MENTAL HEALTH NEWS™

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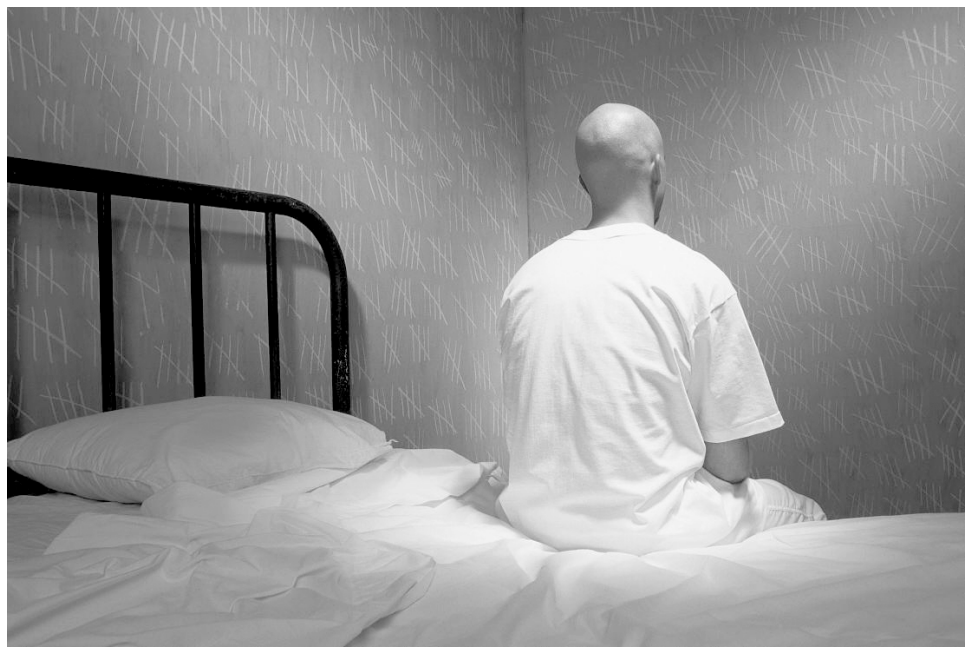
The Psychological Dimensions of Physical Illness

By the National Institute of Mental Health (NIMH)



Depression and Cancer

Research has enabled many men, women, and young people with cancer to survive and to lead fuller, more productive lives, both while they are undergoing treatment, and afterwards. As with other serious illnesses, such as HIV, heart disease, or stroke, cancer can be accompanied by depression, which can affect mind, mood, body and behavior. Treatment for depression helps people manage both diseases, thus enhancing survival and quality of life.

About 9 million Americans of all ages are living with a current or past diagnosis of cancer. People who face a cancer diagnosis will experience many stresses and emotional upheavals. Fear of death, interruption of life plans, changes in body image and self-esteem, changes in social role, lifestyle, and medical bills are important issues to be faced. Still, not everyone with cancer becomes depressed. Depression can exist before the diagnosis of cancer or may develop after the cancer is identified. While there is no evidence to support a causal role for depression in cancer, depression may impact the course of the disease and a person's ability to participate in treatment.

Despite the enormous advances in brain research in the past 20 years, depression often goes undiagnosed and untreated. While studies generally indicate that about 25 percent of people with cancer have depression, only 2 percent of cancer patients in one study were receiving antidepressant medication. Persons with cancer, their families and friends, and even their physicians and oncologists (physicians specializing in cancer treatment) may misinterpret depression's warning signs, mistaking them for inevitable accompaniments to cancer. Symptoms of depression may overlap with those of cancer and other physical illnesses. However, skilled health professionals will recognize the symptoms of depression and inquire about their duration and severity, diagnose the disorder, and suggest appropriate treatment.

Depression Facts

Depression is a serious medical condition that affects thoughts, feelings, and the ability to function in everyday life. Depression can occur at any age. NIMH-sponsored studies estimate that 6 percent of 9- to 17-year-olds in the U.S. and almost 10 percent of American adults, or about 19 million people age 18 and older, experience some form of depression every year. Although available therapies alleviate symptoms in over 80 percent of those treated, less than half of people with depression get the help they need.

