the lives of people living with mental illness and for dedicated service to the mental health community," said Phillip Saperia, executive director of The Coalition. "This years' honorees," he continued, "have each made critical and courageous contributions toward lifting the stigma from mental illness and shedding light on the possibility and realities of recovery."

More than 350 guests attended the lively gala event held at Con Edison corporate headquarters in lower Manhattan. Among the celebrants were leaders and advocates in the mental health field, celebrities, and public officials including authors Jay Neugeboren ("I Remember Robert") and William Styron; N Y State Assembly member James Brennan, Brooklyn Supreme Court Judge Matthew D'Emic, NYC Council members Gerson, Quinn and Brewer; NYS Office of Mental Health Commissioner Thomas Freiden; and Dinyar S. Devitre, Senior Vice President and CFO Phillip Morris.

The Coalition, marking its thirtieth anniversary this year, and more than 100 member organizations serve New Yorkers living with mental illness. Since September 11, New Yorkers including children and adults, have experienced an increase in psychiatric disorders including depression and post-traumatic stress disorder. Coalition agencies and their staff members meet these challenges daily.

Barbara Cook receives her award from Mike Wallace

Dr. John Nash accepts award from Alan Siskind and Phil Saperia

Joyce Pilsner accepts award from Alan Siskind and Phil Saperia

Alan Siskind, Gayle DeRienzi, and Phil Saperia present award to Mike Wallace

Thelma Dye, Alan Siskind and Phil Saperia present award to Sylvia Nasar

In The Mental Health News Spotlight

Residential Care - Recovery - Rehabilitation Honored At HDSW Annual "June & Jazz" Event

On June 6, Human Development Services of Westchester (HDSW) held its annual "June & Jazz" event and honored members of the Social Action Committee of Congregation Emanu-El, headed by Carol Chase of Scarsdale, for their many years of generous support to HDSW and to HOPE House.

HDSW is a not-for-profit organization and the largest provider of residential care for those recovering from psychiatric illnesses within Westchester County. HOPE House, a psychosocial clubhouse for adults recovering from mental illnesses, provides a range of rehabilitative services, including supported education and employment. HDSW also provides case management services and the Neighborhood Preservation Company for the Village of Port Chester since 1979.

While it poured rain outside, inside the Pavilion at the Larchmont Yacht Club, this year's cocktail and hor d'ouvres reception offered musical entertainment by the Fun Jazz Quintet and a raffle with prizes ranging from Caramoor tickets to subscriptions to the Jacob Burns Film Center. Proceeds of the raffle benefited HOPE House. The honorary chairpersons included last year's honoree for her lifetime dedication to community service, Lilian Sicular, and Steven Sicular, of Mamaroneck and New York City. Sponsors included Assemblywoman Amy Paulin, State Senators Suzi Oppenheimer and Nicholas Spano, and Steven J. Friedman, Commissioner of the Westchester County Department of Community Mental Health. Verizon, ICS/Watercross, BridgeCom International, Rye Hospital Center, and Evergreen Computer Solutions, were corporate sponsors. The event also celebrated the first anniversary of HDSW's Special Gift Campaign, co-chaired by Herb Heller of Scarsdale and Isobel Perry of Rye. For more information about Human Development Services of Westchester, please call Nicole Carroll, Director of Development, at (914) 835-8906.

HDSW Executive Director, Andrea Kocsis welcomes State Senator Suzi Oppenheimer

Isobel Perry of Rye welcomes County Legislator George Latimer

HDSW Deputy Director Kathy Pandekakes, Board Member Josh Koerner, Andrea Kocsis

MHA Event Honors Deborah Phillips For Her Innovative Work Linking Kids With Mentors Through "One-One Program"

The Mental Health Association of Westchester County (MHA) held its annual benefit in April at the Beach Point Club in Mamaroneck.

The event honored Debra Phillips for her innovative work in creating and implementing the One-One Mentoring Program. Mrs. Phillips' husband, Stone Phillips of Dateline NBC, was the evening's Master of Ceremonies.

