MENTAL HEALTH NEWS™

YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES
SUMMER 2002 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 4 NO. 3

Anxiety and Depression

35 Million Affected in United States Annually

Part I in a Special Mental Health News Two-Part Investigation

Mental Health News Salutes

Freedom From Fear

a national advocacy, education, research and community support organization that provides a beacon of hope to people whose lives are affected by anxiety and depression

Freedom From Fear was founded in 1984 by Mary Guardino as an outgrowth of her personal experience of suffering with anxiety and depressive illnesses. From FFF's humble beginnings as a small support group, the organization has grown into a nationally recognized advocacy voice for those who suffer from mental illnesses.

Anxiety and Depressive disorders are the most common of all mental illnesses affecting more than 35 million Americans each year. However, when diagnosed, they can usually be quickly and effectively treated. It's easy to allow fear to take over our lives. It's especially true in these difficult times.

Both anxiety and depressive illnesses are severe, chronic and extremely impairing to the individuals who are affected by them. Furthermore, they can have a devastating effect on the family members of those suffering from anxiety and depression.

Thanks to our friends at Freedom From Fear, and other contributors in this issue, we will take a closer look at anxiety and depression from many perspectives.

Please see our *new* table of contents on page 3 for a full listing of articles from FFF and our other outstanding contributors.

Mary Guardino

Mental Health News
the proud recipient
of Awards in 2001 by
Eli Lilly & NYS-OMH

Also in this issue of
MENTAL HEALTH NEWS

MENTAL HEALTH NEWS
65 Waller Avenue
White Plains, NY 10605

PRESORTED
STANDARD
U.S. POSTAGE PAID
WHITE PLAINS, NY
PERMIT NO. 153

SLS Health

Try it.

It might help them.

Rebuilding a life destroyed by addiction can be an a difficult process, yet there is hope.

ERP is that hope. A new therapy, based on established theory, can help your client take control of their life.

ERP Therapy changes your clients behavior by teaching them how to take control of their cravings! Its that simple!

An ERP Kit has all the tools you need for effective ERP treatment.

Buy an ERP Therapy Kit today, so you can provide your client with a better tomorrow.

For your ERP Therapy Kit and training call **1-888-8-CARE-4U** or visit our website at **www.killthecraving.com**. Training dates available in May, June, September, and October of this year.

exposure erp response prevention

ERP®
Now You Can
Give Them More.

Visit our website:
www.killthecraving.com

a product of SLS Health

Residential Treatment
for People with Serious Behavioral Health Disorders

The SLS Brand of Residential Treatment is Effective for

- Psychotic Disorders
- Personality Disorders
- Dual Focused Addiction Disorders
- Anxiety Disorders
- Mood Disorders
- Diagnostically Complex Cases

SLS HEALTH

We have good mind to help you℠

1-888-8-CARE-4U
www.slshealth.com

Dept 279 • 2503 Carmel Avenue
Brewster, NY 10509

SIGMUND

Behavioral Health Software You Prescribe

Sigmund is behavioral health software that does treatment and business the way you do. How? Through Dynamic Configuration®.

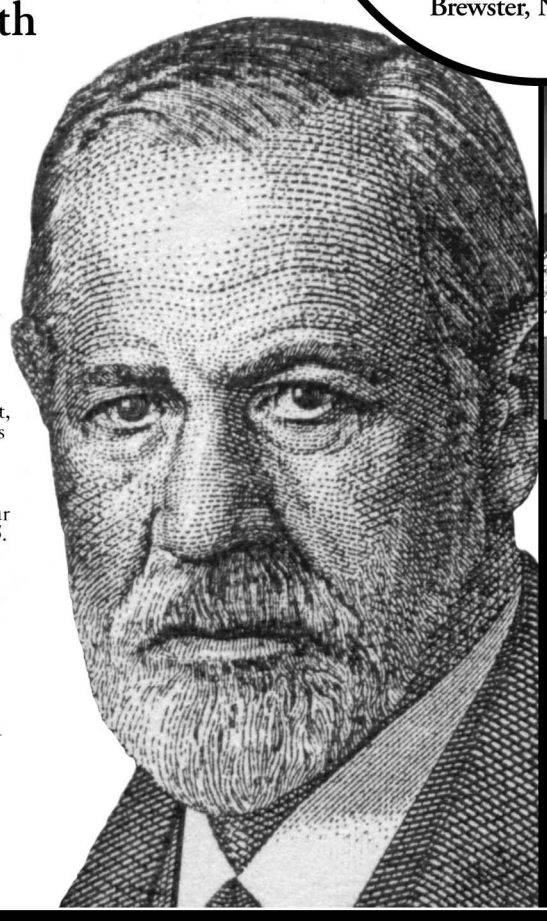
Dynamic-Configuration® creates a Sigmund that has the look, feel, and performance features* you prescribe. Your Sigmund reflects your clients, your services, your professional terminology, your billing practices, and your treatment modalities. And you pay for only the features you want, so that single, and multi-user systems can fit well within your budget.

To learn more and to dynamically-configure your Sigmund call one of our software counselors at **1-800-448-6975**.

sigmund SIGMUND SOFTWARE

Sigmund®
Behavioral Health Software You Prescribe.®

**Choose options from a wide variety of feature clusters: Accounting & Billing, Clinical Treatment Record, Clinical Progress & Outcomes Measurement, Referral Management, Staffing, Outpatient & Inpatient Scheduling and much more.*



Don't Wait

SLS Wellness

- Psychotherapy
- Addictions Counseling
- ADHD Therapy
- Mood Disorders

Call us: 1-845-279-4617

1-888-8-CARE-4U **www.slshealth.com**

Table of Contents

MENTAL HEALTH NEWS™

Ira H. Minot, C.S.W., Founder & Publisher

for advertisement and subscription information see page 32
or call between the hours of 9 am & 5 pm
send all inquiries to:

Mental Health News
65 Waller Avenue
White Plains, NY 10605
(914) 948-6699
(914) 948-6677 fax
mhnmail@aol.com

Subscription & Advertising Information Can Be Found On Page 32

Bring Mental Health Education To Your Community
Become A Sponsoring Community - See Page 33

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 Editor's Desk

The Poor Stepchild A Legacy To Discard!

By Ira Minot, Founder & Publisher, Mental Health News

May was mental health month. Did anybody outside the mental health community notice? I'm not so sure about it.

How could anybody have noticed while we were and continue to be in the grip of heart-wrenching headlines every single day. The War in the Middle-East, the crisis within the Catholic Church, the ongoing War on terrorism in the aftermath of the September 11th attack on America, home-land security, the drought in the northeast, the Enron scandal, to name just a few.

It is fitting with the annually quiet passing of Mental Health Month that we remind everyone that *we* have our own headlines. *Our* headlines involve mental illness, and are not only in the month of May but occur each and every day, and millions of people are affected. Here are just a few of our headlines:

Mental Disorders in America

"An estimated 22.1 percent of Americans ages 18 and older—about 1 in 5 adults—suffer from a diagnosable mental disorder in a given year. When applied to the 1998 U.S. Census estimate, this figure translates to 44.3 million people."

"4 of the 10 leading causes of disability in the U.S. and other developed countries are mental disorders: major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. Many people suffer from more than one mental disorder at a given time."

Depressive Disorders

"Approximately 18.8 million American adults, or about 9.5 percent of the U.S. population age 18 and older in a given year, have a depressive disorder."

"Nearly twice as many women (12.0 percent) as men (6.6 percent) are affected by a depressive disorder each year. These figures translate to 12.4 million women and 6.4 million men in the U.S."

Suicide

"In 1997, 30,535 people died from suicide in the U.S."

"More than 90 percent of people who kill themselves have a diagnosable and treatable mental disorder, commonly a depressive disorder or a substance abuse disorder."

"The suicide rate in young people increased dramatically over the last few decades."

"In 1997, suicide was the third leading cause of death among 15 to 24 year olds."

"Four times as many men than women commit suicide; however, women attempt suicide 2-3 times as often as men."

Schizophrenia

"Approximately 2.2 million American adults, 2 or about 1.1 percent of the population age 18 and older in a given year, have schizophrenia."

Anxiety Disorders

"Approximately 19.1 million American adults ages 18 to 54, or about 13.3 percent of people in this age group in a given year, have an anxiety disorder."

"Women are more likely than men to have an anxiety disorder. Approximately twice as many women as men suffer from panic disorder, post-traumatic stress disorder, generalized anxiety disorder, agoraphobia, and specific phobia, though about equal numbers of women and men have obsessive-compulsive disorder and social phobia."

Eating Disorders

"The mortality rate among people with anorexia has been estimated at 0.56 percent per year, or approximately 5.6 percent per decade, which is about 12 times higher than the annual death rate due to all causes of death among females ages 15-24 in the general population."

Attention Deficit Hyperactivity Disorder (ADHD)

"ADHD, one of the most common mental disorders in children and adolescents, affects an estimated 4.1 percent of youths ages 9 to 17 in a 6-month period."

Autism

"An estimated 500,000 people in the US are living with some form or autism." (NAAR)

Alzheimer's Disease

"Alzheimer's disease, the most common cause of dementia among people age 65 and older, affects an estimated 4 million Americans."

"As more Americans live longer, the number affected by Alzheimer's disease will continue to grow unless a cure or effective prevention is discovered."

"The duration of illness, from onset of symptoms to death, averages 8 to 10 years."

Statistics from NIMH

Ira Minot

Noting the unfortunate reality that hardly anybody outside of the mental health community takes notice of mental health month, is akin to us preaching to the choir. *We* know what the problems of mental illness are -- those outside of our community do not.

The idea of setting a month aside during the year to pay attention to mental health issues is a great idea and must be strengthened in more ways year after year.

However, to build strong political support for funding mental health initiatives, we need to have the financial muscle to end the stereotype that we are the poor stepchild waiting for a handout. We must develop a coordinated system of local and national *political action committees* (PAC's) so we are heard in state and national halls of government.

Today we find local organizations struggling to retain staff and manage programs to serve a population of people with mental illness that is growing while the current funding stream continues to dwindle.

Matt Smith of the Middletown Times Herald-Record sums up the reality of our dilemma in New York State. In his April 15th editorial he states,: "New York's mental health system is in woefully poor condition. The work force is unstable. Money is scarce. And community programs statewide are being cut, even though the number of those in need keeps growing."

Smith continues,: "Mental health has always been treated by the Legislature as the poor stepchild of the health-care system. And that's because lawmakers gain little politically from helping the industry out. Unlike the state hospital system, which is tied to mighty labor unions that contribute heavily to campaigns, the mental-health lobby is made up of a bunch of shallow-pocketed organizations that serve a clientele with no political power. Simply put, there's a pay to play system in Albany. The politically influential 1199 Service Employees International Union, for example, spent more than anyone else on lobbying last year, shelling out more than $2.8 million. In return, the union received $750 million as part of a secret health-care deal ironed out earlier this year between Pataki and labor boss Dennis Rivera. The package, rushed through the Legislature in the middle of the night, paid for hospital-worker raises and also addressed staff shortages at nursing homes. Mental-health workers, however, were left out."

Referring to us in similar terms, Assemblyman Martin Luster, retiring chairman of the Committee on Mental Health, Mental Retardation and Developmental Disabilities, defends the legislature's attempts to prevent $60 million in cuts to the mental health system, stated in an April 23rd editorial to the Albany Times Union: "This attempt by the governor to balance a difficult budget on the backs of those who have little political voice, virtually no economic power and who have been the historic object of stigma and discrimination is outrageous."

I wonder if our mental health community understands the realities of politics in America. The message is clear: *We aren't players.* We lack the level of clout to be assured that our agenda is heard and adopted by decision makers in Washington, Albany and in state capitals throughout the nation.

We'll continue to be at the end of the line unless we organize our supporters through a network of PAC's and raise the money needed to elect candidates that understand our needs.

We must support the heroic efforts of groups like NYAPRS, MHA, NAMI, and The Coalition of Voluntary Mental Health Agencies (to name just a few) who work tirelessly to organize rallies, lobbying and letter writing campaigns. But we need the muscle that a Political Action Committee provides, to back these activities.

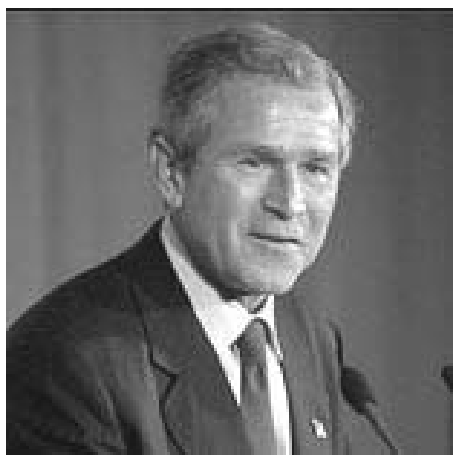
Thank you for your incredible interest and support, and please continue to E-mail's your ideas and comments to me at mhnmail@aol.com.

Best Wishes
Ira Minot, Publisher

MENTAL HEALTH NEWSDESK

Improving Access to Quality Mental Health Care

The White House
Office of the Press Secretary



Today's Presidential Action

In a speech at the University of New Mexico, President Bush today announced his plans to improve access to quality, effective mental health care. The President announced that he will work to pass federal mental health parity legislation to eliminate disparities in the coverage of mental health benefits.

The President also announced the formation of the President's New Freedom Commission on Mental Health to develop recommendations on improving the nation's mental health service delivery system.

Background on Today's Presidential Action

Each year, millions of Americans suffer from mental illness. Many adults and children are significantly disabled by severe and persistent mental illness. Untreated mental illness is a great national problem.

The stigma of mental illness often discourages patients from seeking care despite the existence of new drugs and therapies that have vastly improved the chances for effective treatment and recovery. Without access to necessary and effective quality care, far too many Americans will live with untreated mental illness that too often can lead to homelessness, drug and alcohol addiction or incarceration.

Parity in Mental Health Benefits

Despite the advances that have been made in the science of mental health treatment, many health plans unfairly treat coverage for mental health benefits by imposing copayments, deductibles or limits on outpatient visits that are more restrictive than those placed on physical illness.

The President has a history of supporting parity legislation. In 1997 as Governor of Texas, he signed legislation into law that required plans to provide fair treatment to patients with severe mental illnesses.

The President will work with Senator Domenici and other leaders in the House and Senate to reach an agreement on mental health parity legislation that can pass Congress and be signed into law. The legislation must prevent plans from applying less generous treatment or financial limitations on mental health benefits than are imposed on medical or surgical benefits.

The President's New Freedom Commission on Mental Health

Currently, numerous Federal, State and local government entities oversee mental health programs, policy, funding and the diverse network of public and private providers. More efficient organization and coordination could assist these providers in ensuring effective treatment is received by those in need.

To address this issue, President Bush is establishing the President's New Freedom Commission on Mental Health. The Commission will be composed of fifteen members, appointed by the President, and seven ex-officio members from executive branch agencies. The Commission will identify the needs of patients, the barriers to care, and investigate community-based care models that have success in coordinating and providing mental health services. The Commission will have one year to recommend immediate improvements that can be implemented by all aspects of the public and private mental health system to improve coordination and quality of services with existing resources.

Executive Order
President's New Freedom Commission on Mental Health

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve America's mental health service delivery system for individuals with serious mental illness and children with serious emotional disturbances, it is hereby ordered as follows:

Section 1. Establishment. There is hereby established the President's New Freedom Commission on Mental Health (Commission).

Sec. 2. Membership. (a) The Commission's membership shall be composed of: (i) Not more than fifteen members appointed by the President, including providers, payers, administrators, and consumers of mental health services and family members of consumers; and (ii) Not more than seven ex officio members, four of whom shall be designated by the Secretary of Health and Human Services, and the remaining three of whom shall be designated -- one each -- by the Secretaries of the Departments of Labor, Education, and Veterans Affairs. (b) The President shall designate a Chair from among the fifteen members of the Commission appointed by the President.

Sec. 3. Mission. The mission of the Commission shall be to conduct a comprehensive study of the United States mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system. The Commission's goal shall be to recommend improvements to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. In carrying out its mission, the Commission shall, at a minimum: (a) Review the current quality and effectiveness of public and private providers and Federal, State, and local government involvement in the delivery of services to individuals with serious mental illnesses and children with serious emotional disturbances, and identify unmet needs and barriers to services. (b) Identify innovative mental health treatments, services, and technologies that are demonstrably effective and can be widely replicated in different settings. (c) Formulate policy options that could be implemented by public and private providers, and Federal, State, and local governments to integrate the use of effective treatments and services, improve coordination among service providers, and improve community integration for adults with serious mental illnesses and children with serious emotional disturbances.

Sec. 4. Principles. In conducting its mission, the Commission shall adhere to the following principles: (a) The Commission shall focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation; (b) The Commission shall focus on community-level models of care that efficiently coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services; (c) The Commission shall focus on those policies that maximize the utility of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers; (d) The Commission shall consider how mental health research findings can be used most effectively to influence the delivery of services; and (e) The Commission shall follow the principles of Federalism, and ensure that its recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.

Sec. 5. Administration. (a) The Department of Health and Human Services, to the extent permitted by law, shall provide funding and administrative support for the Commission. (b) To the extent funds are available and as authorized by law for persons serving intermittently in Government service (5 U.S.C. 5701-5707), members of the Commission appointed from among private citizens of the United States may be allowed travel expenses while engaged in the work of the Commission, including per diem in lieu of subsistence. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States. (c) The Commission shall have a staff headed by an Executive Director, who shall be selected by the President. To the extent permitted by law, office space, analytical support, and additional staff support for the Commission shall be provided by executive branch departments and agencies. (d) Insofar as the Federal Advisory Committee Act, as amended, may apply to the Commission, any functions of the President under that Act, except for those in section 6 of that Act, shall be performed by the Department of Health and Human Services, in accordance with the guidelines that have been issued by the Administrator of General Services.

Sec. 6. Reports. The Commission shall submit reports to the President as follows: (a) Interim Report. Within 6 months from the date of this order, an interim report shall describe the extent of unmet needs and barriers to care within the mental health system and provide examples of community-based care models with success in coordination of services and providing desired outcomes. (b) Final Report. The final report will set forth the Commission's recommendations, in accordance with its mission as stated in section 3 of this order. The submission date shall be determined by the Chair in consultation with the President.