Depression results from abnormal functioning of the brain. The causes of depression are currently a matter of intense research. An interaction between genetic predisposition and life history appear to determine a person's level of risk. Episodes of depression may then be triggered by stress, difficult life events,

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Heart Disease and Depression

Staff Writer
Mental Health News

Depression can strike anyone. However, research over the past two decades has shown that people with heart disease are more likely to suffer from depression than otherwise healthy people, and conversely, that people with depression are at greater risk for developing heart disease. Furthermore, people with heart disease who are depressed have an increased risk of death after a heart attack compared to those who are not depressed. Depression may make it harder to take the medications needed and to carry out the treatment for heart disease. Treatment for depression helps people manage both diseases, thus enhancing survival and quality of life.

Heart disease affects an estimated 12.2 million American women and men and is the leading cause of death in the U.S. While about 1 in 20 American adults experiences major depression in a given year, the number goes to about one in three for people who have survived a heart attack.

Depression and anxiety disorders may affect heart rhythms, increase blood pressure, and alter blood clotting. They can also lead to elevated insulin and cholesterol levels. These risk factors, with obesity, form a group of signs and symptoms that often serve as both a predictor of and a response to heart disease. Furthermore, depression or anxiety may result in chronically elevated levels of stress hormones, such as cortisol and adrenaline. As high levels of stress hormones are signaling a "fight or flight" reaction, the body's metabolism is diverted away from the type of tissue repair needed in heart disease.

Although we know more about the cause and treatment of mental illness today, depression often goes undiagnosed and untreated. Persons with heart disease, their families and friends, and even their physicians and cardiologists (physicians specializing in heart disease treatment) may misinterpret depression's warning signs, mistaking them for inevitable accompaniments to heart disease. Symptoms of depression may overlap with those of heart disease and other physical illnesses. However, skilled health professionals will recognize the symptoms of depression and inquire about their duration and severity, diagnose the disorder, and suggest appropriate treatment.

Heart Disease Facts

Heart disease includes two conditions called angina pectoris and acute myocardial infarction ("heart attack"). Like any muscle, the heart needs a constant supply of oxygen and nutrients that are carried to it by the blood in the coronary arteries. When the coronary arteries become narrowed or clogged and cannot supply enough blood to the heart, the result is coronary heart disease. If not enough oxygen-carrying blood reaches the heart, the heart may respond with pain called angina. The pain is usually felt in the chest or sometimes in the left arm and shoulder. (However, the same inadequate blood supply may cause no symptoms, a condition called silent angina.) When the blood supply is cut off completely, the result is a heart attack. The part of the heart that does not receive oxygen begins to die, and some of the heart muscle may be permanently damaged.

Chest pain (angina) or shortness of breath may be the earliest signs of heart disease. A person may feel heaviness, tightness, pain, burning, pressure, or squeezing, usually behind the breastbone but sometimes also in the arms, neck, or jaws. These signs usually bring the person

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From The Publisher

Helping Our Children Understand and Cope With Today's Anxieties Will Prepare Them for the Eventual Stresses They Will Experience As Adults

By Ira H. Minot, LMSW, Founder and Publisher, Mental Health News

In this issue of *Mental Health News* we examine "The Psychological Dimensions of Physical Illness." Much of the literature explores the many psychological issues that affect the primary patient. However, those close to the physically ill person are also vulnerable to psychic distress. Those at risk include the children, spouse, relatives, friends and co-workers who know and care about the person who is sick.

When we are young and growing up, we are all exposed to events in our families and in the world around us that may influence our mental health as we grow into adulthood. We also know that genetics play a major role in the development of our mental fortitude. Added to that mix, is that even the best of parents can unwittingly create weaknesses in the building blocks of their children's psychic development. One way they may do this is by not helping them experience and learn to cope with some of the harsher events around them. Such events include: illnesses, deaths, accidents, interpersonal upheavals and other unfortunate events in the child's immediate or extended families. I don't mean to sound too Freudian about it, but many parents who overprotect their children, may limit their kids ability to learn how to cope with traumatic events later in life.