Proceeds from the event fund enhance MHA's broad range of many programs and services in Westchester.

Stone and Deborah Phillips with Jane Pauley and husband Gary Trudeau

In The Mental Health News Spotlight

Mental Health Association in New Jersey Evening of Excellence - Honors 9/11 Leadership

Staff Writer
Mental Health News

The Mental Health Association in New Jersey held their 3rd Annual Evening of Excellence Recognition dinner on June 12, 2002.

More than 250 guests attended the event honoring members of the mental health community for their contributions in response to the September 11th disaster.

Carolyn Beauchamp, Executive Director presented the MHA Golden Bell Leadership Award to Ken Steward of Avaya, Inc., Maureen Underwood, Ray Handbury, Charles Brown, Meline Karakashian, Sgt. Dwane Rezzetti, LaurieWorm and Sandy O'Connor.

Kevin Stewart, Maureen Underwood, Ray Handbury, Carolyn Beauchamp, Charles Brown, Meline Karakashian, Sgt. Dwane Razzetti, Laurie Worm, Sandy O'Conor

Putnam Family & Community Services Celebrates 5th Anniversary at 'Magic Within' Gala

Staff Writer
Mental Health News

On Thursday, June 6th, Putnam Family and Community Services celebrated its 5th Anniversary at the charming Le Chambord located in Hopewell Junction. More than 180 guests shared in the "Celebrate the Magic Within" Gala Event. Mrs. Myrna M. Benton and, Father Bernard Palka, SA, each received PFCS's Award of Excellence for their extraordinary dedication and commitment to improving the quality of life for all of Putnam County Residents. Proclamations from Governor Pataki and Congresswoman Sue Kelly were also offered to each recipient. The Honorable John Sweeny and Honorable Alana Sweeney as well as Mr. Michael Piazza, Commissioner of Putnam County Social Services, Mental Health and Youth Bureau presented the honorees with their special awards.

PFCS was also celebrating its privatization as a non-profit mental health and chemical dependency treatment facility which began in July, 1997. The evening events included dancing, fine dining, a live and silent auction as well as having a magician that awed the crowd throughout the evening with his close-up and personal style of magic. The Gala was sponsored by Hudson United Bank, Supervised Lifestyles, Bergman and Santoro Families, Centauri Systems, Key Bank, Michaels & Associates, and South Putnam Animal Hospital. The benefit raised over $32,000 and all proceeds will be used directly for program services.

For further information about Putnam Family and Community Services and any of its programs, please call 845-225-2700.

PFCS Executive Director, Edyth Schwartz recognizes honorees for their community service

Mental Health News - Dedicated to Giving Our Mental Health Community the Recognition it Deserves

In The Mental Health News Spotlight

Silver Hill Hospital Bestows Media Award To Founder and Publisher of Mental Health News

Staff Writer
Mental Health News

On a warm sunny weeknight in June, volunteers and supporters of Silver Hill Hospital in New Canaan, Connecticut gathered to show their support for the hospital's excellence in mental health care.

The event, hosted by Steve and Nancy Stillerman of Greenwich, culminated with the presentation of Silver Hill's 2002 Media Award to *Mental Health News* founder and publisher, Ira H. Minot.

Richard J. Frances, M.D., Silver Hill Hospital Medical Director, presented the award to Mr. Minot and stated: "Ira Minot, has single-handedly brought a wonderful new and much needed resource to our community with *Mental Health News*."

In accepting the award, Mr. Minot cited his battle with mental illness as the catalyst for needing to start the newspaper.

Championing the cause to provide free and readily available mental health education directly to the community, *Mental Health News* offers a simple yet effective solution to reaching consumers and families with vital information and hope in dealing with the difficulties of mental illness.

In accepting the media award, Minot recounted his battle with depression as an experience that changed his life forever. "One of the most unfortunate things I learned during my illness was that people can become hopelessly isolated and alone unless they know where to find and access the vital support services that exist in their community." He further stated that: "sometimes a difficult time in a persons life can give them the reason and the resolve to making the path a little easier for those who have to make the same difficult journey."