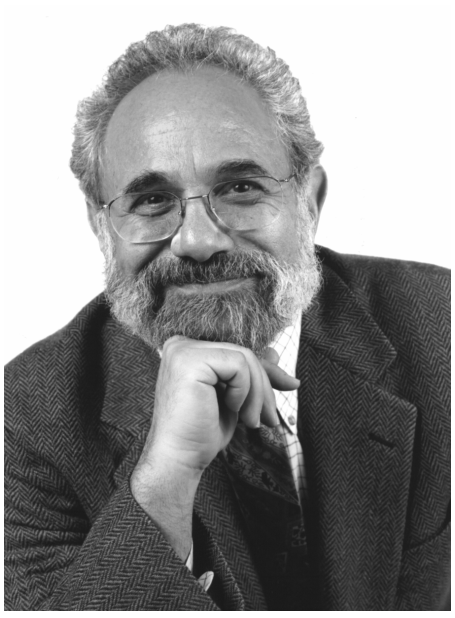
Sec. 7. Termination. The Commission shall terminate 1 year from the date of this order, unless extended by the President prior to that date.

GEORGE W. BUSH
THE WHITE HOUSE,
April 29, 2002.

Point of View

Adult Homes: A Crisis of Conscience

By Michael B. Friedman, CSW



Michael B. Friedman

The recent New York Times coverage of the dreadful conditions in some adult homes in New York State did not surprise me. For those of us who have been active in mental health over the past 30 years or so, it's an old story that makes new headlines every few years. But this time the revelations provoked a crisis of conscience in me. I realize that I have paid too little attention to adult homes as an advocate and that I did too little about them when I was Director of the Hudson River Region of the New York State Office of Mental Health at the end of the Cuomo administration.

During those years I took pride in moving people to the community from the state hospitals for which I was responsible. We considered adult homes part of the community, even though it was obvious then, as it had been obvious for many years, that the large adult homes are institutions, albeit institutions that are different from state psychiatric institutions.

Of course we took steps that were meant to be protective. Staff from my office visited the adult homes to which we sent residents. We stopped referrals to those which were poor and did not improve care quickly. We encouraged, and funded, working relationships between adult homes and local mental health providers to be sure that people with mental illnesses got the mental health care they needed.

Many people got quite decent care. But the fact remains that by our actions we supported a mental health policy that is fundamentally wrong. Many years ago John Talbott called it a policy of "transinstitutionalization" in contrast to the professed policy of deinstitutionalization. Community mental health is about integrating people with mental illnesses into the community. Transinstitutionalization is about meeting arbitrary goals in one institutional system by transferring people to another institutional system. In the beginning it was a policy of desperation, a policy adopted because there was no decent housing in the community for people with mental illnesses who needed some degree of supervision or support. Once New York State developed a policy of providing housing for people with mental illnesses in the community, the use of adult homes became a policy of convenience, making it possible to reduce the perception of the need for more community-based housing.

When I say that housing people with serious mental illnesses in adult homes is the wrong policy, I mean that putting people in large, congregate living facilities--even if they are well-supervised--violates the most fundamental insights and goals of the community mental health movement. The goal of community mental health is to help people lead decent lives as full-fledged members of the general community. Well-supervised adult homes do not, and cannot, fulfill that goal; and, therefore, reforming adult homes by making sure that they are safer and that they provide more services is not enough.

It's an obvious truth, so obvious that I wonder how I have missed it until the most recent set of revelations about scandalous conditions.

Coincidentally, I have just read Jonathan Glover's book Humanity: A Moral History of the Twentieth Century. In it he reviews many of the atrocities committed over the course of the past century and explores what made it psychologically possible for apparently decent people to participate in atrocities. Two of his observations are very important for understanding why good people agree to carry out bad--even shameful--social policy. First, he notes that fragmentation of decision-making results in no one being, or feeling, responsible for the overall policy. We each do our piece, making the best of a situation which is beyond our control. I took pride, for example, in the extent to which my Regional Office instituted some protections. I had done the best I could.

Glover also notes a process of what he calls "moral drift". The making of a decision to pursue the lesser of evils makes it easier to make other decisions between the lesser of greater evils until ultimately one has agreed to something truly awful. I don't think that the adult home situation rises to the level of evil of the atrocities that Glover is exploring, and the current state of adult homes does not reflect exactly the same kind of moral drift. In this case it's more a drift to moral complacency. Each revelation leads to a minor reform and a period of pride in minimal achievement. This contributes to our growing reconciliation with a policy which is fundamentally wrong.

Can understanding why we continue to face the same basic issues about adult homes that first surfaced 30 or so years ago help us make it better? I think it can. We need to be clear that what we need is not the kind of patching of a flawed system that is now being proposed in response to the Times expose. We need a fundamental change in policy. We should move towards responsible deinstitutionalization of adult homes. The goal should be for all people with serious mental illnesses who need supervised or supported housing in the community to get housing in small, homelike settings or in independent living settings with supports. These settings should have a rehabilitative structure designed to promote recovery, independence, and full integration into the community.

Obviously it will take years to achieve these goals. But some actions can be taken immediately which will move in the right direction.

First, the New York State Office of Mental Health (OMH) should take full responsibility for adult homes with a preponderance of people with mental illnesses. (Proposals of the kind that are now surfacing for state agencies to share responsibility are futile because of the power of entrenched bureaucracy.)

Second, OMH should establish a policy that rejects the use of adult homes for people with serious mental illnesses.

Third, OMH should develop a long term plan to create appropriate housing. Some small adult homes can become good community residences. Large adult homes cannot. Therefore, the long term plan will need to include new housing as well as conversions of existing adult homes.

Fourth, while moving towards the creation of appropriate housing for people who now are in adult homes, OMH should institute model programs emphasizing rehabilitation and recovery in the adult homes which remain open.

Fifth, OMH should be responsible for developing adequate systems of oversight and enforcement.

Each time terrible conditions in adult homes have been revealed in the past, we have tinkered with the system. I realize now that I had become inured to it and cynical about it. This time I hope we will all face the truth, that a major change in policy is the only reform that will make a long term difference.

Michael B. Friedman is the public policy consultant for the Mental Health Associations of New York City and of Westchester. The opinions expressed are his own and do not necessarily reflect the views of the Associations.

Mental Health News would like to extend its deep appreciation to the Mental Health Association of Westchester for sponsoring Mr. Friedman's column in each issue of the newspaper.

MENTAL HEALTH NEWS

Salute to Freedom From Fear

An Interview With Mary Guardino, Founder And Executive Director of Freedom From Fear

By Gina Danner, MA

Q. Where did the idea for creating Freedom From Fear (FFF) originate?

A. In 1982, I was finally able to understand the distressing and painful feelings and symptoms that had plagued me all of my life. Through the recommendation of a family member I found a "shrink" (never went to one before). My relative explained to me that she was also experiencing these horrible symptoms for more than 40 years, and this doctor had helped her greatly. Although skeptical, I was desperate so I seized the opportunity. Luckily, the physician was extremely knowledgeable and, more importantly, he was kind and understanding. He told me that I was suffering from depression and an anxiety disorder called agoraphobia. With medication and behavior therapy I would be able to feel better and regain my life. This was amazing since psychiatry was still in the "dark ages" with regard to these treatments. When the "doc" told me that within three months my symptoms would disappear, I didn't believe him. But I was desperate; I had hit bottom. I could barely function. It was scary, so I decided I would follow the protocol. I even quit my job so I could concentrate fully on getting well. As I became stronger and healthier, I sought information about anxiety and depressive illnesses, and I read and read and read. As my knowledge increased, I became more aware of the enormity of the illness and the confusion about what treatments were most effective. The science base for these illnesses was extremely limited in those days. In 1984, when I was well on my way to recovery, I started a support group in my community called Freedom From Fear. I chose this name because fear and avoidance had driven my life for so many years and treatment brought me freedom from fear.

Q. When you began this venture what were your goals?

A. In the beginning, my main goal was to provide a local venue for support, information, and treatment seeking opportunities for members of my community. I soon realized that these needs were overwhelming and treatment opportunities and resources were very limited. Early on in the formation of FFF, the main challenge was where to send people for treatment. I never realized that so many people in my community were suffering from anxiety and depression and the access to treatment was so poor. I did not foresee that my venture would be quite so difficult.

Q. How has Freedom From Fear evolved?

A. In 1986, in order to provide treatment opportunities in Staten Island, a collaboration was created between FFF and the New York State Psychiatric Institute and the Department of Psychiatry of Columbia University. This was the beginning of FFF's involvement in a multitude of research studies that have included clinical trials, biological studies, family studies, and health care research. Because of this important work FFF grew from a community based organization to a national group. With the support and generosity of many, FFF has developed educational programs for consumers, health care providers, and the public. The mission of Freedom From Fear greatly expanded and the organization continues to be actively involved in cutting edge research.

Q. What is the mission of FFF today?

A. FFF's basic mission is to provide support, information, and guidance to individuals and their families who are suffering from anxiety and depressive illnesses. We strongly emphasize the awareness of treatment opportunities and are deeply committed to helping people find appropriate treatment venues via their communities. Each year, FFF assists hundreds of thousands of people in this manner.

Q. What FFF accomplishment are you most proud of or feel has been most successful?

A. This is very simple - the contributions that the organization has made in improving the quality of life for the many people who suffer from mental illnesses.

Q. How do you anticipate the role of Freedom From Fear to change in the future?

A. Communication networks are improving and rapidly expanding. Freedom From Fear is committed to utilizing these venues to reach more and more people with the message that mental illnesses are real illnesses that can be successfully treated, and life can be more productive and fulfilling. There is hope for all who are living lives of darkness and desperation. I know because I've been there, and the miracle of treatment has changed my life.

Mental Health News Web Tip:
Visit Freedom From Fear's Website At
www.freedomfromfear.org
For Vital Information And Answers To Many Key Questions

The Treatment of Anxiety Disorders

By Freedom From Fear
www.freedomfromfear.org

Effective treatments for each anxiety disorder have been developed through research. In general, two types of treatment are available for an anxiety disorder: medication and specific types of psychotherapy (sometimes called "talk therapy"). Both approaches can be effective for most disorders. The choice of one or the other, or both, depends on the patient's and the doctor's preference, and also on the particular anxiety disorder.

Medications

Psychiatrists or other physicians can prescribe medications for anxiety disorders. These doctors often work closely with other mental health professionals who provide psychotherapy. Although medications won't cure an anxiety disorder, they can keep the symptoms under control and enable you to lead a normal, fulfilling life. The major classes of medications used for various anxiety disorders are described below.

Antidepressants

A number of medications that were originally approved for treatment of depression have been found to be effective for anxiety disorders. If your doctor prescribes an antidepressant, you will need to take it for several weeks before symptoms start to fade.

Some of the newest antidepressants are called selective serotonin reuptake inhibitors (SSRIs). These medications act in the brain on a chemical messenger called serotonin. They are started at a low dose and gradually increased until they reach a therapeutic level. SSRIs tend to have fewer side effects than older antidepressants. People do sometimes report feeling slightly nauseated or jittery when they first start taking SSRIs, but that usually disappears with time. Some people also experience sexual dysfunction when taking some of these medications. An adjustment in dosage or a switch to another SSRI will usually correct bothersome problems. It is important to discuss side effects with your doctor so that he or she will know when there is a need for a change in medication.

Similarly, antidepressant medications called tricyclics are started at low doses and gradually increased. Tricyclics have been around longer than SSRIs and have been more widely studied for treating anxiety disorders. For anxiety disorders other than OCD, they are as effective as the SSRIs, but many physicians and patients prefer the newer drugs because the tricyclics sometimes cause dizziness, drowsiness, dry mouth, and weight gain. When these problems persist or are bothersome, a change in dosage or a switch in medications may be needed.

Monoamine oxidase inhibitors (MAOIs) are the oldest class of antidepressant medications. People who take MAOIs must be on a restrictive diet because these medications can not interact with some foods and beverages, including cheese and red wine, which contain the chemical tyramine. MAOIs also interact with some other medications, including SSRIs. Interactions between MAOIs and other substances can cause dangerous elevations in blood pressure or other potentially life-threatening reactions.

Anti-Anxiety Medications

High-potency benzodiazepines relieve symptoms quickly and have few side effects, although drowsiness can be a problem. Because people can develop a tolerance to them and would have to continue increasing the dosage to get the same effect benzodiazepines are generally prescribed for short periods of time. One exception is for panic disorder, for which they may be used for six months to a year. People who have had problems with drug or alcohol abuse are not usually good candidates for these medications because they may become dependent on them. Some people experience withdrawal symptoms when they stop taking benzodiazepines, although reducing the dosage gradually can diminish these symptoms. In certain instances, the symptoms of anxiety can rebound after these medications are stopped.

Buspirone, a member of a class of drugs called azipirones, is a newer anti-anxiety medication that is used to treat GAD. Possible side effects include dizziness, headaches, and nausea. Unlike the benzodiazepines, buspirone must be taken consistently for at least two weeks to achieve an anti-anxiety effect.

Other Medications

Beta-blockers, such as propanolol, are often used to treat heart conditions but have also been found to be helpful in certain anxiety disorders, particularly in social anxiety. When a feared situation, such as giving an oral presentation, can be predicted in advance, your doctor may prescribe a beta-blocker that can be taken to keep your heart from pounding, your hands from shaking, and other physical symptoms from developing.

Taking Medications

Before taking medication for an anxiety disorder:

• Ask your doctor to tell you about the effects and side effects of the drug he or she is prescribing.

• Tell your doctor about any alternative therapies or over-the-counter medications you are using.

• Ask your doctor when and how the medication will be stopped. Some drugs can't safely be stopped abruptly; they have to be tapered slowly under a physician's supervision.

• Be aware that some medications are effective in anxiety disorders only as long as they are taken regularly, and symptoms may occur again when the medications are discontinued.

• Work together with your doctor to determine the right dosage of the right medication to treat your anxiety disorder.

Psychotherapy

Psychotherapy involves talking with a trained mental health professional to learn how to deal with problems like anxiety disorders.

Cognitive-Behavioral and Behavioral Therapy

Research has shown that a form of psychotherapy that is effective for several anxiety disorders, particularly panic disorder and social anxiety, is cognitive-behavioral therapy (CBT). It has two components. The cognitive component helps people change thinking patterns that keep them from overcoming their fears. For example, a person with panic disorder might be helped to see that his or her panic attacks are not really heart attacks as previously feared; the tendency to put the worst possible interpretation on physical symptoms can be overcome.

The behavioral component of CBT seeks to change people's reactions to anxiety-provoking situations. A key element of this component is exposure, in which people confront the things they fear. An example would be a treatment approach called exposure and response prevention for people with OCD. If the person has a fear of dirt and germs, the therapist may encourage them to dirty their hands, then go a certain period of time without washing. The therapist helps the patient to cope with the resultant anxiety. Eventually, after this exercise has been repeated a number of times, anxiety will diminish.

A major aim of CBT and behavioral therapy is to reduce anxiety by eliminating beliefs or behaviors that help to maintain the anxiety disorder. CBT or behavioral therapy generally lasts about 12 weeks. It may be conducted in a group, provided the people in the group have sufficiently similar problems. Group therapy is particularly effective for people with social phobia.

Medication may be combined with psychotherapy, and for many people this is the best approach to treatment. As stated earlier, it is important to give any treatment a fair trial. And if one approach doesn't work, the odds are that another one will, so don't give up.

If you have recovered from an anxiety disorder, and at a later time it recurs, don't consider yourself a "treatment failure." Recurrences can be treated effectively, just like an initial episode. In fact, the skills you learned in dealing with the initial episode can be helpful in coping with a setback.

Anxiety Disorders - A Closer Look

By Freedom From Fear
www.freedomfromfear.org

Major Characteristics

Anxiety disorders are the most common problem seen by psychologists and psychiatrists. Recent national surveys have indicated that a startling 25% of the population reported having symptoms severe enough to warrant the diagnosis for an anxiety disorder at some point in their lives. The demands of stressful situations or even everyday life will cause most of us to feel anxious at different points in our life. What makes these feelings an "anxiety disorder" is that the problem persists for weeks and begins to interfere with occupational and/or social functioning. Symptoms can vary from mild to severe in which case almost total disability can occur. Anxiety disorders are actually a group of separate but sometimes overlapping disorders,. They include: phobias (social phobia, agoraphobia, simple phobia), panic disorder, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress disorder and separation anxiety disorder (a common childhood problem). These separate disorders will be discussed as a group since they share so many of the same symptoms.

Physical & Emotional Symptoms

One of the primary characteristics of all anxiety problems is, of course, fear. While the experience of fear under certain situations is a part of life, fear that significantly interferes with our daily functioning doesn't have to be. Emotionally, fear can vary from experiencing anticipation and tension to, at worst, acute panic attacks. Physical symptoms can include difficulties sleeping, loss of appetite, stomach upset, diarrhea, restlessness, muscle aches and tension headaches. Acute fear, otherwise known as a panic attack, can include a sudden feeling of terror accompanied by: trembling/shaking, sweating, hot/cold flashes, faintness, unsteadiness, dizziness, difficulty concentrating, disorientation, racing heart, chest discomfort, difficulty breathing, dry mouth, numbness in body parts, etc.

Cognitive Characteristics

Cognitions are simply thoughts. These include the ideas or images that come to mind while a person is feeling anxious. Anxious thoughts are generally characterized by the belief that you or someone you know is in some type of danger or that something dangerous is about to happen. One of the main definitions of a phobia is believing that something is dangerous when it really is not; the fear is irrational or excessive. Most anxiety sufferers can see that their thoughts are unrealistic, distorted or excessive but find it very difficult to stop thinking these thoughts. For social phobia, fears are centered around social situations in which one focuses on not getting approval, failing, or being embarrassed. Thoughts during panic attacks include ideas about losing control, going crazy, or dying. Agoraphobic thoughts are often connected to believing that certain sensations or situations are going to lead to another full panic attack and that without someone else around this cannot be stopped or may even be dangerous. Obsessive-compulsive thoughts often include the inability to stop thinking about, contamination, germs, illness, death, sex, religion, personal responsibility, losing control and getting violent with oneself or others. Post-traumatic stress disorder includes flashbacks from a traumatic event, which may also be present in nightmares, and often thoughts about being responsible for the event also appear. Generalized anxiety disorder produces almost constant worry about what might happen in a wide variety of areas in a person's life (e.g. health, financial, etc.). Younger children may be less able to express their fears clearly or may report more primitive fears of harm such as monsters, eyes in the dark, or something bad happening to themselves or parents if they are separated.