Don't get me wrong. Most parents are devoted and loving, in accomplishing the hardest job in the world. However, some parents still adhere to the 'old school of child development.' They believed they should shield their kids from facing many of life's more difficult events. By overly shielding children from having to deal with problems in a psychically normal sort of way, many building blocks of a strong and healthy mental health may be lost. My experience as the youngest of five kids was that there were many instances where I was shielded by my parents from having to deal with some of the major calamities that were going on in the world around me. Going to the hospital to visit ill family members, deaths and funerals, divorces and other emotional upheavals in our own and extended family were kept from me and existed in an invisible world away from my own. At the time, it was certainly a pleasant world for a child to live in, and provided me with a basically happy life at home, school, and with my friends. But all that troublesome stuff that was floating in that hidden world around me would visit me later on in my life. Periods of unexplained blue moods began to creep into my life as I grew from secondary school into high school. I did not have a clue as to their origin, and Mom and Dad certainly were not able to give me the insight I needed.

As we grow into adulthood, many children begin to experience certain (almost predictable) psychic weakness when it comes to loss, separation, death and dying

Ira H. Minot, LMSW

and handling illnesses and interpersonal problems with those around them. We all have problems coping in these areas, but my hunch is that these sensitivities are a remnant of an overly protected childhood.

Many parent's today still hold to the old mental health philosophy of "push back your problems, and move on." Can this prove to be been a recipe for later emotional problems in their children? Another mistake is made when families know there is history of mental illness in the family, and thru fear, shame, and lack of understanding, do not openly acknowledge this situation. Knowing that there is a family history of mental illness is actually a good thing to know about, because it can provide early intervention strategies for families to spot and quickly deal with emotional problems in other family members before they reach a crisis point.

When I was in my early 30's my Mom became seriously ill with Lymphoma, a deadly form of cancer. Over the course of time, she went in and out of remission while the cancer and the chemotherapy took its toll on her body. Throughout her illness, I felt terribly distressed—a normal reaction to such a situation. What I realized later on, was that I should have had someone to talk with, to help me deal with my feelings rather than trying to tough it out as I had been brought up to do.

In keeping with my parents rules on keeping problems in a lock-box, we were on our own to deal with a hopeless situation. Although she put up a valiant fight for some years, Mom did not make it. I will never forget my last visit to see her in Florida while she was in a cancer induced semi-conscious state in the hospital. When she opened her eyes and saw that I was at her bedside, she struggled to feebly write me a message on a piece of paper. She wrote, "What are you doing here? Go home. I will be OK." Several days later she died. What a sad, yet perfectly rational way (in her own mind) to say goodbye to me.

As parents, we need to be more open with our children when it comes to serious illness, death, divorce and other stresses. Although it is a difficult area to explain to a child, they will benefit greatly and thank you for being there for them in this way.

I found some helpful advice on the internet at a Merck pharmaceutical site: www.merck.com/mmhe/sec23/ch287/ch287a.html, which follows in the following quoted text.

"In order to thrive, a child must experience the consistent and ongoing care of a loving, nurturing caregiver, whether it be a parent or someone else. The security and support that such an adult can provide give a child the self-confidence and resiliency to cope effectively with stress.

In order to mature emotionally and socially, children must interact with people outside the home. These interactions typically occur with close relatives; friends; neighbors; and people at childcare sites, schools, churches, and sports teams or other activities. By coping with the minor stresses and conflicts of these interactions, children gradually acquire the skills to handle more significant ones.

However, certain major events, such as illness and divorce, may challenge a child's abilities to cope. These events may also interfere with the child's emotional and social development. For example, a chronic illness may prevent a child from participating in activities and also impair performance in school.