Steve and Nancy Stillerman, Ira Minot, Dr. Richard Frances

***Beers Story* from page 13**

with mental disabilities of all kinds and used the findings of these surveys to advocate state by state for increased funding so as to humanize the institutions. (It was later that the National Committee began to recognize the wisdom of reduced use of institutions.)

At the core of the National Committee's work was a constant cycle of research and reform. In this regard, as Albert Deutsch points out in *The Mentally Ill in America*, Beers and the National Committee were of a piece with the Progressive Era, the period during which they began their work. It was also typically "progressive" in its use of Meyer's concept of "mental hygiene". This concept arose from his awareness that people's psychological states and their ability to manage and overcome mental illness, were highly dependent on their social environment. Meyer was perhaps the first to realize that people with mental illnesses with social supports fared better than people without them. This emphasis on the importance of the environment to people's ability to fare well in our society was typical of the Progressive Era.

Eventually, however, Beers and the National Committee developed a new insight—that all sorts of troubling human behavior, not just the behavior associated with "insanity"—might reflect issues of mental health and illness. This insight was the source of the development of the child guidance movement in America, which emerged under the leadership of the National Committee with support from the Commonwealth Fund. The initial goal of this movement was to help juvenile delinquents and reduce delinquency not with harsh punishment and so-called "reform", but with good childrearing and treatment. Later the movement spread to the fields of education, family service, and child development.

The child guidance movement has left a remarkable legacy. The model it developed for child guidance clinics became the model for outpatient mental health clinics for all populations throughout the United States. This model is the source of the concept of a mental health treatment team consisting of psychiatrists, psychologists, and social workers—a concept which is now embedded in the delivery of mental health services in this country. Even more fundamentally, the child guidance movement fostered widespread efforts to use psychological knowledge to help children develop into decent adults, efforts which have been prevalent ever since. Perhaps even more fundamental has been the linkage that has developed in the American mind between troublesome behavior and emotional disturbance.

Clifford Beers was not the originator of all of the ideas that emerged from the National Committee on Mental Hygiene. But he was, by his very person, their inspiration; and he had the wisdom to allow other people's ideas to guide the movement that he created—a remarkable ability in its own right.

Beers' ideas, and the ideas of those who worked with him, have been among the most influential of the 20th century. They are embedded in the shape and substance of America's mental health system. They continue to inspire advocacy for greater humanity towards people with mental illnesses and to reach those who still do not get services they need. The persistent power of his ideas is also evident in the fact that many of them remain controversial sixty years after his death. Debates continue about the viability of prevention, about how far-reaching the field of mental health should be, and even about the kinds of alliances that are needed to advance the cause of mental health.

Clifford Beers was a great builder of alliances as well as a visionary, a leader, a man of powerful moral determination, and a relentless fundraiser. We certainly could use another like him today.

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Michael B. Friedman is Public Policy Consultant for the Mental Health Associations of New York City and of Westchester County. He also teaches courses on health policy and on social advocacy at The Columbia University School of Social Work.

Schizophrenia And Substance Abuse

By Richard J. Frances, M.D.
Medical Director, Silver Hill Hospital

The importance of integrating and coordinating services for mental health and substance abuse patients is becoming increasingly recognized. Nowhere is such integration more important than in the treatment of substance-abusing patients with schizophrenia. Treating patients with dual diagnosis is a challenge. The clinician must be able to make the correct diagnosis, be familiar with substance-specific interactions, and understand the issues related to treatment of patients with comorbid schizophrenia and substance abuse.

Substance-abusing patients with schizophrenia pose the greatest challenge to providers of public care. These patients often cannot hold a job, lack family support, and have legal problems. An additional challenge is that clinicians must treat both the mental disorder and the medical complications of substance abuse.