Behavioral Characteristics

Behavioral characteristics are primarily different forms of avoidance. Avoidance can take a variety of forms. Often it's as simple as giving in to the urge not to go to a certain place or to quickly escape if the discomfort gets too powerful. Sometimes avoidance can take on more complicated forms such as compulsions or rituals in which certain actions may be excessively repeated even though it doesn't make sense to repeat them. Examples would include excessive cleanliness, ordering, or checking. Avoidance is a natural, almost automatic way that people try to reduce anxiety, physical distress and panic attacks. Unfortunately, avoidance never helps a person to learn how to cope and instead worsens the problem.

How common is anxiety?

Anxiety related disorders are the most common psychological problem. Recent national surveys reveal that a startling 25% percent of the population will suffer from an anxiety disorder at sometime in the course of their lives.

Complications

Without proper treatment, a variety of possible complications could arise in conjunction with simple anxiety. Left untreated, anxiety may begin to interfere with social functioning, resulting in difficulties in professional and/or personal relations. Often after a prolonged period of suffering from an anxiety disorder, a person may become frustrated, hopeless, and eventually depressed. Estimates vary but as many as 59% of anxiety sufferers may at some point also simultaneously suffer from clinical depression. Another common complication is the use of alcohol or other drugs as a way to feel calmer. Of course, this only worsens the condition in the long run; this is commonly referred to as "self-medicating."

Treatment

Behavior and cognitive-behavior therapies are among the treatments which have been most extensively evaluated and have repeatedly proven their effectiveness for treating anxiety disorders. Behavior Therapy (BT) is often confused with behavior modification, but they are not the same. Behavior modification is using a plan of rewards and punishments to change behavior; this may help with children but IS NOT what is meant by behavior therapy for adult anxiety disorders. Behavior therapy emphasizes unlearning avoidant and compulsive behavior and re-learning new alternative behaviors. These behavioral alternatives may include deep muscle relaxation, breathing retraining, assertiveness training, conflict resolution, etc. The primary purpose is to gradually replace escaping, avoiding and compulsions, which only worsen the problem, with other new behaviors. Learning alternative coping skills gradually allows a person to start confronting or exposing themselves to the triggers for the anxiety. This gradual exposure is an important but difficult part of behavior therapy. Done in a planned systematic way, exposure eventually desensitizes a person and the triggers no longer cause anxiety, or at least not as intensely.

At Mental Health News
Every Month is Mental Health Month !

An Overview of Depression

By Freedom From Fear
www.freedomfromfear.org

Depression is a serious medical illness. In contrast to the normal emotional experiences of sadness, loss, or passing mood states, clinical depression is persistent and can interfere significantly with an individual's ability to function.

Symptoms of depression include sad mood, loss of interest or pleasure in activities that were once enjoyed, change in appetite or weight, difficulty sleeping or oversleeping, physical slowing or agitation, energy loss, feelings of worthlessness or inappropriate guilt, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. A diagnosis of unipolar major depression (or major depressive disorder) is made if a person has five or more of these symptoms and impairment in usual functioning is nearly every day during the same two-week period. Major depression often begins between ages 15-30 or even earlier. Episodes typically recur.

Types of Depression

Depressive disorders come in different forms, just as is the case with other illnesses such as heart disease. This article briefly describes three of the most common types of depressive disorders. However, within these types are variations in the number of symptoms, their severity, and persistence.

Major depression is manifested by a combination of symptoms that interfere with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. Such a disabling episode of depression may occur only once but more commonly occurs several times in a lifetime.

A less severe type of depression, dysthymia, involves long-term, chronic symptoms that do not disable, but keep one from functioning well or from feeling good. Many people with dysthymia also experience major depressive episodes at some time in their lives.

Another type of depression is bipolar disorder, also called manic-depressive illness. Not nearly as prevalent as other forms of depressive disorders, bipolar disorder is characterized by cycling mood changes: severe highs (mania) and lows (depression). Sometimes the mood switches are dramatic and rapid, but most often they are gradual. When in the depressed cycle, an individual can have any or all of the symptoms of a depressive disorder. When in the manic cycle, the individual may be overactive, overtalkative, and have a great deal of energy. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment. For example, the individual in a manic phase may feel elated, full of grand schemes that might range from unwise business decisions to romantic sprees. Mania, left untreated, may worsen to a psychotic state.

Depression can be devastating to all areas of a person's everyday life, including family relationships, friendships, and the ability to work or go to school. Many people still believe that the emotional symptoms caused by depression are "not real," and that a person should be able to shake off the symptoms if only he or she were trying hard enough. Because of these inaccurate beliefs, people with depression either may not recognize that they have a treatable disorder or may be discouraged from seeking or staying on treatment because of feelings of shame and stigma. Too often, untreated or inadequately treated depression leads to suicide.

• Depression affects nearly 10 percent of adult Americans ages 18 and over in a given year, or more than 19 million people in 1998.

• Unipolar major depression is the leading cause of disability in the United States and worldwide.

• Nearly twice as many women (12 percent) as men (7 percent) are affected by a depressive illness each year.

• Evidence from studies of twins supports the existence of a genetic component to risk of depression. Across six studies, the average concordance rate in identical twins (40%) for unipolar depression is more than twice the concordance rate in fraternal twins (17%).

• Research has shown that stress in the form of loss, especially death of close family members or friends, may trigger major depression in vulnerable individuals.

Treatment

Antidepressant medications are widely used effective treatments for depression. Existing antidepressant drugs are known to influence the functioning of certain neurotransmitters (chemicals used by brain cells to communicate), primarily serotonin, norepinephrine, and dopamine, known as monoamines. Older medications -- tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) -- affect the activity of both of these neurotransmitters simultaneously. Their disadvantage is that they can be difficult to tolerate due to side effects or, in the case of MAOIs, dietary and medication restrictions. Newer medications, such as the selective serotonin reuptake inhibitors (SSRIs), have fewer side effects than the older drugs, making it easier for patients to adhere to treatment. Both generations of medications are effective in relieving depression, although some people will respond to one type of drug but not another. Medications that take entirely different approaches to treating depression are now in development.

Psychotherapy is also effective for treating depression. Certain types of psychotherapy, cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT), have been shown to be particularly useful. More than 80 percent of people with depression improve when they receive appropriate treatment with medication, psychotherapy, or the combination.

What is Generalized Anxiety Disorder ?

By Freedom From Fear
www.freedomfromfear.org

Generalized anxiety disorder (GAD) is characterized by 6 months or more of chronic, exaggerated worry and tension that is unfounded or much more severe than the normal anxiety most people experience. People with this disorder usually expect the worst; they worry excessively about money, health, family, or work, even when there are no signs of trouble. They are unable to relax and often suffer from insomnia. Many people with GAD also have physical symptoms, such as fatigue, trembling, muscle tension, headaches, irritability or hot flashes. Fortunately, through research supported by the National Institute of Mental Health (NIMH) and by industry, effective treatments have been developed to help people with GAD.

How Common Is GAD?

• About 2.8% of the adult U.S. population ages 18 to 54 - approximately 4 million Americans - has GAD during the course of a given year.

• GAD most often strikes people in childhood or adolescence, but can begin in adulthood, too. It affects women more often than men.

What Causes GAD?

Some research suggests that GAD may run in families, and it may also grow worse during stress. GAD usually begins at an earlier age and symptoms may manifest themselves more slowly than in most other anxiety disorders.

What Treatments Are Available for GAD?

Treatments for GAD include medications and cognitive-behavioral therapy.

Can People With GAD Also Have Other Illnesses?

Research shows that GAD often coexists with depression, substance abuse, or other anxiety disorders. Other conditions associated with stress, such as irritable bowel syndrome, often accompany GAD. Patients with physical symptoms such as insomnia or headaches should also tell their doctors about their feelings of worry and tension. This will help the patient"s health care provider to recognize that the person is suffering from Generalized Anxiety Disorder.

A Special "Thank You" From Mental Health News
To Jane E. McCarty For Volunteering Her Editorial Expertise !

A Look at Panic Disorder

By Freedom From Fear
www.freedomfromfear.org

Panic disorder is characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms which may include chest pain, heart palpitations, shortness of breath, dizziness or abdominal distress. These sensations often mimic symptoms of a heart attack or other life-threatening medical conditions. As a result, the diagnosis of panic disorder is frequently not made until extensive and costly medical procedures fail to provide a correct diagnosis or relief.

Many people with panic disorder develop intense anxiety between episodes. It is not unusual for a person with panic disorder to develop phobias about places or situations where panic attacks have occurred, such as in supermarkets or other everyday situations. As the frequency of panic attacks increases, the person often begins to avoid situations where they fear another attack may occur or where help would not be immediately available. This avoidance may eventually develop into agoraphobia, an inability to go beyond known and safe surroundings because of intense fear and anxiety.

Fortunately, through research supported by the National Institute of Mental Health (NIMH) and by industry, effective treatments have been developed to help people with panic disorder.

How Common Is Panic Disorder?

• About 1.7% of the adult U.S. population ages 18 to 54 -- approximately 2.4 million Americans -- has panic disorder in a given year.

• Women are twice as likely as men to develop panic disorder.

• Panic disorder typically strikes in young adulthood. Roughly half of all people who have panic disorder develop the condition before age 24.

What Causes Panic Disorder?

Heredity, other biological factors, stressful life events, and thinking in a way that exaggerates relatively normal bodily reactions are all believed to play a role in the onset of panic disorder. The exact cause or causes of panic disorder are unknown and are the subject of intense scientific investigation.

Studies in animals and humans have focused on pinpointing the specific brain areas and circuits involved in anxiety and fear, which underlie anxiety disorders such as panic disorder. Fear, an emotion that evolved to deal with danger, causes an automatic, rapid protective response that occurs without the need for conscious thought. It has been found that the body's fear response is coordinated by a small structure deep inside the brain, called the amygdala.

The amygdala, although relatively small, is a very complicated structure, and recent research suggests that anxiety disorders may be associated with abnormal activitation in the amygdala. One aim of research is to use such basic scientific knowledge to develop new therapies.

What Treatments Are Available for Panic Disorder?

Treatment for panic disorder includes medications and a type of psychotherapy known as cognitive-behavioral therapy, which teaches people how to view panic attacks differently and demonstrate ways to reduce anxiety. NIMH is conducting a large-scale study to evaluate the effectiveness of combining these treatments. Appropriate treatment by an experienced professional can reduce or prevent panic attacks in 70% to 90% of people with panic disorder. Most patients show significant progress after a few weeks of therapy. Relapses may occur, but they can often be effectively treated just like the initial episode.

Can People With Panic Disorder Also Have Other Illnesses?

Research shows that panic disorder can coexist with other disorders, most often depression and substance abuse. About 30% of people with panic disorder abuse alcohol and 17% abuse drugs, such as cocaine and marijuana, in unsuccessful attempts to alleviate the anguish and distress caused by their condition. Appropriate diagnosis and treatment of other disorders such as substance abuse or depression are important to successfully treat panic disorder.

Post-Traumatic Stress Disorder

By Freedom From Fear
www.freedomfromfear.org

Post-traumatic stress disorder (PTSD) can be an extremely debilitating condition that can occur after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that can trigger PTSD include violent personal assaults such as rape or mugging, natural or human-caused disasters, accidents, or military combat.

Military troops who served in Vietnam and the Gulf Wars, rescue workers involved in the aftermath of disasters like the Oklahoma City bombing, survivors of accidents, rape, physical and sexual abuse, and other crimes, immigrants fleeing violence in their countries, survivors of the 1994 California earthquake, the 1997 South Dakota floods, and hurricanes Hugo and Andrew, and people who witness traumatic events are among those at risk for developing PTSD. Families of victims can also develop the disorder.

Fortunately, through research supported by the National Institute of Mental Health (NIMH) and the Department of Veterans Affairs (VA), effective treatments have been developed to help people with PTSD. Research is also helping scientists better understand the condition and how it affects the brain and the rest of the body. NIMH is conducting a national education program on anxiety disorders, which include PTSD, panic disorder, obsessive-compulsive disorder, social phobia, and generalized anxiety disorder.

What Are the Symptoms of PTSD?

Many people with PTSD repeatedly re-experience the ordeal in the form of flashback episodes, memories, nightmares, or frightening thoughts, especially when they are exposed to events or objects reminiscent of the trauma. Anniversaries of the event can also trigger symptoms. People with PTSD also experience emotional numbness and sleep disturbances, depression, anxiety, and irritability or outbursts of anger. Feelings of intense guilt are also common. Most people with PTSD try to avoid any reminders or thoughts of the ordeal. PTSD is diagnosed when symptoms last more than one month.

How Common Is PTSD?

About 3.6 percent of U.S. adults ages 18 to 54 (5.2 million people) have PTSD during the course of a given year. About 30 percent of the men and women who have spent time in war zones experience PTSD. One million war veterans developed PTSD after serving in Vietnam. PTSD has also been detected among veterans of the Persian Gulf War, with some estimates running as high as 8 percent.

When Does PTSD First Occur?

PTSD can develop at any age, including in childhood. Symptoms typically begin within three months of a traumatic event, although occasionally they do not begin until years later. Once PTSD occurs, the severity and duration of the illness varies. Some people recover within six months, while others suffer much longer.

What Treatments Are Available for PTSD?

Research has demonstrated the effectiveness of cognitive-behavioral therapy, group therapy, and exposure therapy, in which the patient repeatedly relives the frightening experience under controlled conditions to help him or her work through the trauma. Studies have also shown that medications help ease associated symptoms of depression and anxiety and help promote sleep. Scientists are attempting to determine which treatments work best for which type of trauma.

Some studies show that debriefing people very soon after a catastrophic event may reduce some of the symptoms of PTSD. A study of 12,000 school children who lived through a hurricane in Hawaii found that those who got counseling early on were doing much better two years later than those who did not.

Do Other Illnesses Tend to Accompany PTSD?

Co-occurring depression, alcohol or other substance abuse, or another anxiety disorder are not uncommon. The likelihood of treatment success is increased when these other conditions are appropriately identified and treated as well.

Headaches, gastrointestinal complaints, immune system problems, dizziness, chest pain, or discomfort in other parts of the body are common. Often, doctors treat the symptoms without being aware that they stem from PTSD. NIMH, through its education program, is encouraging primary care providers to ask patients about experiences with violence, recent losses, and traumatic events, especially if symptoms keep recurring. When PTSD is diagnosed, referral to a mental health professional who has had experience treating people with the disorder is recommended.

Who Is Most Likely to Develop PTSD?

People who have been abused as children or who have had other previous traumatic experiences are more likely to develop the disorder. Research is continuing to pinpoint other factors that may lead to PTSD.

It used to be believed that people who tend to be emotionally numb after a trauma were showing a healthy response, but now some researchers suspect that people who experience this emotional distancing may be more prone to PTSD.

Reducing the Stress in Your Life

By Freedom From Fear
www.freedomfromfear.org

What is Stress?

Stress is the way that we respond to change in our lives. It is the way our bodies react physically, emotionally, cognitively, behaviorally to any change in the status quo. These changes do not have to be only negative things; positive change can also be stressful. Even imagined change can cause stress.

Stress is highly individual. A situation that one person may find stressful may not bother another person. Stress occurs when something happens that we feel imposes a demand on us. When we perceive that we cannot cope or feel inadequate to meet the demand, we begin to feel stress.

Stress is not all bad. We need a certain amount of stress in our lives because it is stimulating and motivating. It gives us the energy to try harder and keeps us alert. When we find ourselves in situations that challenge us too much, we react with the "fight or flight" stress response. Stress actually begins in our brains and it is expressed in our body. Once we perceive a stress, our body sends our chemical messengers in the form of stress hormones to help our bodies handle the stress.

Chronic Stress

Stress hormones are important to help us meet the demands of stress occasionally, but if they are repeatedly triggered, disease will occur. Our body does signal us when we are we are experiencing the effects of chronic stress.

Physical Symptoms Are:

Headaches, tension, fatigue, insomnia, muscle aches, digestive upset, Restlessness, Appetite change, alcohol, tobacco, drug use.

Mental Symptoms Are:

Forgetfulness, low productivity, confusion, poor concentration, lethargy, negativity, busy mind.

Emotional Symptoms Are:

Anxiety, mood swings, irritability, depression, worrying, little joy, anger, resentment, impatience.

Social Symptoms

Lashing out, Decrease sex drive, Lack of intimacy, Isolation, Intolerance, Loneliness, Decrease in social activities, Desire to run away

Spiritual Symptoms Include:

Apathy, loss of direction, emptiness, loss of life's meaning, cynicism, unforgiving, feelings of martyrdom.

Managing Stress

Being able to manage stress is important in order to live healthy, happy and productive lives.

Negative Coping

Ignoring the problem, withdrawal, procrastination, alcohol/drug use, smoking, overeating, Inactivity, over committed, buying things.

Positive Coping Skills:

Become aware of your reactions, maintain a healthy balanced diet, exercise regularly, balance work and play, practice relaxation techniques, meditate, develop a support system, pace yourself, simplify your life.

Self-Care Techniques

Daily choices to care for oneself helps one's feelings of worth and increases a sense of well-being.

Deep, slow diaphragmatic breathing, listening to relaxation tapes, avoid caffeine, Use positive affirmations, do something you love, allow extra time for projects, leave work at the office, do not ruminate over the past, try to live in the present, take brisk walks, listen to your body's signals, finish what you start.

Do less, enjoy more !!

The Whole World Is Medicine Suffering From The Zen Point Of View

By Brenda Shoshanna, Ph.D.

Brenda Shoshanna

"The Whole World Is Medicine: What is the Illness?"

Part of the natural human condition is to be subject to suffering -- to pain, loss, anxiety, sorrow, as well as times of joy, delight and fulfillment. However, when happiness comes, we want to hold onto it, insure it will remain with us forever. When painful times come, we want to push them away, numb ourselves, withdraw. But this is not the way of Zen. From the Zen point of view, we must learn how to hold all of life in the palm of our hands.