Events affecting the child may also have adverse consequences for people close to the child. Everyone who cares for a sick child is under stress. The consequences of such stress vary with the nature and severity of the illness and with the family's emotional and other resources and supports.

Many life events, including illness or death of someone close, divorce, and bullying, are scary or unpleasant for children. Even events that do not directly affect the child, such as natural disasters, war, or terrorism, may cause anxiety. Fears about all of these, rational or irrational, can preoccupy a child.

Children often have difficulty talking about unpleasant topics. However, open discussion can help the child deal with difficult or embarrassing topics and dispel irrational fears. A child needs to know that anxiety is normal and will get better.

Parents should discuss difficult topics during a quiet time, in a private place, and when the child is interested. Parents should remain calm, present factual information, and give the child undivided attention. Acknowledging what was said with phrases such as, "I understand," or with a quiet nod encourages the child to confide; so does reflecting back what was said. For example, if a child mentions anger about a divorce, one could say, "So, the divorce makes you angry," or "Tell me more about that." Asking how the child feels can also encourage him to discuss sensitive emotions or fears—for example, fear of abandonment by the noncustodial parent during a divorce or guilt for causing the divorce.

By disclosing their own feelings, parents encourage children to acknowledge their fears and concerns. For example, about a divorce, a parent might say, "I am sad about the divorce, too. But, I also know it is the right thing for mommy and daddy to do. Even though we cannot live together anymore, we will both always love you and take care of you." By doing this, parents are able to discuss their own feelings, offer reassurance, and explain that divorce is the right choice for them. Sometimes children, particularly younger ones, need to hear the same message repeatedly.

Sometimes a parent must raise a difficult topic with a child, such as telling the child about a serious illness in a relative or friend. If tragedy affects someone else, children may feel more confident, and less helpless, if they can contribute—for example, by picking flowers; writing or drawing a card; wrapping a present; or collecting food, clothing, money, or toys. When a child appears withdrawn or sad, refuses to engage in usual activities, or becomes aggressive, the parent should seek professional help.

A parent may also have to address a difficult aspect of the child's own behavior. For example, a parent who suspects the child or adolescent of using drugs or alcohol should address the issue directly with the child. A parent might say "I am worried that you are using drugs. I feel this way because . . ." The parent should then calmly list the behaviors that concern him, limiting the list to three or four behaviors. If the child denies there is a problem, the parent should restate the concerns calmly and explain to the child that there is a plan of action in place (such as an appointment with a pediatrician or counselor).

Throughout any discussion, the parent should reassure the child that he is loved and will be supported."

I want you to know that there is a lot of good news relevant to this discussion. The mental health community has many wonderful resources to which people can turn for help with a multitude of individual and family problems. Unfortunately, many individuals and families are not familiar with this and many are ashamed or afraid to ask for help.

Mental Health News is actively trying to change this. We strive to provide our readers with relevant and up to date information about mental illness, while providing a roadmap to the providers of mental health services in your community. We think this is a good way to eradicate stigma and to provide hope to many.

With your support of our community education mission, we will continue to bring new and vital issues that impact the lives of people with mental illness to the forefront. Please continue to send me your comments and suggestions to my E-mailbox at mhnmail@aol.com. □

Good luck in your own recovery
and NEVER give up trying.
Have a Wonderful Fall!!

Letter To The Publisher

Beware the Injustice of The Court System for People With Mental Illness: Death Qualified Juries and Other Forms of Bias

By Joseph A. Deltito, MD

On June 20, 2001 a then 36 year old Andrea Yates systematically drowned her 5 children ages 6 months to 7 years old. (At the current time I am writing this editorial she is in the middle of her second trial for the murder of these children. It is likely that her trial will not be concluded by the deadline for submission of this editorial but her fate will be known by the time this issue of The Mental Health News reaches its readership. For this publication anomaly I apologize, nevertheless I will continue with her story.) After she completed the drowning of her children she called her husband telling him that he "Better come home...it's the children…all of them" and also called 911 asking for them to come to the house. Upon interview with the police she said "I killed my children, I am a bad mother." It appears in retrospect that she was not saying that she was a bad mother because she killed her children, but as she was a bad mother (she believed she was possessed by Satan) she needed to kill her children in order to insure their eternal salvation in Heaven. She stated that she believed that "God would take them up," if she did not kill them they would go to hell. She was arrested and charged with the murder of her children.