Persuading substance-abusing schizophrenic patients to comply with treatment is difficult, particularly because substance abusers often have problems with authority figures. This problem is compounded when paranoia and psychosis are part of the clinical picture. Ironically, patients with addictions may resist taking medication prescribed by a physician, although they continue to take the abused substance to relieve their symptoms. Patients with schizophrenia also are harder to involve in 12-step programs such as Alcoholics Anonymous (AA). These programs often are not adequately supportive of patients with psychoses and emphasize confrontation, which may be problematic for patients and family members.

Addictive disorders and schizophrenia must be treated in synchrony, which requires a skilled staff and integration of available treatment resources. Patients with a dual diagnosis are more likely to require inpatient treatment and longer hospital stays than those with either disorder alone.

Because cures for schizophrenia and substance abuse are unlikely, worthwhile treatment goals are extended periods of sobriety, better medication compliance, and longer periods of remission. To achieve these goals, general mental health practitioners skilled in the diagnosis and treatment of addictive disorders and addiction counselors with psychiatric skills are needed. The complexity of treating intoxication, withdrawal symptoms, and the chronic effects of addiction in relation to chronic mental disorders emphasizes the need for addiction psychiatrist to supervise teams, head programs, and treat difficult patients.

Patients with dual diagnoses can benefit from treatment programs that provide continuity of care. Coordination and integration of self-help programs, such as the National Alliance for the Mentally Ill (NAMI), Alanon, AA and other 12-step programs is also necessary. Therapists who treat schizophrenic, substance-abusing patients must provide more support, be less confrontational, and help reduce feelings of guilt and blame throughout the family.

Psychoeducation and cognitive behavioral approaches are helpful in treating schizophrenic, chemically dependent patients. Educational programs should emphasize the importance of abstaining from substance abuse and taking prescribed medications. Clearly, addiction programs have been more successful at helping patients withdraw from illegal substances and general psychiatric services have been better at persuading patients to take antipsychotic medications. A dual diagnosis program must combine both efforts.

It is essential that the clinician establish a trusting relationship with the patient. This relationship is best begun by helping the patient solve practical problems related to housing, work and welfare. Family members should be involved in the patient's treatment, but may also need support themselves.

When applied to chronic mentally ill, substance-abusing patients, the case management model has been useful in helping mobilize treatment and community resources; however, this approach also increases treatment costs. Helping patients participate in AA, Alanon and NAMI support groups and finding groups appropriate for these dual-diagnosis patients may be difficult. Sometimes patients may need to start with individual therapy before they are ready to participate in groups.

Schizophrenic patients who abuse substances need long-term rehabilitation and often participate in group therapy with other patients with chronic mental illnesses. Increasingly, the focus has shifted from inpatient treatment to partial hospital programs that are highly structured and involve group participation, recreational activities, and occupational therapy. Patients may also benefit from early outpatient intervention, use of the least restrictive alternative, and use of partial hospitalization when possible. Therapists must develop flexible programs that combine addiction and psychiatric treatment. Wherever possible, case management should be provided for patients with chronic disorders.

Schizophrenia and substance abuse present special challenges in diagnosis, substance-specific interactions, psychosocial intervention, and psychopharmacotherapy. Errors can easily be made by overemphasizing the treatment of either disorder rather than providing a synchronous approach that leads to abstinence from substance abuse and remission of psychotic symptoms.

Richard J. Frances, M.D. is the President and Medical Director of Silver Hill Hospital, New Canaan, CT. Silver Hill Hospital is a nationally recognized, non-profit psychiatric and substance abuse treatment facility, providing inpatient, outpatient, partial hospital programs and transitional living.

***Trauma* from page 19**

the disaster and to obtain new resources. This includes an NIMH grant in partnership with Mount Sinai's Child Psychiatry Division and a SAMHSA National Child Traumatic Stress Initiative grant.

All three Saul Z. Cohen Chairs will be presenting at an October 7th conference hosted by the Center for Trauma Program Innovation. The day long conference "Building Safe Communities: Coping with Uncertainty and Violence" will feature leading scholars and clinicians in presentations and workshops designed to help identify ways to enhance safety and build community during these uncertain times.