The Difference Between Heaven and Hell

Zen practice teaches that the way in which we receive our sorrows, the way in which we understand what is happening and responding to anxiety, makes the entire difference between heaven and hell. What can turn into a long, convoluted time of anguish or depression can also be experienced differently, so that the pain we feel is not compounded and intensified, but instead becomes an accompaniment to a purposeful day.

"Laura," a mother in her mid-forties woke up one day to find herself feeling ill. She initially discounted it as a passing virus; but weeks passed and her moods became uncontrollable anxiety and depression appeared along with other symptoms. She was put on medication and tried as many kinds of treatment as she could find - acupuncture, herbs, etc. Yet her condition remained unchanged.

One afternoon a friend offered to teach her Zen meditation. She felt she had nothing to lose and followed the basic instructions. "It felt good," Laura said, "but not spectacular. Bells didn't go off." Nevertheless, she felt somewhat more balanced and light-hearted and was drawn back to the meditation cushion again. Soon she decided to spend time sitting regularly each day.

Within six months Laura was off medication, in balance, and she felt refreshed and alive as she greeted each day. When asked about Zen, she says simply, "I don't know exactly what happened, but it has simply saved my life."

Pull The Poison Arrows Out

When the Buddha was asked who he was, he said he was a doctor coming to cure the ills of the world. He said we have all been shot with poison arrows, (or afflictions, delusions) and he had come to show us how to pull the poison arrows out. He did not say he would pull it out for us. In Zen practice we do not depend on others but learn instead who we really are, how to connect with our intrinsic strength and wisdom, and pull our own poison arrows out. A well known Zen saying advises, "Don't put a head on your head. What is wrong with your own head anyway?"

As we practice, we patiently remove one poison arrow after the next. We do not seek to explain the cause of each arrow, we do not dwell upon one problem after another; instead we go to the root of our suffering and pull it out.

The Whole World Is Medicine

But what exactly is the medicine Laura is receiving? In order to understand this better, it is necessary to see how Zen practice works, the effects it has upon mind and spirit, how it is radically different from the ways in which we usually respond.

Zen practice is the practice of honoring and making friends with all of ourselves, all of life, including our suffering. A famous saying in Zen is:

"To separate what we like from what we dislike is the disease of mind."

Sosan

This teaches that we do not reject one part of ourselves or our experience. We do not say this experience is good and that one is bad, I hate this and love that. I will seek this and turn away from that. This very way of life itself is the illness. It causes us to split both from ourselves and our lives.

When Pain Comes, We Receive That

As we sit on the cushion we experience whatever arises. When pain comes, we receive that. (We do not question, analyze or dwell upon it, simply receive what comes to us.) When it is time for pain to dissolve, we allow it to go. When joy comes, we let it in. Then we give thanks for it all.

As we practice we learn how to thoroughly experience what is happening moment by moment, and soon realize that if we are completely with each moment, the next breath will bring something new. When we do not reject our suffering, or add anything to it, pain is simply pain. It is what we add to it that turns it into suffering, makes it thick and solid, so that it can't subside.

Pain is not bad. It is simply pain. When we avoid pain, it turns into suffering. There is an enormous difference between pain and suffering. Pain often cannot be avoided. Suffering can. As we learn the difference between them, many fears, anxieties and sorrows subside. In the simple receiving, pain transforms into something quite different and an amazing strength arises within.

Who Is The Patient?

In Zen practice we do not label ourselves patients, crazy or sick. We do not label ourselves anything. The labeling only compounds the problem. The Buddha said that all suffering is caused by the three poisons that all of us contain -- greed, anger and delusion. Rather than live them out, build them up, identify with them or struggle against them, we see them for what they are and let them go.

Our monkey mind may make its objections. Our monkey mind reacts to everything, spins out endless chatter, explanations and mental machinations (delusions) that we usually take as true. Our monkey mind enjoys and seeks these poisons as if they were honey itself.

As awareness increases our Buddha Nature (divine nature), our potential for health, clarity and love matures and we become able to discern the difference between poison and medicine. We are then able to be aware of the beauty, joy and wonder of all life. We can laugh when we're happy and cry when we're sad. We become one with the sound of the birds, the touch of a friend, the heat of summer, the loss of a dream, the new buds of spring -- whatever comes.

This open, direct experience will bring us all the healing, joy and strength we need for everything. Try this wonderful practice, even once. As you do, you will recover a day that may have been lost to you.

"This day will not come again,
Each minute is a priceless gem."

Exercise 1: (Zen In Action) Return to the Source

In the midst of speaking, working, cleaning or any other activity, stop a moment. Pay attention to where you are and to your breathing. Actively take your attention back from the external world and follow your breath. Do this at least three times a day.

Brenda Shoshanna, Ph.D., the author of Zen Miracles (Finding Peace In An Insane World), Wiley, (upon which this article is based); is a psychologist in private practice, speaker, and offers workshops on Zen and psychology. The relationship expert on "i.village.com," and publisher of the free ezine "Touchstones To Love," she is the author of many other books as well, including "365 Ways To Give Thanks," "Why Men Leave" and "Journey Through Illness and Beyond." On the net at www.Brendashoshanna.com, you may E-mail Dr. Shoshana at: Topspeaker@Yahoo.com.

Mental Health News Tip: Meditation Exercises Can Often Help Reduce Anxiety

DMDA - Finger Lakes: Making A Difference

By George Griffith, Chapter President
DMDA-Finger Lakes, Elmira, NY

George Griffith

There have been many opportunities for me since being diagnosed as Manic-Depressive. Opportunities are a funny thing. They come when one least expects them; they are often the last thing an individual would consider, and I think they leave the most enduring impression (when seized or missed) that a person can expect in life.

Mental Health News Founder and Publisher, Ira Minot, has given DMDA of the Finger Lakes just such an opportunity. With his help, we will now be able to bring our message and extend our mission to a much greater audience throughout the Finger Lakes Region of New York State and Western New York.

We at Depressive and Manic Depressive Association (DMDA) of the Finger Lakes, located in Elmira, New York, are first and foremost a Support Group, for those with mood disorders. Our mission is to bring understanding to the public about Mood Disorders, to dispel the stigma(s) towards them, and to provide a forum for those without a *voice* who continue to struggle with a terrible affliction.

DMDA of the Finger Lakes provides a support group to help people find out that they are not alone in dealing with depressive and bi-polar illnesses. We provide an opportunity to share our thoughts and feelings and experiences from living with these mood disorders. We share hope and acceptance in our weekly meetings. We do not give professional advice but provide the invaluable experience of sharing with each other about our illness and to know we are not alone!

Some of the topics of our weekly meetings focus on: *Recognizing Stress, How people want to be treated when they're depressed, What is Treatment Resistance?, and Dual Disorders: Concepts and Definitions.*

We have been working diligently since November 1997 to fill the enormous gap in community education that exists, for victims of clinical depression, bipolar disorder (manic-depression), anxiety, panic attack, and the many diseases and disorders classified as mood disorders.

On a regular basis, I find a larger gap of knowledge between clinicians and clients than I ever would have believed possible. Mental health has become an issue, which has gone from whispers to shouts, yet there is no issue I have encountered that still has so far to go in order to gain acceptance. At DMDA our main thrust is to increase tolerance for mental health concerns.

It was first thought that people should move from the traditional 'crutch society' notion, to a "support" alliance. Such was the simplicity of the 1990's. The tendency of finding empathy in cloaking life disorders into more benign sounding ailments like stress, emotional discord, dysfunction, and finally something impressive sounding like "bipolar disorder," is no longer fashionable. During the unprecedented upwardly moving economy of the time, and having a dire concern for longer and healthier life, we found many people trying to find wellness while encountering situations that didn't have a very favorable outcome. We were all grateful for the advent of Prozac and many breakthroughs in pharmacology. However, that was merely a first step and unfortunately, fads come and go. Pioneering research and development of new therapies (both pharmacological and informational) have uncovered the need to address society's honesty in its definition of *acceptance*.

Manic-Depression, Unipolar Depression, PTSD and Anxiety are not only emotionally and physically painful, but are very dark and dangerous places for the mind. These mood disorders are *chemical brain imbalances*, which are more likely to be dealt with through denial and/or talk therapy that is abruptly discontinued. The frustration encountered by these stricken persons combined with side effects that are produced in a 'hit-or-miss' medication adventure is often unbearable. This is due to the further disruption of one's remaining faculties, and how one is able to live and function while stricken with a mood disorder. In short, more ground is lost than gained at the onset of therapy until issues, med-therapy side effects, and the discipline of new treatment strategies have taken hold.

It is our genuine belief that we can enlighten and lessen this load by breaking the isolation often felt by the depressed person and to help modify the "unwarranted" euphoria of hypomania/mania.

It is our hope that with this opportunity - to have a voice in *Mental Health News* - we can reach more people with education, outreach and support.

For further information about DMDA Finger Lakes, please call us at (607) 734-4789 or write to us at DMDA-Finger Lakes, Inc., 375-377 West Church Street, Elmira, New York 14901.

DMDA of the Finger Lakes Inc.
DMDA

Ideal Treatment Environment vs. Realistic Treatment Options

By Milissa B. Cerio
CSWR, ACSW, CASAC

Over the past twenty years, I have attended numerous professional educational conferences, read countless books and consulted with scores of mental health professionals in my role as a licensed social worker that counsels individuals diagnosed with mood disorders. There seems to be a general consensus of the "ideal treatment environment" for those with mood disorders. This includes choosing a competent psychiatrist that one feels comfortable with, regular therapy sessions with a social worker or a psychologist for individual and/or group therapy, adequate insurance coverage or financial means to allow for as much therapy as needed, funds to cover the cost of prescription medications, a strong support system of friends and family who are educated about the mood disorder, and an employer who will make necessary accommodations on the job. A great plan; but it is hardly realistic for many people with mood disorders.

All too often, people have little choice of a psychiatrist and social worker and are relegated to who is covered by their medical plan or who is taking new patients. Often, medical coverage provides for a limited number of psychiatric and social work sessions. High co-pays for prescription medication or medical coverage that does not have a prescription plan keeps many from taking adequate medications. Individuals with mood disorders frequently have a long history of fractured or failed relationships and even those with strong support systems may feel that people around them really don't understand what they are going through. Supportive employers are few and far between and financial stress and unemployment can be a heavy weight when one is also trying to manage a mental illness.

The majority of the individuals that I have seen in my private practice have not had the advantage of the "ideal treatment environment." It has been my challenge to help people find ways to overcome the barriers to effective treatment. While patients may not have a choice of a psychiatrist, they can assist their psychiatrist by educating themselves about their symptoms by keeping a regular mood chart documenting mood states, sleep patterns, medication, etc. Patients who meet income guidelines may qualify for the Patient Assistance Program. This is a program offered by most drug companies to provide medication free of charge to eligible patients in conjunction with information from their psychiatrist. Patients too often do not realize they have this option open to them and instead don't take medication because they don't have the money for it.

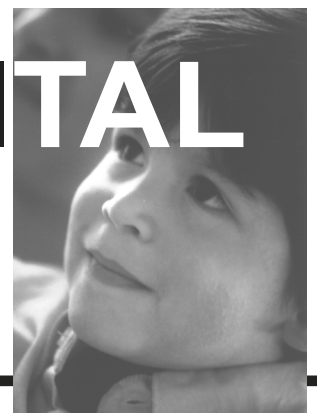
I always encourage people to take advantage of support groups that are available to them in their community. Support groups are not a substitute for therapy but they do provide a place for acceptance and connection with others who can understand and share their experience and successes. Often individuals with mood disorders do not feel like they are as dependent on their friends and family when they have a support group to go to. Ultimately this can help them improve their primary relationships.

The Depressive and Manic Depressive Association of the Finger Lakes was begun in Elmira, New York in 1997 in response to a community need for a support group that is free of charge and open to the public. Individuals with mood disorders lead it. This group is part of a parent group, National DMDA (NDMDA). For information about how you can start a support group in your area, contact NDMDA at www.ndmda.org. or call (800) 826-3632.

FOUR WINDS HOSPITAL

Where You'll Find Respectful and Caring Professionals

800 Cross River Road • Katonah, New York 10536 • 914-763-8151 • www.fourwindshospital.com



Understanding A Child's Anger

Temperament-Linked Anger Control Difficulties: Theoretical Perspectives

By Norman Brier, Ph.D.

Anger is generally defined as an emotional state characterized by a sense of displeasure and/or hostility. To experience and/or display anger is not abnormal. Rather, anger is a clinical problem when it is experienced or displayed to excess, that is, too frequently, too intensely, or for too long a duration of time. With regard to etiology, anger control problems can be divided into two primary categories. The first category is linked to a mood disorder, most often in the form of depression. When problems with anger are primarily a result of a mood disorder, they are not usually evident early in life or in most settings. Further, the intensity and frequency of the individual's anger waxes and wanes. The second category is linked primarily to temperament, defined as biologically based, individual differences in reactivity to external and internal stimulation, and individual differences in patterns of motor and attentional self-regulation. When problems with anger are primarily a result of temperament, anger is evident early in life, manifest in many situations, and relatively stable across time. The categories of mood and temperament are not mutually exclusive. For some youngsters, anger problems are a result of an interaction of the two.

Norman Brier, Ph.D.

For youngsters with temperament-linked anger management problems, five etiological factors seem to play an especially important etiological role. The first factor is the individual's level of emotional reactivity, or synonymously, excitability, responsivity, and/or behavioral and physiological arousability. These terms refer to the intensity of stimulation that is needed to elicit an emotional response and the strength of the emotional response once a response is elicited. The latency, intensity, and duration of the individual's arousal, and the length of time he or she needs to recover from being aroused are markers that can be used to assess emotional reactivity. Youngsters with temperament-linked anger control problems are highly reactive. They are extremely aware of even subtle changes in physiological arousal, react quickly, with a high level of intensity, and maintain the state of high arousal for a relatively long period of time. In addition, youngsters with temperament-linked anger control problems tend to have difficulty directing their attention away from their internal state of arousal.

The second factor is inhibitory control, the individual's ability to willfully prevent, delay, or modulate the form and duration of the behaviors that are present when aroused. Thus, this factor describes the individual's ability to suppress a dominant or usual response to a provocation and the ability to replace it with a subdominant or less frequent response. Youngsters with temperament-linked anger control problems tend to have difficulty containing an angry response to a perceived provocation, delaying or ceasing angry behavior once it is ongoing, and withholding a response to other potential provocations while responding to the initial provocation. Poor inhibitory control results in an inability to sufficiently consider social information and the alternatives and consequences available.

The third factor relates to deficits in language competence, the ability to employ language in the form of self-guidance. Language or self-directed speech allows the individual to analyze social information, review past options, create and explore hypothetical new ones, and plan how to execute the option selected. Temperament-linked anger control problems have been found to be more frequent in children who are less able to use internalized speech to provide self-directed commentary and instruction. Youngsters with temperament-linked anger problems tend to be less able to use language to anticipate potentially distressing events, to develop alternative responses, to consider consequences, to understand the meaning and intention of what is said to them, and to effectively communicate their feelings and intentions to others.

The fourth factor relates to social perception, the ability to focus on relevant interpersonal cues (and not focus on irrelevant cues), see or hear relevant interpersonal information, understand what has been seen or heard, and appropriately integrate this information into a plan of action. Youngsters' with temperament-linked anger control problems tend to have difficulty correctly perceiving social information, fail to fully and carefully scan their interpersonal environment, and attend to, and remember, only a limited subset of the total, available, social cues. In particular, they seem to be prone to misinterpreting the actions of others and are often biased towards the belief that another person is intentionally acting provocatively.

The final factor is the "goodness of fit" between the youngster's temperament and the characteristics, expectations, and demands of his or her interpersonal context, especially the characteristics, expectations, and demands of the youngster's

See *A Child's Anger*
Continued on Page 22

Four Winds Hospital
is the leading provider of Child and Adolescent
Mental Health Services in the Northeast

Finding a Place for Faith in Psychiatric Treatment

By Marek Fuchs

Reprinted from The New York Times, April 27, 2002

A Hasidic boy, 16, was a patient in a psychiatric ward and hearing the voice of God.

Dr. Samuel Klagsbrun, his psychiatrist, wrote a medical order for the boy to be sure to put on his tefillin, the black arm wrapping that religious Jews wear when praying, as he normally would. "It raised some eyebrows," said Dr. Klagsbrun, who added that finding religion's proper place in psychiatry was "a true art form." In this case, hearing God's voice fell under the category of psychosis and had to be treated, but the boy's identity as a member of the Hasidic community was an organizing force in his life and needed to be retained.

Finding the balance between religion and psychiatry has been a chief focus of Dr. Klagsbrun's life. Born in Belgium to an Orthodox Jewish family, Dr. Klagsbrun became a refugee in World War II, landing in Brooklyn in 1941 at the age of 9. Educated in yeshivas, he went on to the Jewish Theological Seminary in Manhattan. "But I never wanted to become a rabbi," he said. Eventually, he left the seminary to go to medical school to follow his passion, psychiatry, which, he soon discovered, all but ignored religion. "Psychiatrists were not paying any attention to religion or the spiritual aspects of life," Dr. Klagsbrun said. "And religion and religious values and backgrounds and spiritual dimensions are extremely important to people's dynamics."

In his five decades in the field, Dr. Klagsbrun, who is now executive medical director of Four Winds Hospital in Katonah, N.Y. said that the relationship between religion and psychiatry had evolved considerably. Like Four Winds, many psychiatric hospitals have broadened the scope of religious counseling offered; psychotherapists have become more comfortable handling religious issues; and clergymen, often the first people those with mental illnesses turn to, are seeking out psychological education and experience. Dr. Klagsbrun himself is back at the Jewish Theological Seminary, where he is now a professor of pastoral psychiatry. All of this is quite a change from the historic relationship between religion and psychiatry, one that was fraught with distrust and unease.

Samuel C. Klagsbrun, M.D.