She was a woman with obvious and long standing psychiatric illness. While there is debate as to which may be the most appropriate diagnosis there is no doubt that she had a psychotic illness at play for at least two years continuously and episodic features of psychosis, depression and suicidality over a longer period than that. She had made two suicide attempts in the past with multiple and consistent psychiatric treatments for at least 7 years previous to her killing her children. The working Diagnosis most speculated on in the Courts and in the Media has been Post-Partum Psychosis which is seen in about one in every five hundred births in the USA. (I ,personally, highly suspect she suffers from a severe form of Bipolar disorder with delusional and hallucinatory features exacerbated by the multiple births of her children and inappropriate psychopharmacological treatments.) She had been treated with various forms of antidepressants and antipsychotic medicines over the years and had been recently taken off antipsychotic medicines previous to the killing of her children. She was charged with murder and because there were the "aggravating circumstances," that she killed someone under the age of 6 and killed multiple persons, she was deemed by the State of Texas to be eligible for the Death Penalty.

Her lawyers felt she was clearly insane at the time of the murders and planned on using an Insanity Plea Defense. In fact they felt she was so compromised by her mental illness that she was not competent to stand trial (basically so delusional that she could not cooperate in her own defense).So initially there was a hearing to

Joseph A. Deltito, MD

determine whether or not she could be tried at all. At this hearing for her "mental competency" she stated that she wanted to be executed so that she and Satan, in possession of her, would both be destroyed. She also maintained that she did not want to plea not guilty and did not need an attorney. She cut her hair in a particular way because she believed the number, 666 (representing the Antichrist), was printed on her scalp. In short she should have appeared to anyone as markedly compromised by her mental illness. Nevertheless she was determined to be competent to stand trial in the State of Texas.

With some background presented on this particular case I now wish to focus on two areas I see as Injustice on the part of the Courts (although I think there are many other examples of Injustice surrounding the whole case of Andrea Yates). It is also my educated medical opinion that no murder charges should have been pursued in the first place in an individual who was so obviously persistently and seriously mentally ill and insane at the time of the killings. The concept of Insanity is a legal and not a strictly medical term. In general it means that due to a mental disorder or defect a person did not comprehend right from wrong, or could not understand the consequences of their actions. (In this case the prosecution argued narrowly that she did comprehend that others would judge what she did as wrong; yet obviously she was following a higher authority of God to save her children through her killing them. It follows that she, in her delusional state believed what she did was not only considered by her as "not wrong" but as "right" as it followed God's will.) Her ability to judge right from wrong was obviously markedly compromised.

Many are familiar with the concept of "Double Jeopardy" and why it is important to keep the state from engaging in this practice. Simply stated we maintain that an individual can not be tried over and over for a particular crime if the State's Prosecutor is determined to find someone guilty even if previously found not guilty for that particular crime. Once judged not guilty one should be freed from the fear of future prosecution. I believe most Americans on some philosophical and visceral level agree with this principal. In the Yates case the State of Texas decided to try her for the murders of not all 5 of her children, but on only 3. They apparently did so with the strategy that if they lost the case and she was acquitted for reasons of insanity they could then try her again for the death of the fourth child. Should there be a similarly "unsatisfactory" outcome of this next trial and she would be acquitted a second time they could then try her a third time for the death of the fifth child. Therefore they would have 3 chances to find her guilty on what any reasonable and fair-mined individual would see as the same crime. Hence they included "Double Jeopardy" within their overall strategy. The system stacked the deck against her from the beginning!