Since the tragic events of 9/11, the CTPI continues WTC - related work in conjunction with JBFCS programs, particularly its Youth Counseling League Division's on-site program, Jewish Connections and the Child Development Center. This has included: expanded school-based services for ground zero schools; outreach to schools served by the Board of Jewish Education and a Bi-national program for schools in Jerusalem in collaboration with the Israeli Center for Psycho-Trauma and a program for an oft-overlooked population following disasters: infants, toddlers and pre-school children. Because so many deaths occurred in families that had very young children, the CTPI's Loss and Bereavement Program for Children and Adolescents has expanded its traumatic bereavement services. Support for the CTPI's rapid growth comes from private individuals, government and foundation grants and UJA-Federation grants.

As the CTPI continues to respond to September 11th, it will simultaneously give priority to addressing the reality of everyday trauma in the lives of all Jewish Board clients. It will apply the knowledge gained from both efforts to promote healing and recovery for everyone.

***PTSD* continued from page 17**

idea – and so you are trying to persuade the patient that facing the trauma rather than turning away from it would be helpful.

Medications can be an important part of stabilization and initial treatment if someone is really symptomatic. Sometimes a person will need a medicine before he or she can engage in psychotherapy and occasionally you will see a patient who will completely recover with just the medication alone. I think it's rare but recent studies have shown it can happen Probably between 10%-40% of the time over a 6-month period.

The best proven treatments at this point are the SRI's. There are several large multi-center trials that have shown these medications work directly for the PTSD symptoms of re-experiencing, avoidance and hyper arousal. This is a very different model than what was believed even 10 years ago when medications were really just seen as an adjunct to the primary treatment of psychotherapy. Now we know that the medicines, in combination with supportive therapy, can directly reduce these symptoms.

Q: So the SRI's that you refer to would be more commonly known by what name?

A: There are large multi-center trials with sertraline, paroxetine, and flluoxetine now, and sertraline and paroxetine have an FDA indication for PTSD. The paroxetine trial, which was published a few months ago, was the first to show equal effectiveness in both men and women. Before this, there was some controversy as to whether the SRIs were as effective in men as they were in women.

Clinicians should also know that there are medications other than the SRI's that can work for PTSD. If the SRI doesn't work or if the patient does not want the SRI because of the sexual side effects, it is worth trying a couple of other kinds of medications.