From the primitive thought that mental illness was linked to possession by the devil, Freud's more general skepticism of religion took hold in the first half of the last century, creating hesitancy on the part of many in the psychiatric field to even address the subject. Barbara Stimmel, a psychoanalyst and the president of the New York Freudian Society in Manhattan, said that the divide was not entirely Freud's fault. Like many others in the intellectual and scientific fields, Dr. Stimmel said, Freud was personally wary of religion, but "was not such a super rationalist that he denied the mystical, the spiritual and the transcendent." American Freudianism, however, became obedient to an orthodoxy that made no distinction between Freud's personal and professional thoughts. "But," Dr. Stimmel said, "Freud did know that no psychoanalyst worth his salt would ever leave religion out of a psychoanalytic relationship."

Dr. Harold G. Koenig, a professor at Duke University Medical Center and the author of "The Healing Power of Faith: Science Explores Medicine's Last Green Frontier" (Simon & Schuster, 1999), says members of the clergy are also becoming better schooled in psychological matters. "They used to feel that depression was something you could snap out of if you read the Bible and went to church enough," Dr. Koenig said. "It's been a struggle to get them to realize that it could be biological, not the product of weak faith."

For Dr. Klagsbrun, a defining moment came early in his career when he was doing a rotation at a Veterans' Administration hospital in Connecticut. "There was a profoundly depressed patient who had been there for seven years," he said. Because psychiatrists rotated on six month stints, Dr. Klagsbrun said: "I was his 14th psychiatrist, poor fellow. He looked at me kind of despairingly, and I didn't blame him." The patient did not want to tell his story yet again, and Dr. Klagsbrun, assuming there would be no new ground to cover, said he thought that "I'd be putting it on autopilot." But Dr. Klagsbrun posed a simple question about religious upbringing, and issues surrounding a strict Roman Catholic childhood came tumbling out. The patient expressed surprise that after all his psychiatrists, Dr. Klagsbrun was the first to ask about his religious background. Then he expressed apprehension that, during the course of therapy, Dr. Klagsbrun could ever comprehend his feelings of guilt. "I had to assure him that an old yeshiva boy knows a thing or two about guilt," Dr. Klagsbrun said.

But just as religion must be seen as an organizing force in people's mental health, Dr. Klagsbrun said, it also must be looked at for its potential harm. "It's a bit of a no-no," he said, "but we need to examine to what extent a religious upbringing opens the door to problems." The most obvious cause, he said, is repression. In religious families, communities and organizations, he said, "unacceptable thoughts are considered a sin and are pushed away, put in a mental repository where they go unexamined." Because of his background and ability to speak Yiddish, Dr. Klagsbrun sees many Hasidic patients. In all such insular communities, he said, there is a tendency to "hide mental illness as much as they can until they can't hide it anymore." But forgiveness and the sense of new beginning – the most basic tenets of all religions – "also go hand in hand with psychotherapy," Dr. Klagsbrun said.

Although people like Dr. Klagsbrun's 16-year-old patient who hear God's voice – or think they are God – remain the most noticeable example of religion's intersection with psychiatric illness, the more common problems is those with depression so severe that they lose everything, even the faith that once explained the world to them. "These people," Dr. Klagsbrun said, "are the hidden tragedy."

Dr. Samuel C. Klagsbrun is the Executive Medical Director of Four Winds Hospital which is located in Katonah, New York.

Four Winds provides comprehensive Inpatient and Outpatient mental health services for Adults, including psychiatric and dual diagnosis treatment

Four Winds Hospital - Outpatient Treatment Services

1-800-528-6624

Child Partial Hospitalization Program

- **Ages 5-12**
- **Treatment alternative to inpatient care**
- **24 hour crisis intervention**
- **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**
- **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)**

CHOICES (OASAS licensed)

A full service Alcohol/Chemical Dependency Outpatient Center providing day and evening services for Adults including:

Clinic Services

- **Assessments**
- **Interventions**
- **Early Recovery Group**
- **Dual Diagnosis Track**
- **Individual and Family Counseling**
- **Acupuncture for Detoxification**
- **New York State Department of Motor Vehicles**
- **Women's Group**

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

Visit our website at *www.fourwindshospital.com* for a photo tour and further information about inpatient and outpatient services.

Four Winds outpatient services include Child, Adolescent and Adult Partial Hospitalization Programs and an Adult Alcohol/Chemical Dependency Outpatient Center

A Child's Anger
Continued from page 21

caregivers. The "fit" between youngster with a temperament-linked predisposition to anger, and key individuals in their environment, thus plays an important role in determining if the youngster's predisposition to an anger control problem will be realized or not realized. For example, the behavior and attitudes of the youngster's caretakers have the potential to increase or decrease his or her reactivity and/or amplify or lessen the effects of a stressful environment.

In summary, the prototypical etiological path for youngsters' with temperament-linked anger control problems can be summarized as follows: A triggering event or perceived provocation occurs. The youngster reacts in an emotionally and behaviorally unregulated manner, due, in part, to inadequate social perceptual and language skills, and, in part, to an inadequate match between his or her self control needs, and the characteristics of the care-giving environment. A too intense and/or too prolonged, inappropriate and/or out-of-proportion angry reaction results.

Dr. Brier is the Clinical Professor of Pediatrics and Psychiatry Albert Einstein College of Medicine Of Yeshiva University Children's Evaluation & Rehabilitation Center, Bronx, New York, and a psychologist in private practice in Bedford, New York. He can be reached at 914-234-4475.

Help Wanted

MENTAL HEALTH NEWS

Volunteer Positions Available
Leading To Full-Time Paid Positions
Excellent Learning Opportunity
Flexible Hours
Commitment To Mental Health Advocacy And Education Required

Composition

- Editorial
- Proof Reading
- Research
- Writing

Production

- Layout
- Graphic Design
- Type-Set
- Pre-Press
- PC & MAC

Sales

- Marketing
- Promotion
- Sales
- Accounts
- Subscriptions

Office

- Telephone
- Copy
- Typing
- Bookkeeping
- Mail

Call (914) 948-6699

PUTNAM FAMILY & COMMUNITY SERVICES INC.

Opportunities to Heal Grow and Recover

Putnam Family & Community Services is:

Welcoming
Offering professional treatment in a healing environment

Accessible
Open Mon-Thurs 8am-9pm
Fri. 8am-6pm - Sat 9am-5pm

Affordable
PFCS does not deny treatment to anyone because of inability to pay

Caring
Our services treat each person as a whole

Comprehensive

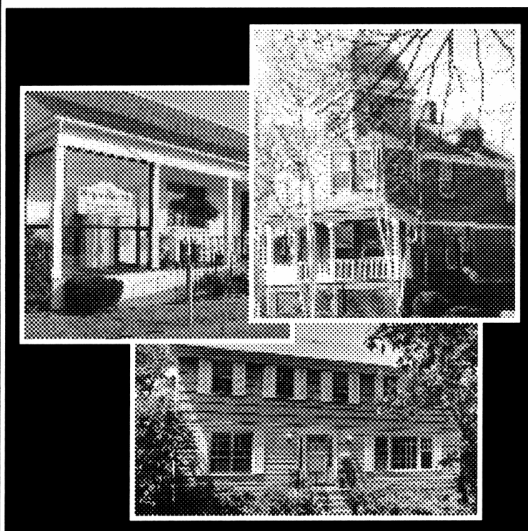
Prevention, treatment, rehabilitation and self help including:
Mental health and chemical dependency counseling for all ages
Psychiatric evaluations and medication management
Crisis Intervention
Recovery and rehabilitation through Continuing Day Treatment
Advocacy and linkage through Case Management

1808 Route Six Carmel, New York

(845) 225-2700

HDSW

Human Development Services of Westchester



HUMAN DEVELOPMENT SERVICES OF WESTCHESTER
930 MAMARONECK AVENUE
MAMARONECK, NY 10543
(914) 835-8906

HOPE HOUSE
100 ABENDROTH AVE.
PORT CHESTER, NY 10573
(914) 939-2878

Creating Community

- *Human Development Services of Westchester* serves adults and families who are recovering from episodes of serious mental illness, and are preparing to live independently. Some have had long periods of homelessness and come directly from the shelter system.
- *In the Residential Program,* our staff works with each resident to select the level of supportive housing and the specific rehabilitation services which will assist the person to improve his or her self-care and life skills, with the goal of returning to a more satisfying and independent lifestyle.
- *The Housing Services Program,* available to low and moderate income individuals and families in Port Chester through the Neighborhood Preservation Company, includes tenant assistance, eviction prevention, home ownership counseling, landlord-tenant mediation and housing court assistance.
- *Hope House* is a place where persons recovering from mental illness can find the support and resources they need to pursue their vocational and educational goals. Located in Port Chester, the Clubhouse is open 365 days a year and draws members from throughout the region.

Social Anxiety

By Freedom From Fear
www.freedomfromfear.org

Social anxiety, also called social phobia, is a disorder characterized by overwhelming anxiety and excessive self-consciousness in everyday social situations. People with social anxiety have a persistent, intense, and chronic fear of being watched and judged by others and of being embarrassed or humiliated by their own actions. Their fear may be so severe that it interferes with work or school and other ordinary activities. While many people with social anxiety recognize that their fear of being around people may be excessive or unreasonable, they are unable to overcome it. They often worry for days or weeks in advance of a dreaded situation.

Social anxiety can be limited to only one type of situation, such as a fear of speaking in formal or informal situations, or eating or drinking in front of others, or in its most severe form, may be so broad that a person experiences symptoms almost anytime they are around other people. Social anxiety can be very debilitating. It may even keep people from going to work or school on some days. Many people with this illness have a hard time making and keeping friends.

Physical symptoms often accompany the intense anxiety of social anxiety and include blushing, profuse sweating, trembling, and other symptoms of anxiety, including difficulty talking and nausea or other stomach discomfort. These visible symptoms heighten the fear of disapproval, and the symptoms themselves can become an additional focus of fear. Fear of symptoms can create a vicious cycle: as people with social anxiety worry about experiencing the symptoms, the greater their chances are of developing the symptoms.. Social anxiety often runs in families and may be accompanied by depression or alcohol dependence.

How Common Is Social Anxiety?

• About 3.7% of the U.S. population ages 18 to 54 - approximately 5.3 million Americans - has social anxiety in any given year.

• Social anxiety occurs in women twice as often as in men, although a higher proportion of men seeks help for this disorder.

• The disorder typically begins in childhood or early adolescence and rarely develops after age 25.

What Causes Social Anxiety?

Research on the causes of social anxiety is ongoing.

• Some investigations implicate a small structure in the brain called the amygdala in the symptoms of social anxiety. The amygdala is believed to be a central site in the brain that controls fear responses.

• Animal studies are adding to the evidence that suggests social anxiety can be inherited. In fact, researchers supported by the National Institute of Mental Health (NIMH) recently identified the site of a gene in mice that affects learned fearfulness.

• One line of research is investigating a biochemical basis for the disorder. Scientists are exploring the idea that heightened sensitivity to disapproval may be physiologically or hormonally based.

• Other researchers are investigating the environment''s influence on the development of social anxiety. People with social anxiety may acquire their fear from observing the behavior and consequences of others, a process called observational learning or social modeling.

What Treatments Are Available for Social Anxiety?

Research supported by NIMH and by industry has shown that there are two effective forms of treatment available for social anxiety: certain medications and a specific form of short-term psychotherapy called cognitive-behavioral therapy. Medications include antidepressants such as selective serotonin reuptake inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs), as well as drugs known as high-potency benzodiazepenes. Some people with a form of social anxiety called performance anxiety have been helped by beta-blockers, which are more commonly used to control high blood pressure.

Cognitive-behavior therapy is also very useful in treating social anxiety. The central component of this treatment is exposure therapy, which involves helping patients gradually become more comfortable with situations that frighten them. The exposure process often involves three stages. The first involves introducing people to the feared situation. The second level is to increase the risk for disapproval in that situation so people build confidence that they can handle rejection or criticism. The third stage involves teaching people techniques to cope with disapproval. In this stage, people imagine their worst fear and are encouraged to develop constructive responses to their fear and perceived disapproval.

Cognitive-behavior therapy for social anxiety also includes anxiety management training -- for example, teaching people techniques such as deep breathing to control their levels of anxiety. Another important aspect of treatment is called cognitive restructuring, which involves helping individuals identify their misjudgments and develop more realistic expectations of the likelihood of danger in social situations.

Supportive therapy such as group therapy, or couples or family therapy to educate significant others about the disorder is also helpful. Sometimes people with social anxiety also benefit from social skills training.

Treating Anxiety In Childhood OCD

By Flemming Graae, M.D., Director, Child and Adolescent Psychiatry Services and Marni Jaffer, R.N.,C, Coordinator, OC and Anxiety Disorders Service, New York Presbyterian Hospital Westchester Division

Obsessive-Compulsive disorder is a common psychiatric disorder affecting 2-3% of the U.S. population. The World Health Organization has underscored OCD as one of the ten leading medical disorders worldwide in terms of the disability and economic cost it causes. These are remarkable statistics, considering its frequency and the accompanying disproportionate morbidity and social burden. Recent studies suggest that the onset of the disorder is often in childhood or adolescence, even as early as age three, with an average onset age of ten. Thus, a serious disorder of childhood requires early recognition and treatment.

It is often remarked that many people with OCD are unrecognized and untreated, unrecognized because OCD is hidden or not familiar to people, untreated because it is unrecognized. This is especially true for children, given normative parameters for obsessions and compulsions that may obscure recognition, and lack of public knowledge of normal development and how children demonstrate or hide problematic signs and symptoms. OCD can be chronic, and one must assume that there is an even greater impact of untreated or partially treated OCD in the developing child.

Obsessions are persistent, recurring thoughts, impulses, or images that are experienced as intrusive, inappropriate, and distressing, and which are not excessive worry about realistic things. Compulsions are repetitive behaviors or mental acts that a person is driven to perform according to rigid rules in order to reduce distress and the associated worry thoughts. Sometimes there are no apparent obsessional thoughts associated with the compulsions. To reach the threshold of an OCD diagnosis, the symptoms must cause significant impairment in terms of marked distress, time occupied (more than one hr/day), or interference in daily activities.

Childhood OCD is similar to adult OCD, but with developmental differences, that is, children have pre-rational or concrete thinking, are more suggestible, a greater tendency for unmodulated affect, fluid fantasy and reality testing, and varying ability to recognize and describe internal affective and cognitive states. Children may also not experience obsessions as unpleasant, indeed, may experience obsessions and compulsions as satisfying, necessary, or assumed or neutral. A common obsessional theme concerns fear of harm to self or other, usually a caretaker, sibling, or peer. A typical harm obsession might be a fear of physical contamination, with consequent compulsive maneuvers to reduce the anxiety, such as by hand washing or avoiding exposure to triggers of the fear, such as not touching door knobs. Another obsession might be concern about imagined misdeeds, past or future, sometimes with a religious or moral symbolism. Others might be a concern for symmetry or order. Common compulsions include bathing, grooming, checking, touching, or ordering in patterns or sequences. Most children have both obsessions and compulsions, with prominent behavioral maneuvers, sometimes well-disguised, perhaps apparent in one context and not in another, such as at home and not at school. On occasion, a child may have obsessions without compulsions, or may have compulsions with only minimal premonitory urge, varying in feeling tone from neutral to intense anxiety. Childhood OCD symptoms can vary considerably over time, by type, intensity, and pattern of symptoms, which may overlap or replace each other, and may have insidious or abrupt onset. Children will often use phrases such as "getting it just right" to describe the repetitions needed to reach a sense of relief and closure. Thus, the obsessional doubting can be episodic or frequent, context or situation-specific, and may or may not have identifiable triggers. It commonly leads to avoidant behaviors as well as to ritual relief.

Flemming Graae, M.D. and Marni Jaffer, R.N.,C

Often, obsessions and compulsions can lead to severe interference in a child's life, such that a child may not be able to engage in necessary and age-appropriate activities. The child may even be profoundly disabled. For example, a child may be unable to leave the house because of washing or dressing rituals or fears of exposure to environmental triggers, or may be refusing to eat, except in specific ways, or be failing academically because of compulsive redoing or intrusive interruptions of reading or writing. In such circumstances a child may become isolated, depressed, even suicidal. More than half of children with OCD will still have it years later, and long term effects will mean gaps and deficits in development and a high risk for additional problems, such as substance abuse and worsening depression. And the impact on the family can be as severe as for the child. Parents may rearrange their jobs and daily routines, marriages may be shaken, and siblings may lack for needed attention.

Comorbid conditions are common, such as tic disorders, Attention Deficit Disorder, mood disorders, and other anxiety disorders. These add complexity to treatment, and, of course, increase risk for chronicity and long-term morbidity. There is also evidence that some cases of OCD are triggered or worsened by the body's immune response to certain infections, such as streptococcus. This has been termed PANDAS, or Pediatric Autoimmune Neuropsychiatric Disorder Associated with A Beta Streptococcus.

There is treatment for childhood OCD, and often it works, and works well. It should consist of multiple approaches, and may, but not necessarily, involve medication or other medical interventions. The essential treatment involves the child, primarily, but also the family, especially the adult caretakers. The psychotherapy techniques used have been adapted from Cognitive-Behavioral Treatment (CBT), family therapy, and social skills training, and are applied in combinations specific to a child's clinical situation and appropriate for the child's developmental maturity. A core technique called *exposure response prevention* (ERP) is typically used, which involves gradual desensitization to fear thoughts and triggers, with prevention of the usual compulsive or avoidant behaviors that, while relieving anxiety, also perpetuate it.

If a child's distress or impairment is significant or a child is unable to engage effectively with treatment, then medication can provide essential relief, reducing the anxiety and the need to obsess or ritualize, and allow psychotherapy to work. The most common and most effective medications used for OCD are called Specific Serotonin Reuptake Inhibitors (SSRI). They can work quite well, with side-effects that are usually mild. These include Prozac, Zoloft, Luvox, Celexa, and Paxil. Side effects may include insomnia, inappropriate impulsive behavior, changes in appetite, or hypomania or mania. Usually these side-effects are mild or transient, but they can be problematic, requiring tapering or stopping of the SSRI. Manic symptoms would require stopping the SSRI. If the SSRI is not working adequately, due to side-effects or significant residual OCD, another SSRI may work better for an individual.