Most people in this country both understand and accept the procedure of being judged by "A jury of one's peers" who are considered to be impartial, fair-minded and who can not benefit in anyway by the verdicts they reach. When the State of Texas decided to pursue the Death Penalty in the Yates case they then engaged in the practice of impaneling a "Death Qualified Jury." In Texas for someone to be found guilty of murder the 12 members of the jury need to unanimously agree that the defendant is guilty beyond a reasonable doubt. Even if just one juror declines to reach such certainty of guilt a "Hung-jury" is declared and a whole new trial needs to be brought against the defendant. Similarly 100 % unanimity is also needed in reaching a verdict of not guilty. In the case of Andrea Yates it would be a verdict of not guilty for reasons of Insanity .Therefore the prosecutions seeks to and is allowed to reject all those potential jurors from actually getting on a jury if they flat out declare that they do not believe in the Death Penalty and would never vote guilty if it meant the defendant may possibly be executed. People could object for any reason: Religious, Philosophical or Practical. So eventually we arrive at a jury that is comprised of those who are willing to vote for Death. It appears both obvious and supported by behavioral research that such a group of individuals not only are willing to impose Death if they feel the defendant is guilty but compared to the general pool of potential jurors are more likely to convict someone. Such people may be more moralistic, more vindictive, more frightened by a perceived criminal class of people, feel defense lawyers are more devious and dishonest, believe that if the State bring charges against someone they are most likely guilty, are more willing to potentially make the mistake of finding a truly innocent person guilty and very concerned over letting a potentially guilty person go unpunished. In fact these biases are recognized by Prosecutors who may otherwise be inclined not to pursue the Death Penalty in a given case but nevertheless will do so knowing they will have an easier "Sell" of guilty to such a jury. Simply put, such jurors are more likely to convict anyone of any accused crime than would the normally constituted jury which would include objectors to the Death penalty. It is an unintended consequence of constructing a Death Qualified Jury that you add bias towards an ultimate conviction.

In all honesty I have no solution to this issue; to allow those who are firmly against the death penalty on such juries would mean that there would in essence be no trial at all as one could never reach a unanimous vote of guilty. But now recognizing that an individual is being judged by a jury psychologically biased towards conviction makes me personally unable to accept such verdicts as fair and certainly I do not find them to be acceptable. I would rather have a person's punishment limited to "Life" (in prison) at least knowing the process in some basic way was fair (I do confess to be basically against the Death Penalty except in only exceptionally limited circumstances for reasons beyond those discussed in this essay).

Back to Andrea Yates. She had a first trial that ended in her being found guilty of murder of 3 of her children. It was hen decided not to give her the death penalty and she was sentenced to life in prison. After the trial it was discovered that a very prominent Psychiatrist employed by the prosecution gave testimony about Andrea Yates which was proven to be false. The prosecution mentioned this evidence in its closing arguments and made it a cornerstone of their case suggesting she willfully and in sound mind voluntarily elected to murder her children. The judge declared a mistrial and she was transferred from a Prison to a Psychiatric Hospital. (The Psychiatrist in question appeared to confuse some facts in giving his false testimony, and did not appear to be willfully or maliciously lying). She is currently in the middle of her retrial, this time the death penalty is not being sought. Yet in many ways she is still fighting for her life. If convicted she will most likely spend the rest of her life in a prison, if found not guilty by reason of insanity she will not be released but remanded to a Psychiatric Hospital where she may also spend the rest of her life. Injustices can occur in all sorts of legal proceedings, but I firmly believe that those with severe Mental illness are particularly exposed to the possibilities of being grossly mistreated by "The System." At least that's the way I see it!

Joseph A. Deltito, M.D. is a Clinical Professor of Psychiatry at New York Medical College and has an office practice for psychopharmacological consultations and forensic psychiatry in Greenwich, Connecticut. He is a forensic Psychiatry consultant for Court TV and CNN. Dr. Deltito serves on the Clinical Advisory Board of Mental Health News. □

A Follow-up to Our Summer Autism Issue

Researchers Gain Insight Into Why Brain Areas Fail To Work Together
Basis For Why People With Autism Think In Pictures

By The National Institute of Child Health and Human Development (NICHD)

Researchers have found in two studies that autism may involve a lack of connections and coordination in separate areas of the brain. In people with autism, the brain areas that perform complex analysis appear less likely to work together during problem solving tasks than in people who do not have the disorder, report researchers working in a network funded by the National Institutes of Health. The researchers found that communications between these higher-order centers in the brains of people with autism appear to be directly related to the thickness of the anatomical connections between them.