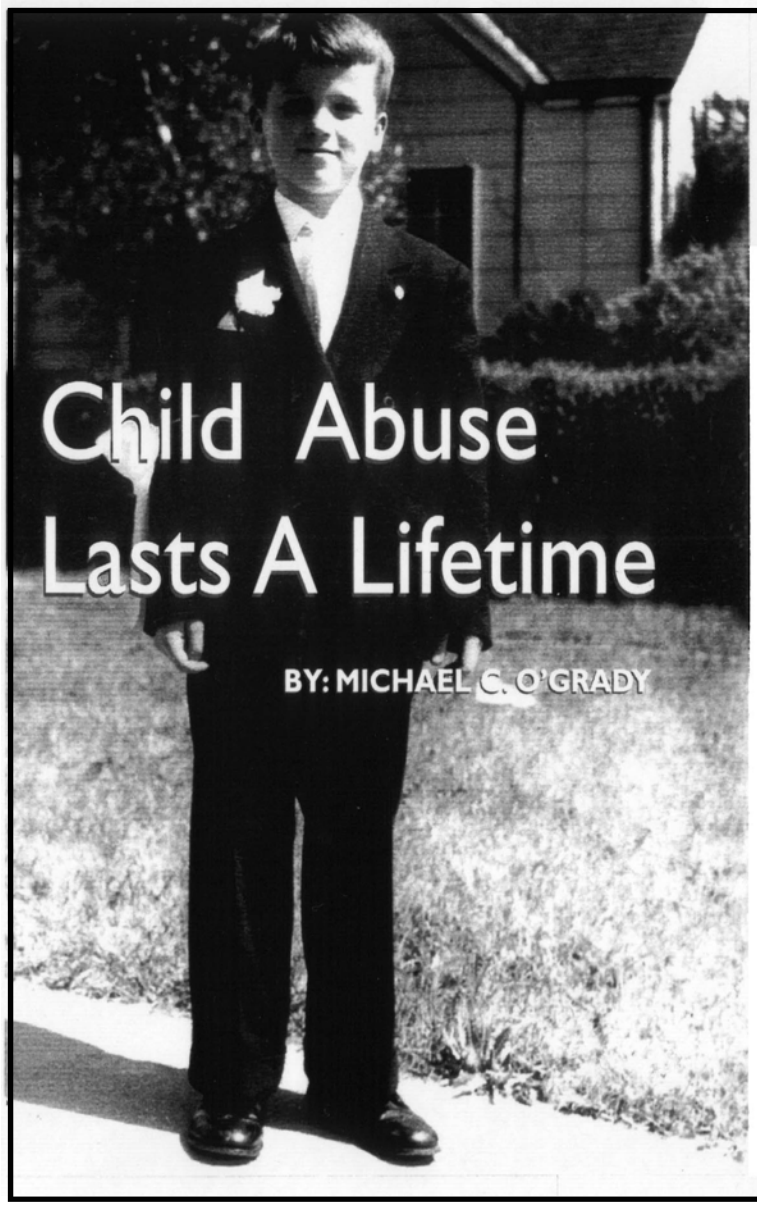
One medication you should probably *not* use without careful consideration is a benzodiaephine because of the risk of addiction, although sometimes patients do need it and it can be very helpful if used responsibly.

Q: Is there anything special that you would like to say to readers of Mental Health News concerning your work at the Psychiatric Institute and Columbia University here in New York, or about any research studies where you are seeking candidates to participate.

A: Yes. Thank you. This is very important…we have medication, psychotherapy and biological studies going at our center—and we treat people at no cost if they are participating in the research. We also have a treatment program for persons needing help related to 9/11, even if they do not wish to participate in research. Some of the studies also pay individuals for their time, and we are always looking for new participants. Our main number is 212-543-5367.

Mental Health News Internet Tip:
For more information about the New York State Psychiatric Institute, log onto their website at www.nyspi.cpmc.columbia

see ad's below regarding research studies & treatment



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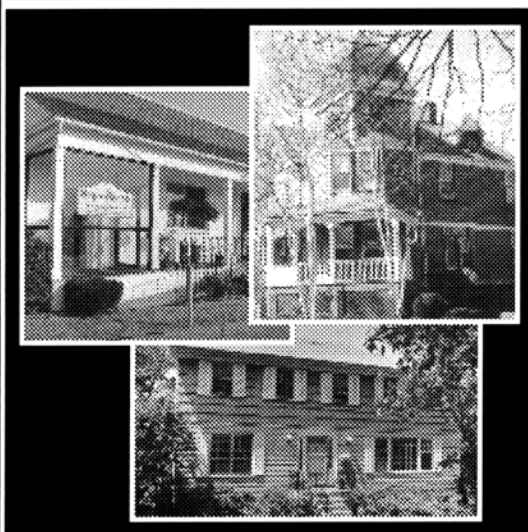

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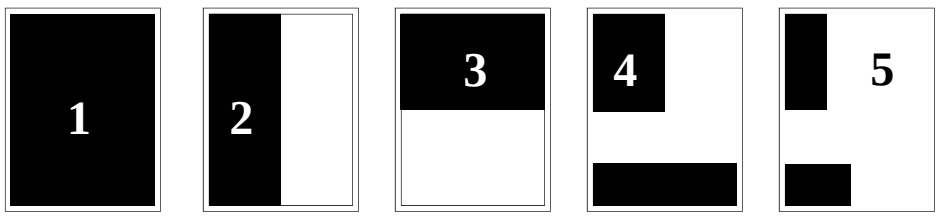

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