Sometimes other medications are used as well to target certain problems, symptoms or control comorbid conditions. On occasion, when multiple treatment approaches are not adequate, other interventions may be helpful, e.g., antibiotics, immunoglobin, plasmapheresis, etc.

New interventions for OCD will become available as research and development permits, perhaps certain forms of alternative medicine or specific antibody therapy, but, at present, CBT that has been developed for childhood OCD, and SSRI therapy, are the most clearly effective for most children. Finding clinicians, however, who have the special skills to deliver these treatments is not easy. Even experts in child psychiatry may not be familiar with these treatments, especially with the psychotherapy techniques. Experts in childhood anxiety disorders are often clustered in hospitals and universities, but may also be found in the community by researching provider lists of the Obsessive Compulsive Foundation, Anxiety Disorders Association of America, American Academy of Child and Adolescent Psychiatry, or American Association of Behavior Therapy. A new foundation devoted to supporting research, education and treatment of childhood anxiety disorders called The Children with Anxiety Disorders Foundation (Can-Do) will also soon be a resource for identifying expert clinicians.

For the references in this article, please call 914 997-5952.

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.

Parity for mental health in insurance and health plans remains a top NAMI priority. Nationally, we are working to persuade the House of Representatives to hold hearings and move legislation already adopted by the Senate with wide support. A House version of the Wellstone-Domenici bill passed by the Senate last year was killed strictly along party lines early this year by a small group of Representatives. But a glimmer of hope was seen with a March 13th hearing of the Committee on Education and the Workforce, Subcommittee on Employer-Employee Relations. More important, the business community is beginning to see the light of parity, with positive testimony by Henry Harbin, MD, for Magellan Health Services and the American Managed Behavioral Healthcare Association, and a favorable Commentary in the December 17, 2001 BusinessWeek.

The science of mental health research has reached parity with other areas of medical science and technology. Breakthroughs in both pharmacology and brain research are rapidly bringing state of the art of research into mental illnesses and substance and chemical dependency into the 21st Century.

Within the past decade many new drugs have come onto the market and are treating mental illnesses with amazing success. The resulting reduced hospitalizations and disability and increased rehabilitation and productivity are enormous benefits to patients, families and employers. Currently, there are more than 100 more new psychotropic drugs in various stages of study and approval, bringing the promise of recovery closer for even more persons struggling to live with mental illness.

Recent research into brain disease has shed light on the biological and genetic causes of many mental illnesses, and has led to a better understanding of the organic basis of such diseases. "Brain Mapping" techniques now offer a diversity of methods for the measurement of brain function, including the use of Computed Tomography (CT) for the diagnosis of disease. Other brain imaging methods include Magnetic Resonance Imaging (MRI), Single Photon Emission Computed Tomography (SPECT) scanning and Positron Emission Tomography (PET) scanning. These techniques not only aid in diagnosis, but also are assisting scientists to unlock what had until only recently been mysteries of the brain.

Finally, since the mapping of the human genome, genetic research is making significant progress in establishing the basis for potential cures for various mental illnesses and brain disease. The result of all of this encouraging progress is that a number of mental illnesses are actually more treatable than many "physical" illnesses. The treatment success rate for a first episode of schizophrenia is 60%, the rate is 65% to 70% for major depression and 80% for bipolar disorder. Compare this with the only 41% of heart patients who are benefited by the popular and insurance-covered procedure called angioplasty. The potential for even more breakthroughs in treatment, and even cures, is vast, as are the potentials for erasing the stigma and discrimination that has flowed from the outdated concept that mental illnesses were somehow different from other diseases.

Pressure mounts in New York to re-enact the Community Mental Health Reinvestment Act, which keeps savings from the downsizing of the state psychiatric system within the mental health field at the local level. NAMI-NYS calls for tying such re-enactment with a major, nonpartisan study of mental health needs and system capacity. Joined by the Mental Health Association of New York State, Families Together in New York State and others, NAMI-NYS has taken a bold lead to try and ensure that future changes are made in accordance with a system wide, rational and nonpartisan planning effort. Within that context, NAMI-NYS supports badly needed cost-of-living adjustments (COLAs) and Medicaid fee hikes to improve the horrendous wage levels of community mental health workers. The result of these low wages is a personnel turn-over rate of crisis proportions.

NAMI-NYS recently has spoken out against two legislative proposals. One, at the state level, would have the effect of severely restricting access to electroconvulsive therapy (ECT) in a manner unlike any other medical treatment. Assembly Mental Health Committee Chair Martin Luster sponsors this idea which NAMI-NYS believes is ill-conceived and unnecessary. ECT is a proven safe and effective treatment beneficial to many people. United States Senator Chuck Schumer has proposed linking lists of persons seeking medical treatment for mental illness at psychiatric hospitals with the National Criminal Background Check System. The intent is to prohibit gun sales to dangerous people, but its impact strikes very wide of the mark. I have even gone so far as to call this "Medical McCarthyism," as it relies so heavily on myth and misperception about persons with mental illness, and flies in the face of all we have tried as a society to accomplish in the areas of medical confidentiality, privacy and civil rights. It would also create ill-advised and dangerous dis-incentives to seeking needed medical care. Both Luster and Schumer are friends of NAMI and the feeling is mutual; however, we must differ with them on these ideas.

NAMI-NYS held our annual Legislative Breakfast and Conference in Albany on February 12th with more than 250 in attendance from across the state. Our Agenda for Action called for: parity, more funding for supported housing and community residences, adult home reform, the planning study and reinvestment, more support for Program for Assertive Community Treatment (PACT) teams and employment opportunities, establishing presumptive Medicaid eligibility for persons with mental illness leaving hospitals and prisons, increased research funding and criminal justice reforms.

NAMI National's annual convention will be held June 26-30 in Cincinnati with the theme of Building Communities of Hope: Science, Supports and Dignity. NAMI-NYS's 2002 Educational Conference and 20th Anniversary Celebration will be held October 25-27 at the Crowne Plaza Hotel in White Plains, New York. Both events promise to be spectacular.

A Mental Health News Message:
Contact Your Local NAMI Chapter to find an important community of hope and support for consumers, families and friends.

The MHA Connection

Mental Health Association in New York State, Inc.

194 Washington Avenue Suite 415
Albany, NY 12210
Phone: (518) 434-0439 Fax: (518) 427-8676
Website: www.mhanys.org

By Joseph A. Glazer
President & CEO, MHANYS

Joseph A. Glazer

It is a pleasure to join my colleagues as a writer for this outstanding publication, Mental Health News.

Recognizing that the Mental Health News readership is growing by leaps, it is possible that not all the readers are familiar with the role and structure of the Mental Health Association (MHA) network. MHAs are an affiliated group of organizations, numbering more than 340 across the country, all linked to the National Mental Health Association (NMHA) in Alexandria, VA. The Mental Health Association in New York State, Inc. (MHANYS) is based in Albany, and is the statewide organization representing 33 affiliates serving 54 of New York's 62 counties.

MHANYS provides training, education, information, linkage and advocacy for its network. We are recognized across the state for our work in employment, parenting, information, antidiscrimination, criminal justice and mental health advocacy. We are partners with the NYS Office of Mental Health, working with them on numerous programs that build teams, develop new models and help communities better understand and serve the needs of people living with mental illnesses. We are also partners with the federal Center for Mental Health Services, as we embark on Phase II Community Action Grants.

One will be implementing Individualized Placement and Support (IPS), an exemplary employment model in Orange County, New York, while the other will bring a unique model of Jail Diversion to Albany County.

We partner with our affiliates in all of our efforts, and this is demonstrated most greatly in our advocacy. With the state budget appearing near resolution as deadline for this article approached, the most pressing budget issues we focused on this year were the extension of the Community Mental health Reinvestment Act, a Cost of Living Adjustment (COLA) for community mental health workers, and a 10% Medicaid Fee hike.

Beyond the budget, several issues remain on the table for 2002. First, Mental Health and Chemical Dependency Parity must be adopted this year. According to a recent actuarial study by PriceWaterhouseCoopers, the cost of eliminating discrimination against mental health and chemical dependency in commercial health insurance amounts to $1.26 per person per month. According to a recent poll by Zogby International, 77% of those asked believed that the current discriminatory practices should be eliminated, and 81% were willing to pay the $1.26 more for their own policies.

MHANYS also continues to draw attention to New York's lack of a comprehensive system of community-based care. Our state lacks housing, sufficient community-based services, sufficient compensation so that high quality workers are recruited and retained, and continues to be far too invested in the oversized state psychiatric hospital system. Every day, a thousand of our kids are in state run institutions, half of them not even in their home state. We are working to fix this system.

We are working to protect access to high quality medication and treatment through Medicaid and commercial health insurance. We are among the state's leaders in efforts to help people living with mental illnesses get redirected from the criminal justice system, demanding proper treatment for those who are incarcerated, and ensuring access to treatment, through the immediate restoration of Medicaid when people are released from prison, jails and hospitals.

MHANYS is also striving to make it easier for busy people, including those who are focused on furthering their own recovery, to be heard. You can join one of our many MHA affiliates across the state, or you can work directly with our advocacy efforts to make your voice heard.

We have begun an on-line advocacy effort, focusing on both current issues, as well as the core root of advocacy—educating elected officials.

Our website, which can be found at www.mhanys.org, can link you directly with state legislators. On our home page, a click on "Advocacy Now, Contact your Legislators" will give you the opportunity to send letters of support or opposition regarding pressing legislative matters to your Senators and Assembly members in Albany.

"Real People, Real Stories" is an opportunity for people who are working towards their recovery to tell their stories directly to the state legislators who represent them in Albany. This program seeks to provide first hand information to decision makers to help them better understand recovery and living life to the fullest.

By clicking on "Real People, Real Stories" on our Home Page, you can share your thoughts with your state legislator. Please tell them about what has worked for you, what has not, and obstacles you have encountered along the way.

Please keep in mind that you should try to build positive images of recovery. Threatening or harassing anyone, including an elected official, does a disservice to what our message is about, and could have serious, including legal, consequences. MHANYS is not responsible for the content of any messages sent through "Real People, Real Stories."

Should you have any questions, you can always contact our organization directly, at 518-434-0439, or visit us and contact us through our website, www.mhanys.org.

Mental Health News Wants To Help You Get Connected

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

Franklin Marquit, CEO and Founder, NAMH, Inc.
NAMH • 365 Main Street, Catskill, NY 12414 • 518-943-2450 • www.namh.org

Franklin Marquit

I am pleased to report that we just completed our fifth annual "Art of Healing Conference," and the consensus of all the participants was that this was our *best ever conference*. The theme of this year's three-day conference was "The Path to Healing." Other comments about the conference were that we provided "high quality workshops," and that this was a "life changing event." All I can do is step back and say, wow!

Our presenters were 60% recipient and 40% non-recipient. We have learned through past conference experience that diversity among workshop topics is the key to our success. This conference included old and new exciting workshops thus reaching out to a more diversified audience. Our past history of success and improvements in planning and implementation resulted in a wider dissemination of expressive arts and complementary healing techniques. Through this process, our goal was to improve on the quality of mental health recipient programming and prevention services. By presenting effective healing and recovery techniques, this unique conference enabled recipients to take a more active role in their own recovery by using these self-help techniques to reduce the occurrence of more severe symptoms. Many of our dynamic workshops are effective in reducing stress and learning new holistic coping strategies to foster day-to-day self management.

A review of current literature on complementary healing indicates a growing acceptance of non-medical means to improve recovery and quality of life for recipients. The number of research citations is very large for topics like aromatherapy, vitamin therapy, journal writing, relaxation techniques, expressive arts, yoga and visualization. It is clear that the information and interest in non-traditional healing techniques has increased over the past decades. Our conference is a capstone for this national trend in the 2000's and the launching pad for the recipient wellness movement. Wellness is a state of total well being including emotional, social, intellectual, physical, spiritual health and vocational.

When participants were asked what they liked best about the conference, the most frequent response was the mutual support and sharing of insights they experienced. In response, we will continue to use the "hands-on" experiential format of holistic learning which focuses on processing and enhancing the environment conducive to healing. This approach to learning will also highlight working together, sharing resources, and enhancing participants' feelings of support and connectedness.

National Artists for Mental Health began in 1991 as a peer-run drop-in center for mental health recipients in Greene County, New York. As the Founder and a mental health advocate, I teamed up with noted artist Ralph Ivery to create an organization based on the idea that "expressive art" has the "power to heal." We began holding expressive art sessions at the Drop-In Center in Catskill, NY. Participants worked in any medium they wished, from painting and drawing to sculpture and creative writing. Far from a formal art instruction class, these sessions stressed the importance of the act of creating as a means to getting in touch with personal issues and becomeing more self-aware. One underlying belief was that communication is the foundation of recovery, and the need to communicate was often hampered by the boundaries and limitations of our spoken language. The expressive arts provided unlimited ways in which to communicate the most complex thoughts, feelings, and emotions.

At first, some participants were reluctant to participate. Some felt that they were not artists and therefore had no business trying to create art. Mr. Ivery, who led the workshops, continually encouraged and promoted the idea that the act of creating was more important than what was created. To further combat this self-esteem issue, it was decided to hold a public art exhibit to display the work created in the sessions. This would give outside validation to the works and instill pride in those who created them.

Ever mindful of additional alternatives of support for my own recovery and that of my peers, I began investigating the options available in the field of Holistic Health. The nurturing of the mind, body, and spirit fit nicely with the idea of treating the whole person, a linchpin in expressive arts healing. Soon, workshop demand began to grow with the conference and Holistic Health workshops are now part of our core conference presentations.

In all these ways and others, NAMH promotes the use of the expressive arts and holistic health to improve the quality of mental health treatment, healing and prevention.

The need for this conference stems from the reality that many people in recovery simply aren't aware that there are options beyond the traditional medical model. This is what is meant by having choices and self-determination in one's own recovery process. There is a very real threat of stagnation in recovery, especially when there is heavy reliance on the medical model. Although medications are an important part in stabilization and recovery, this stabilization is only one part of recovery. It's one piece of the holistic pie. Many people diagnosed with mental illness stagnate at this level, find themselves frustrated and dissatisfied, and may decide to simply give up and accept their fate.

This does not necessarily mean that one can replace the traditional model with these approaches. From my perspective, I believe it can enhance and be a supplement to the recovery process. It is generally accepted that severe and persistent symptoms of mental illness are either the result of biochemical imbalances or emotional trauma. In our experiences, we have yet to find a replacement for the fast-acting and consistent stabilization that medication provides when combating such potent forces. Therefore, we promote complementary techniques as healing supplements designed not to replace, but to enhance and integrate the process of recovery. In our conference and other presentations, we make this point very clear, as there is always a potential danger when one discontinues a recovery plan. This point can not be emphasized enough; complementary healing is a supplement to be integrated into a recovery plan, not a replacement for it. I personally believe that the more whole person coping strategies that are incorporated into one's recovery plan that often, there are less symptoms to deal with and less medication is needed.

For the purpose of knowledge dissemination of supplemental recovery options designed to improve mental health recovery, our conference is the ideal platform. Our three-day conference presents 35 to 40 workshops and other presentations encompassing a wide range of techniques and approaches. For participants, it is a wealth of information, and because of the experimental nature of the workshops, it is a proving ground where they can gain first-hand experience. Thus, each participant has the opportunity to truly gauge the efficacy of each approach. Within the development and implementation of our conferences, it is our desire to continue to disseminate this knowledge long after the conference is over.

Our goal is to continue to plan, coordinate and implement a three-day conference that will enhance the use of expressive arts and complementary healing techniques in the mental health community. By increasing the number of attendees who actually experience the benefits of whole person healing, we will increase the likelihood that these strategies will be employed and further integrated into the traditional medical model of mental health recovery.

This year all workshops and the keynote address focused on expressive arts, complementary techniques, and advocacy. Examples of the types of workshops offered included: Dance/ Movement Techniques, The Healing Power of Poetry and Art, an Introduction to Psychodrama, The Role of the Expressive Arts, Wellness Action Planning, Food Mood Connection, Nutrition, Drawing, Guided Visualization, Spirituality, Mask Making, Aromatherapy, Expressing your Dreams Through Art, Healing Oneself Through Art, Zen Art Practice, Art and Your Livelihood, Meditation and Grant Writing.

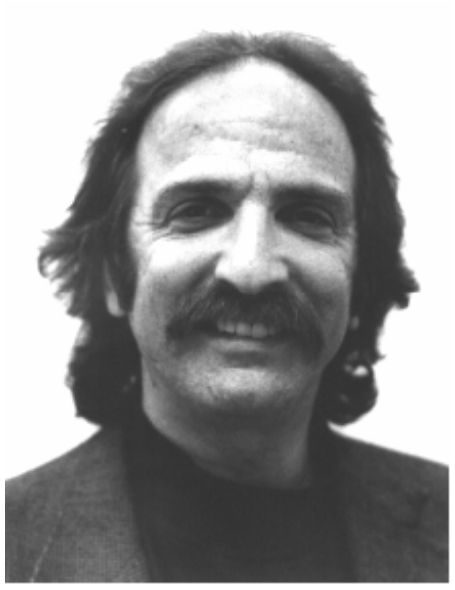
By offering workshops that experientially teach healing techniques and providing keynote addresses that support them, we provide the necessary ingredients of skill and support for individuals to adopt these strategies and bring them home and take a more active role in their own recovery. Service providers and family members will also gain useful information and techniques to reduce stress and enhance personal growth. This, in turn, may result in more service providers and families integrating these healing approaches into treatment plans and everyday life. Thus, our program supports the overall health of our peers directly and indirectly. Join us in our recipient wellness movement.

I wish to thank Mental Health News Publisher, Ira Minot, for his vision and concern for reporting on consumer issues and in giving NAMH an opportunity have a regular column in Mental Health News. I urge everyone to write to Ira at mhnmail@aol.com to give him a well deserved thumbs-up and to let him know how you like our new NAMH column.

For more information about NAMH, please contact us at (518) 943-2450 or e-mail us at namh@namh.org and please visit out our website which can be found at www.namh.org.

THE NYAPRS ADVOCACY WATCH

By Harvey Rosenthal,
New York Association of Psychiatric Rehabilitation Services



Harvey Rosenthal

"New York State's Mental Health Community Getting More Powerful All The Time"

"...the mentally ill are among the most powerless of all populations, lacking the political influence to demand change..." from "Ingredients of a Failing System: A Lack of State Money, a Group Without a Voice" by Clifford J. Levy, New York Times, April 28, 2002

Last January 29, upwards of 600 New Yorkers with psychiatric disabilities and community mental health professionals assembled at the Hart Theater in Albany's Egg, determined to use their growing involvement in New York's political process to press state leaders for a package of 7 priorities.

Developed from a series of grassroots forums conducted throughout New York State by the New York Association of Psychiatric Rehabilitation Services (NYAPRS) during the previous fall, the group's priorities included:

- **Medicaid Buy-In:** a measure addressing the top reason why most New Yorkers with disabilities have not gone to work, by creating a system where they can pay into the continuation of their critical Medicaid health care benefits.

- **Cost of Living and Medicaid Fee Hike:** funding increases to address the workforce crisis in hard-pressed community mental health agencies.

- **Restoration of the Community Reinvestment Act:** renewal of New York's landmark program to re-direct savings from state hospital downsizing to address the most urgent needs in New York's community mental health service system.

- **Adult Home Reform**

- **Electroshock Rights and Protections Legislation**

- **Legislation to Stop the Inhumane Solitary Prison Confinement for Inmates with Psychiatric Disabilities**

The first priority, state approval of the Medicaid Buy-In, was approved even before NYAPRS members got to town. The Buy-In was attached to the major healthcare agreement that preceded the beginning of state budget discussions, a deal fashioned to provide hospital and nursing home workers with a multi-year pay hike package. NYAPRS members had led the way in the fight for the Buy-In over the preceding 18 months, working closely with colleague groups in the state's disability advocacy community to lead a fervent series of demonstrations, media work and call-in campaigns that even included having several of our staff arrested outside the Governor's office.

Hence, one of the highlights of the January 29th NYAPRS legislative day was giving an award to Assembly Speaker Sheldon Silver for his special effort to tie the Buy-In to the healthcare deal and to celebrate this landmark work incentives program, which is due to take effect next April, with our many new friends in the state's cross-disability movement.

Second, breaking news out of Albany today (May 3) is that community mental health agencies will be one of the few groups tapped by legislative leaders and the Governor to join the hospital and nursing home groups in receiving new funding to provide pay increases for their hard-pressed dedicated workforce. The increases will apparently come in the form of a 3% Cost of Living Adjustment (COLA) for those agencies funded by state grants, and a 10% fee hike for those agencies funded by Medicaid.

From January to April, NYAPRS members from across New York has joined our friends and colleagues in New York's mental health advocacy community to put on a fierce campaign that graphically laid out the crisis in our community mental health service system and the case for a COLA and Medicaid hike, a campaign peppered with an Albany demonstration, numerous statewide phone and fax drives, a post card campaign and concerted media work that yielded 3 supportive editorials and a steady stream of newspaper, radio and TV coverage.

The advocates' work will not stop here though: they will continue to keep the pressure on all fall to prevent a potential post-Gubernatorial election effort to pull back the funding increases.

Third, as of today, it appears that Senate and Assembly mental health leaders are determined to see new legislation passed shortly that will restore and renew the Community Reinvestment program, giving hopes for additional funding relief in the coming years.

Fourth, this year, NYAPRS members joined the campaign for adult home reform, highlighting the terrible plight of almost 15,000 New Yorkers with psychiatric disabilities who reside in deplorable conditions in deficient homes all too often run by untrained and unscrupulous owners. Led by Co-President Jody Silver and Public Policy Co-Chair Ray Schwartz, our members have vigorously worked alongside our colleagues from SCAA, NAMI and other groups to help publicize this scandal and to help draft corrective policy papers.

These efforts were capped, last week, by a well-timed Albany press conference held to coincide with the final installment of a hard-hitting expose written by New York Times investigative reporter Cliff Levy. The advocates' efforts were well rewarded, with a host of new measures proposed even a half hour before their news conference by the Governor, and with the Assembly's announcement to promptly hold public hearings on this issue.

Among the measures put forth by the Governor and the Health Department are the establishment of a special state workgroup to address this scandal that will bring adult home resident advocates to the table with the heads of all the relevant state agencies, new funding for in-home advocacy, legal rights and peer bridger services and for more state investigators, a complete cut off of referrals to deficient homes, higher fines, public posting of home deficiencies and consideration for a single locus of state accountability through the potential creation of an Adult Home 'Czar.' While much more needs to be done, these measures are important steps along the way.

Fifth, we are expecting to see passage of several new bills increasing the rights and protections of those New Yorkers who are considering or being considered for controversial electroshock treatment. NYAPRS members, led by Public Policy Committee Co-Chair Susan Perr have strongly supported the Assembly's newly revised package of 4 bills boosting informed consent and requiring greater state oversight over the procedure and the equipment. We have also strongly advocated with the Senate, which appears to be prepared to approve several of the measures shortly.

Finally, mental health groups led by NYAPRS' Lauren Pareti have joined with an impressive array of legal rights, prisoner's rights and related groups to push for new legislation that would stop the inhumane solitary confinement of state prison inmates with psychiatric disabilities. Recent reports show that 1/3 of all suicides in New York's prisons are by inmates with such backgrounds who were confined in these 'special housing units', or SHUs. The groups are expecting to see passage of an Assembly bill this year, and will be looking to get approval by the Senate and Governor next year.

While we may battle tremendous social stigma, lack huge financial resources and have been plagued by fragmentation and disunity in the past, New York's mental health community has come a long way this year in successfully being heard in Albany.

Next step: the successful mobilization of tens of thousands of New York voters into a unified and powerful mental health voter block !

Save The Dates:
September 10 - 13, 2002,
NYAPRS 20th Annual Conference
Nevele Grande Resort
Ellenville, NY
Contact: Mary McLaughlin
NYAPRS
1 Columbia Place
Albany, NY 12207
(518) 436-0008

WORKING WITH MEDICATIONS

Understanding Psychotropic Medications: Where do they come from?

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

Dr. Richard H. McCarthy

Most Psychiatric medications work in the brain by changing how the nerve cells communicate with one another. This, in turn, changes how the brain functions over time. It is this change in how the brain functions that we regard as healing. Unfortunately, it is not possible to have a drug work at only one small part of the brain. Nor is it possible to have a drug only do what we want. All medications have beneficial effects, which is why physicians prescribe medications and patients take them. However, there are negative effects as well, which physicians would prefer to avoid and patients certainly dislike. This combination of desirable and undesirable effects of medication is a necessary correlate of how drugs are discovered and developed. In this column I will discuss a little bit about how our drugs were discovered in the past, how we go looking for them in the present and how we test them to make sure that they are both safe and effective.

Discovering Antipsychotic Medication

The first major discovery of psychopharmacology came not from psychiatry but from anesthesia, and most of our subsequent medications have evolved from this chance beginning. In the early 1950's, anesthetists were looking for a medication that would block inappropriate, compensatory, but harmful, autonomic responses of the body that would occur during surgery. In essence, the body's self-corrective mechanisms would get in the way of the surgery that was being performed. Chlorpromazine, more commonly known today by the brand name Thorazine, prevented these over reactions and, thus, made surgery safer. It was also noticed that surgical patients who happened to also suffer from psychosis would improve somewhat after the use of this medication. More importantly, chlorpromazine, when used to address the symptoms directly, was shown to be able to ameliorate the symptoms of psychosis. In an early clinical trial in Montreal, six consecutive psychiatric patients were treated with chlorpromazine on admission to the hospital. Amazingly, all of these patients were discharged within six months. At the time this was an absolutely stunning occurrence. There were very few, if any, effective treatments for acute psychosis. In those days, length of hospital stay was measured in years, not months or days. Frequently, patients were admitted to the hospital and would never leave at all, spending the rest of their lives there. While it may be hard to believe today, in those days before FDA (Food and Drug Administration) approval, chlorpromazine was smuggled into the United States by families desperate to treat their loved ones. The discovery of this single drug that was able to treat psychosis inspired scientists to look for other agents. Unfortunately, the tools available for scientists, then as now, were limited.

Discovering Antidepressant Medication

The discovery of the first medications that could treat depression occurred in medicine not psychiatry. In the early 1950's it was noticed that tuberculosis patients who were being treated with iproniazid often had prolonged elevation in their mood. This medication ultimately was shown to be ineffective against tuberculosis, but investigators began to examine other medications from the same class of drugs, the MAOIs, the Mono Amine Oxidase Inhibitors. Some of these proved to be quite useful treatments for depression. Perhaps, more importantly, knowledge of the biological and pharmacological properties of the MAOIs led scientists to investigate the role of two brain chemicals, norepinephrine and serotonin as possible links to depression. From what we knew about biology, physiology and pharmacology, it was reasonable to believe that slight changes in the chemistry and, therefore, the shape of the molecule might lead to better medications. Following the discovery of chlorpromazine's usefulness in the treatment of psychosis, scientists modified the molecule and came up with a new drug called imipramine. When this drug was tested on people with psychosis, psychiatrists noticed that it did little for the psychosis but did make patients considerably less depressed. In relatively short order, scientists had found both medications could treat depression and important clues about how the brains of depressed people might function. What followed was a period of significant activity during which time a wide variety of medications were discovered.

What is safe and what is likely to work?

Before a medication is ever used with people, it is first tested on animals. Scientists must first determine that a medication is not toxic and that it is safe to give to people. Secondly, scientists must determine whether the medication is likely to effectively treat the illness of interest. The first question, determining safety and toxicity, is relatively straightforward. Usually, but not always, medications that harm animals will also harm people and often in similar dose ranges, when adjusted for size. The second question is far more complicated. We simply do not know if animals suffer from psychosis or depression or any other psychiatric disorder. Even if they do we do not know what the symptoms of these illnesses would look like in animals. As a result, we need to have approximations, called animal models, of these human illnesses in animals. There are two kinds of animal models.

Animal Models of Mental Illness

In the first model, called an animal assay, scientists examine specific behavioral and physiological responses of an animal that previous scientific evidence suggests are important in a disorder. If we alter dopamine levels in the brains of rats we can cause changes in certain behaviors to occur. By measuring how different medications change these behaviors, we get a general index of the effects these medications might have on people. For example, we know that dopamine is an important chemical in schizophrenia and that lowering the amount of this chemical can help reduce the symptoms of psychosis. We also know that we can make rats quite stiff if we give them medications that lower brain levels of dopamine. Any medication that can make a rat stiff might also lower dopamine in the brains of people with schizophrenia and, therefore, help alleviate psychosis. Similarly, any medications we find, as in this particular example, will simultaneously alleviate psychosis as they cause adverse effects such as stiffness. This is because both the desired and undesired effects are caused by the same chemical system operating in different parts of the brain. Animal assays tell us about an underlying biology and how that biology is influenced by medications. A limitation of animal assays is that we will largely be developing drugs that work in the same way that other, previously discovered, drugs work. This method may help us develop newer drugs, but it is not likely to lead us to novel drugs, drugs that work by a different mechanism and that might be more effective.

The second kind of animal model is referred to as homologous model. These models seek to create a disorder in animals that is similar to the disorder in people. So, for example if we can find a way to make a rat anxious we might also be able to develop a treatment that could minimize that anxiety.

See: *Medications* on Page 31

Aging With Anxiety - A Comprehensive Approach

By: Laszlo Papp, M.D. and Debbie Eisenstadt Mandel, M.A., Columbia University College of Physicians and Surgeons, New York City.

The elderly are confronted by many real life stresses such as: illness, disability, retirement, poverty, alienation, widowhood and the empty nest. These stressors may cause the elderly to present with a variety of physical and emotional problems warranting a visit to the family practitioner who might not even consider the possibility that these symptoms are due to anxiety. A common patient doctor scenario is, "Well, at your age with all that you are experiencing, what do you expect?" It is also possible that this scenario reflects a prejudice against the elderly. For example, we accept and understand an identity crisis in teenagers but ignore it in the elderly. For women, widowhood may be compounded by the dilemma of holding on to their married name which is an important part of their identity. Dismissing their anxiety disorders, their tears, as part of "generalized aging," may parallel the earlier medical approach to dementia, until we began to understand the pathophysiology and course of Alzheimer's disease.

The truth is that Generalized Anxiety Disorder (GAD) is more prevalent in the elderly than in the young. At least 20% of the elderly suffer from clinically relevant anxiety, yet the diagnostic criteria are the most deficient, and the disorder is the least researched. First, the symptoms of GAD are highly variable including signs of motor tension, autonomic hyperactivity and hyper-arousal. Patients are restless, unable to relax and experience fatigue. Motor tension causes frequent headaches, chronic muscle pain in the shoulders, neck and lower back. Second, recall in some of the elderly is poor and, therefore, most symptoms are not communicated. Third, many elderly see their non-mental health practitioners for gastrointestinal, cardiac symptoms, endocrine abnormalities, and nutritional deficiencies, etc. and, therefore, the underlying or concomitant condition of GAD is rarely addressed.

Recent studies exploring late life anxiety disorders suggest that most patients can benefit from medical management including tapering medications when appropriate along with Cognitive Behavioral Therapy (CBT). This strategy should help patients realize a reduction in drug use and an alleviation of both psychological and physical symptoms.

The long-term use of anxiolytic medications in older patients is controversial. While the benefits are numerous, (e.g., rapid onset, effective symptom relief and gradually improving side effect profiles of newer compounds), these benefits need to be weighed against drug dependence, cognitive impairment, and accidental falls. It has been confirmed in several well controlled trials that CBT as an adjuvant to medications has many advantages for the elderly. In addition to facilitating medication taper, CBT can be easily extended to address co-morbid conditions most commonly, depression. Almost every psychological measure, whether of anxiety, depression or collateral symptoms such as somatization or hostility, show significant improvement following CBT treatment.

One of the most attractive features of CBT is its flexibility and hospitality to alternative treatments. A wide variety of techniques, strategies and exercises are easily incorporated without undermining the main tenets of the treatment. Nowadays, complementary medicine is on the rise because patients feel that traditional medicine may not have all the answers. Through traditional and progressive medical programs, many of them mind/body workshops, patients learn to participate actively in their own healing. The success of CBT techniques suggest that simple tools of self-empowerment, easily learned cognitive strategies and behavioral exercises may transform the lives of many elderly even without formal medical intervention.

Increasingly, senior citizens are attending workshops on de-stressing and coping with anxiety, depression, anger and resentment. They are taught autohypnosis, meditation and breathing practices as well as gentle yoga and qi-gong exercises. The regularity and consistency of these workshops at senior centers establishes continuity for the participants who in turn socialize and share in these support groups. In addition to the specific techniques learned, the group setting also alleviates the social isolation that frequently fosters and exacerbates anxiety. Learning to relax by creating auto hypnotic affirmative statements could also supplement CBT. Learning to reinterpret the personal stressful picture, as well as bringing attention to rhythmic and deep breathing, provide the elderly with a sense of much needed control. As some of the elderly do not even report their anxiety and depression because of the stigma attached, these workshops could provide a non-judgmental first line recourse, paving the way for a comprehensive evaluation and treatment, if needed.

Mainstream medicine is finally recognizing the value of non-traditional approaches, much of it from Eastern traditions. Hopefully, we can also garner the respect attributed to the elderly inherent in these traditions.

Laszlo Papp, M.D. is Associate Professor of Psychiatry and Director of the Biological Unit at Columbia University. He is also Director of The Anxiety Disorders Research program at North Shore Long Island Jewish Health Systems.

Debbie Eisenstadt Mandel, M.A., is author of the forthcoming book, Turn On Your Inner Light, a noted university lecturer and motivational speaker. She creates mind/body workshops for senior centers, medical centers, universities and corporations and has been featured in publications, on radio and television.

Medications from page 30

This model has the potential to develop novel drugs that work by an entirely different mechanism than previous medications. However, this model is limited because what we think may be anxiety in a rat may be something else altogether. A classic example of this occurred several years ago when scientists tried to breed very anxious rats. One of the things that rats do when they are anxious is move around and defecate frequently. If we place rats on a grid and count the number of boxes they run into and the number of "pellets" they defecate, we may have a measure of how anxious the rat is. The scientists selected the rats that moved around the most and defecated the most frequently, believing that they had the most anxious rats. After several generations of breeding these rats, one with another, what they ended up with were rats that might have been anxious but, most importantly, they had non-functioning anal sphincters. They had developed rats that would defecate often not rats that were necessarily anxious. Obviously, medications that were developed using this model would probably be more effective at causing constipation than treating anxiety. There are other difficulties with the development and use of homologous models in medication development. Homologous models of behavior seek behaviors that are the same and often only get behaviors that look the same. If we are going to compare behaviors across species we will often think we are looking at one thing when we are really looking at something else. Perhaps a biological analogy would help here. The fins of fish and flippers of seals look similar, perform many of the same functions in the same environment but have evolved in totally different ways. While we can learn something about flippers when we look at fins, we cannot learn everything; and we may not learn what we want to know.

People Enter the Picture

At present, we first find potential medications by screening drugs using animal models and secondly, by testing these medications with people. The animal models establish toxicity and safety as well as the possibility that a drug may effectively treat illnesses. However, in order to establish that a medication is truly both a safe and effective treatment, it must be tested with people. Collectively, all of these studies are referred to as Clinical Trials. These trials take place in three quite different, closely monitored phases. Each phase has a different objective, and participation in any phase can only occur after a volunteer has been informed of the potential risks and benefits and given his consent.

Phase I trials involve small numbers of healthy volunteers who are free of mental illness. Each of these dozen or so volunteers is given the study medication in a variety of doses. The only purpose of Phase I trials is to establish that the medication is safe for humans to take. As a result, volunteers in these trials have large batteries of tests that they must take throughout the study period to assess the biological, pharmacological and psychological effects of the drug. If a medication passes this phase, and most do, it goes on to Phase II.

After informed consent, Phase II Clinical trials take place. The purpose of this set of trials is to determine if a medication actually addresses the psychiatric problem that we think that it does. Thus, a few hundred patients with the illness in question who have volunteered are given the medication. There is typically a control group. The scientists compare the positive and negative responses of the volunteers that took the new medication with the responses of those volunteers who did not receive the new medication. This helps the researchers determine that the medication is doing what they want it to do. If a medication is found to be treating the psychiatric difficulty in question, it is then moved foreword into Phase III.

Phase III clinical trials involve thousands of volunteers all of whom have the illness under study. Typically there are multiple study sites throughout the United States. There is almost always a placebo control group. This group of patients does not receive the test medication but instead receives an inactive substance, such as sugar. This group is particularly important in determining whether or not the new medication is better than no treatment at all. If it is not, then it is unlikely to be approved. The Control Group is also very useful in determining the relative frequency of adverse effects of the new medication. Should a medication pass Phase III, i.e., it is shown to be both safe and effective, the information is presented to the FDA for approval. If you look up a drug in the PDR (Physicians Desk Reference), you can read the document that describes the drug and its actions and adverse effects that the FDA approved.

Following approval, new medications continue to be monitored for a period of ten years. This is referred to as Phase IV. Occasionally, approved drugs are withdrawn during Phase IV because of unusual and unanticipated adverse effects occur.

Psychiatric medications go through a lengthy process before they end up in the pharmacy. While the methods we have evolved to discover medications thus far are somewhat primitive, some of the newer technologies offer hope that we will be able to develop far better medications than you have had available thus far. These technologies include the development of more elaborate medications, far better animal assays and homologous models, dramatically improved and more sophisticated chemistry, better understanding of the biological basis of illness, and finally the development of better ways to examine the functioning of the brain.

Subscribe

Yes! I want to receive each Quarterly issue by Mail

- ☐ Consumer/Survivor/Ex-Patient ($15/year)
- ☐ Student ($25/year) School/Program _____
- ☐ Individual/Family ($35/year)
- ☐ Group - 50 Copies Each Issue ($250/year)

Order a Gift Subscription for A Friend - Give a Gift of Hope

Name & Title: _____

Organization: _____

Street: _____

City: _____ State: _____ Zip: _____

Include your Check Payable to:
Mental Health News

cut out this coupon and mail it with your check to:

Mental Health News
65 Waller Avenue
White Plains, NY 10605
(914) 948-6699

Advertise

*** 25% Savings - Book 3 Get 1 Free!!**

- ☐ Business Card - 4 issues ($320)
- ☐ Eighth Page (1 issue $300 - 4 issues* $900)
- ☐ Quarter Page (1 issue $500 - 4 issues* $1,500)
- ☐ Half Page (1 issue $750 - 4 issues* $2,250)
- ☐ Full Page (1 issue $1,000 - 4 issues* $3,000)
- ☐ Inside Cover Pages (please call)
- ☐ Back Cover Page (please call)
- ☐ Supplement Section (please call)

Name & Title: _____

Organization: _____

Street: _____

City: _____ State: _____ Zip: _____

Include your Check Payable to:
Mental Health News

cut out this coupon and mail it with your check to:

Mental Health News
65 Waller Avenue
White Plains, NY 10605
(914) 948-6699

Communicate Your Message To Our 60,000 Readers

Promote Programs & Services | **Expand Your Private Practice** | **Fill Vacant Positions**
Conduct Reader Reply Surveys | **Recruit Volunteers** | **Boost Your Fundraising Campaign**

Deadline Calendar & Ad Size Specifications

Deadline	Release Date
August 1, 2002	October 2002 (fall issue)
November 1, 2002	January 2003 (winter issue)
February 1, 2003	April 2003 (spring issue)
May 1, 2002	July 2002 (summer issue)

Ad Size Chart

	Width	Height
Full Page (1)	10.10”	12.65”
Half Vertical (2)	4.95”	12.65”
Half Horizontal (3)	10.10”	6.28”
Quarter Vertical (4)	4.95”	6.28”
Quarter Horizontal (4)	10.10”	3.09”
Eighth Vertical (5)	2.43”	6.28”
Eighth Horizontal (5)	4.95”	3.09”

Treating Anxiety in Patients With Alcoholism

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

Although increasing attention is being paid to the high frequency and significant consequences of comorbid anxiety symptoms and disorders with alcohol disorders, there has been relatively little systematic study of treatment approaches to these problems. State-of-the-art treatment involves integrating current understanding of anxiety and alcohol disorders and tailoring treatment to individual patient needs. Anxiety and alcohol disorders are the most prevalent disorders in psychiatry, and they usually lead to psychiatric consultation. They present complicated problems of differential diagnosis and difficult treatment selection choices.

The advantages and disadvantages of medications for specific anxiety disorders are affected by the presence of alcoholism. It is more difficult to make an accurate diagnosis of anxiety disorders in alcoholism, especially when the patient is intoxicated. Treatment outcome for alcoholism and anxiety disorders is worse when both conditions are present; however, there is hope that targeting both disorders can improve treatment outcome. Anxiety disorders and alcoholism are underdiagnosed and treatable illnesses, and it is gratifying to correctly diagnose and work with these conditions. There is a need for public education because many consider alcoholism and anxiety disorders to be moral weaknesses, and an illness model aids in diagnosis and treatment. There also are challenges specific to this population. For example, it may be harder to help some patients who attend Alcoholics Annonymous (AA) to accept medication for panic disorder or help patients with agoraphobia or social anxiety who attend AA. However, the combinations of approaches and new developments in pharmacologic and nonpharmacologic treatment for both disorders add to hope for better results.

Magnitude of The Problem

Few people are not affected directly or indirectly by anxiety and/or alcohol disorders. According to recent studies, lifetime prevalence of substance abuse, including alcoholism, is the most prevalent psychiatric disorder (16.9%). Alcohol disorders have a lifetime prevalence of 13.5% and anxiety disorders are the second most common lifetime disorder with a prevalence of 14.6%. Lifetime prevalence of anxiety disorders combined with alcohol disorders is 19.4%, of substance abuse plus panic disorders is 35.8%, and substance abuse plus obsessive compulsive disorder is 32.8%. Approximately 40% to 50% of patients with alcoholism who do not have anxiety disorders have anxiety symptoms.

Although each of these disorders has profound complications and a significant impact on family, work and health issues, effects are worse when the disorders are comorbid. For example, a patient with panic disorder, agoraphobia, and alcoholism may be paralyzed by incapacitating anxiety, housebound, unable to work, chronically intoxicated and unable to make outpatient appointments. Clinicians should be attentive to the high risk of suicide in these patients. Patients with panic disorder have a lifetime suicide attempt rate of 7% and those with comorbid panic disorder (including depression and alcohol disorders) have a rate of 26.3%. Suicidality in alcoholic patients occurs in approximately 17% and is more likely in those who also have anxiety and depressive disorders.

Why, When, And How To Treat Anxiety And Alcoholism

Anxiety disorders are highly treatable, and treatment of anxiety disorders may prevent secondary alcoholism. However, when both are present, alcoholism must be treated first or in synchrony with the other because continued drinking interferes with psychotherapy and pharmacotherapy and reduces compliance. The treatment outcome of alcoholism and anxiety disorders is worse when comorbidity is present; however, it can be improved by attending to both disorders.

When anxiety symptoms are present during alcohol rehabilitation, the question must be raised as to whether medications should be used in treatment. Treatment may improve compliance, function, and comfort and prevent relapse, and medication should be the treatment of choice when anxiety is stable, increasing, or incapacitating and an anxiety disorder diagnosis is clear. Treatment with medication often may not be needed because anxiety may resolve, and medications may be abused and facilitate relapse. Patients in rehabilitation may attribute improvement falsely to the medication rather than to abstinence. In some cases, the use of medications may make an accurate diagnosis more difficult, and medications should not be used when symptoms are transient and diminishing and there is no impaired function. If the diagnosis is unclear and the symptoms are mild, it may be safer to start with nonpharmocologic treatment. Often, the clinician must resist the patient's wishes for quick symptom relief in the interests of making an accurate diagnosis and reducing the chances of relapse.

Psychotherapy for patients with anxiety disorders and alcoholism involves combinations of cognitive-behavioral therapy, relaxation training, stress management , hypnosis, systematic desensitization, assertiveness training, expressive psychotherapy, supportive psychotherapy, family therapy, group therapy, 12-step programs, environmental manipulation, psychoeducation, and aerobic exercise. The advantages of using psychotherapy to treat anxiety in patients with alcoholism include a sense of empowerment and improved self-esteem that comes with not needing to depend on a chemical to feel better. Group therapy and self-help groups develop support networks that are useful for maintaining abstinence as well as providing a support with exposure in patients with social avoidance. Nonpharmacologic treatments may receive more support and acceptance from Alcoholics Anonymous peers. These treatments avoid adverse drug responses and overdose potential (problem of drug interactions) and do not reinforce drug-taking behavior. For those reasons, it is often better to try psychotherapy first in alcoholic patients whose anxiety or anxiety disorder is not severe. In addition to the psychosocial approaches mentioned above, good nutrition, avoidance of caffeine, marijuana, and nicotine, avoidance of overwork, and work changes are additional tools.

Pharmacotherapy

A variety of factors must be considered in selecting medication for patients with alcoholism, including the spectrum of efficacy of a particular drug, its safety in alcoholism, the addiction potential of the drugs themselves, adverse effects of these drugs, especially with the liver, as well as other medical complications of alcoholism. The table below lists the selected pharmacologic treatments of anxiety disorders in patients with alcoholism.

Anxiety Disorder	Medications
Generalized Social Phobia	Fluoxetine Buspirone (MAO inhibitors)
Performance Anxiety	Propranolol Afenolol (β-blockers)
Generalized Anxiety Disroders	Buspirone Imipramine
Panic	Imipramine Fluoxetine (MAO inhibitors)

Among the antidepressants, imipramine has been best studied and has the advantages of proven efficacy in panic disorder treatment, blood levels that can be monitored for efficacy and compliance, not being addictive, and effectiveness with associated depression. Disadvantages include the danger of an overdose, unpleasant side effects and noncompliance, lowering of seizure threshold, and the need for carefully adjusted doses based on either induction of liver metabolism, which can lead to a need for higher doses, or liver failure, which can lead to a need for lower doses. In open-ended studies, fluoxetine has been promising in the treatment of panic disorder and does not have the disadvantages of the danger of overdose, does have fewer side effects than other antidepressants, and appears to be well tolerated by alcoholic patients. Although no antidepressant has been proven to be specifically useful in treating primary alcoholism, it has been hypothesized that serotonergic drugs may reduce alcohol relapse.

Monoamine oxidase inhibitors may be helpful in treatment-resistant patients. They may indirectly deter a patient's drinking behavior because of the fear of a "cheese reaction," and they may alleviate comorbid atypical depression. On the negative side, patients with alcoholism have more difficulty in complying with dietary restrictions, and there may be a dangerous interaction from drinking wine or abusing substances. For example, a patient with alcoholism and organicity may be forgetful and have difficulty remembering dietary restrictions, leading to an adverse reaction.

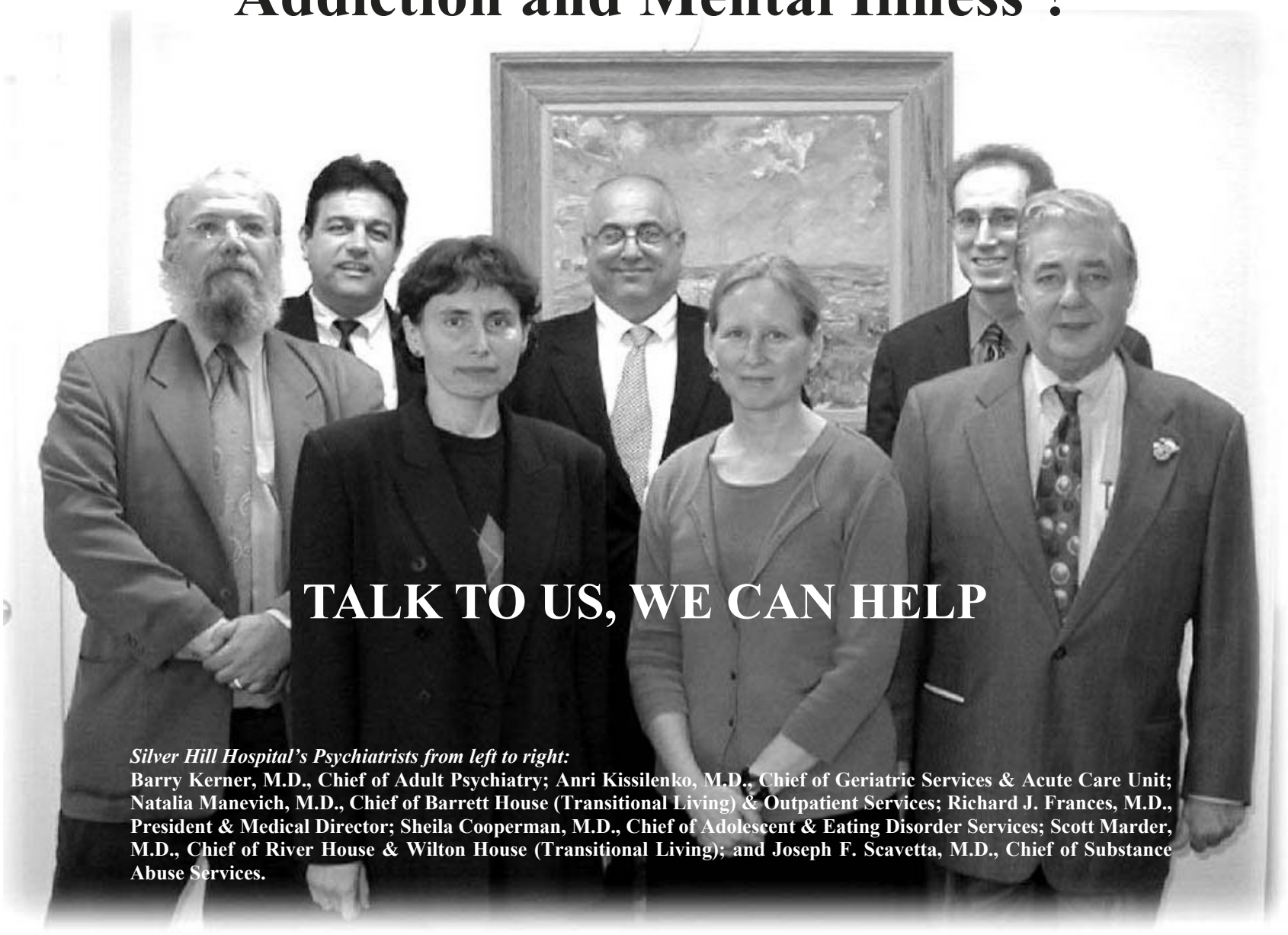
Buspirone is a promising drug for treating patients with anxiety disorders and alcoholism because it has low abuse potential, does not potentiate alcohol, and may be useful for anxiety of protracted abstinence. Disadvantages include its gradual onset of affect, lack of anticonvulsant properties, and ineffectiveness in treatment of alcohol withdrawl per se.

The advantages of sympathetic blockers such as propranolol and clonidine are that they can be taken as needed, are not addictive, and do not potentiate alcohol's effects. They tend to be used for the treatment of performance anxiety and sometimes social phobia. They may not be effective for panic or phobic disorder and may cause sedation, hypotension and hypertension.

There has been controversy over whether benzodiazepines should be contraindicated to treat anxiety disorders in patients at high risk for alcohol problems and whether they increase the risk of relapse or abuse. There are dangers of self-medication, dose escalation and abuse, either by themselves or combined with alcohol, and disinhibition, which may lead to a drinking relapse. Although benzodiazepines are used for alcohol detoxification, the long-term use of benzodiazepines is contraindicated in treating anxiety in patients with alcoholism unless patients have been treatment-resistant and are stable in their recovery, medication is closely monitored by the physician, and a family member is included in the therapeutic alliance. In choosing a benzodiazepine for a patient with alcoholism, it is important to consider that benzodiazepines with slow onset have less abuse potential. Oxazepam is not dependent on liver metabolism has a slow onset, and is less reinforcing then other benzodiazepines. In general, it is best to try to avoid the use of benzodiazepines in the treatment of alcoholism with anxiety.

Dealing with anxiety in the patient with alcoholism is challenging. The clinician must recognize it, help the patient accept it and confront it, educate the patient to understand it, and help the patient not to drink despite it. The use of nonpharmacologic and pharmacologic treatment must be closely monitored, and the right combination of treatments must be selected to fit the individual patient's needs.

Are You or A Loved One Among the Millions of Americans Suffering From Both Addiction and Mental Illness ?



TALK TO US, WE CAN HELP

Silver Hill Hospital's Psychiatrists from left to right:
Barry Kerner, M.D., Chief of Adult Psychiatry; Anri Kissilenko, M.D., Chief of Geriatric Services & Acute Care Unit; Natalia Manevich, M.D., Chief of Barrett House (Transitional Living) & Outpatient Services; Richard J. Frances, M.D., President & Medical Director; Sheila Cooperman, M.D., Chief of Adolescent & Eating Disorder Services; Scott Marder, M.D., Chief of River House & Wilton House (Transitional Living); and Joseph F. Scavetta, M.D., Chief of Substance Abuse Services.

Silver Hill Hospital has the leading doctors in treating addiction and mental illness.

We are a team of caring and dedicated professionals whose mission is to support you on your journey toward a healthier and more productive life

For more information please call 1 (800) 899-4455
Or visit our web-site at www.silverhillhospital.com

Silver Hill Hospital

Center of Excellence in Psychiatric and Addiction Treatment

SERVING THE COMMUNITY FOR 70 YEARS

CALL US TO PUT IT ALL TOGETHER.

Anxiety · Stress · Mood Swings
Changes in Relationships · Lack of Energy
Eating Disorders · Hopelessness · Irritability
Substance Abuse · Sleeplessness · Problems at Work

If you're suffering from emotional stress or have any of the above symptoms prompted by a medical problem, we can help. From toddlers to seniors, the Behavioral Health Center at Westchester is uniquely qualified with a comprehensive range of behavioral health services. If you need counseling, therapy or medication, help is just a phone call away.

To put it all together, simply call 914-493-7088

Behavioral Health Center

70 Years of Caring in Times of Crisis

WESTCHESTER MEDICAL CENTER
WORLD-CLASS MEDICINE THAT'S NOT A WORLD AWAY.

Valhalla, New York 10595 ▪ (914) 493-7000 ▪ Fax (914) 493-7607 ▪ www.wcmc.com