In a separate report, the same research team found that, in people with autism, brain areas normally associated with visual tasks also appear to be active during language-related tasks, providing evidence to explain a bias towards visual thinking common in autism.

"These findings provide support to a new theory that views autism as a failure of brain regions to communicate with each other," said Duane Alexander, M.D., Director of NIH's National Institute of Child Health and Human Development. "The findings may one day provide the basis for improved treatments for autism that stimulate communication between brain areas."

The studies and the theory are the work of Marcel Just, Ph.D., D.O. Hebb Professor of Psychology at Carnegie Mellon University in Pittsburgh, Pennsylvania, and Nancy Minshew, M.D., Professor of Psychiatry and Neurology at the University of Pittsburgh School of Medicine and their colleagues.

The research was conducted by the Collaborative Program of Excellence in Autism, a research network funded by the NICHD and the National Institute on Deafness and Other Communication Disorders.

People with autism often have difficulty communicating and interacting socially with other people. The saying "unable to see the forest for the trees" describes how people with autism frequently excel at details, yet struggle to comprehend the larger picture. For example, some children with autism may become spelling bee champions, but have difficulty understanding the meaning of a sentence or a story.

An earlier finding by these researchers described how a group of people with autism tended to use parts of the brain typically associated with processing shapes to remember letters of the alphabet.

Participants with autism in both current studies had normal I.Q. There were no significant differences between the participants with and without autism in age or I.Q.

The first of the two new studies recently was published online in the journal "Cerebral Cortex". In that study, the researchers used a brain imaging technique known as functional magnetic resonance imaging, or fMRI, to view the brains of people with autism as well as a comparison group of people who do not have autism. All of the study participants were asked to complete the "Tower of London" test. The task involves moving three balls into a specified arrangement in an array of three receptacles. The "Tower of London" is used to gauge the functioning of the prefrontal cortex.

This brain area, located in the front, upper part of the brain, deals with strategic planning and problem-solving. The prefrontal cortex is the executive area of the brain, in which decision making, judgment, and impulse control reside.

A little further back is the parietal cortex, which controls high-level visual thinking and visual imagery, supporting the visual aspects of the problem-solving. Both the prefrontal and parietal cortex play a critical part in performing the "Tower of London" test.

In the normal participants, the prefrontal cortex and the parietal cortex tended to function in synchrony (increasing and decreasing their activity at the same time) while solving the Tower of London task. This suggests that the two brain areas were working together to solve the problem.

In the participants with autism, however, the two brain areas, prefrontal and parietal, were less likely to function in synchrony while working on the task.

The researchers made another discovery, for the first time finding a relationship between this lower level of synchrony and the properties of some of the neurological "cables" or white matter fiber tracts that connect brain areas.

White matter consists of fibers that, like cabling, connect brain areas. The largest of the white matter tracts is known as the corpus callosum, which allows communication between the two hemispheres (halves) of the brain.

"The size of the corpus callosum was smaller in the group with autism, suggesting that inter-regional brain cabling is disrupted in autism," Dr. Just said.

In essence, the extent to which the two key brain areas (prefrontal and parietal) of the autistic participants worked in synchrony was correlated with the size of the corpus callosum. The smaller the corpus callosum, the less likely the two areas were to function in synchrony. In the normal participants, however, the size of the corpus callosum did not appear to be correlated with the ability of the two areas to work in synchrony.

"This finding provides strong evidence that autism is a disorder involving the biological connections and the coordination of processing between brain areas," Dr. Just said. He added, however, that the thickness, or extent, of connections between brain areas may not be the basis for the disorder. Although the neurological connections between the prefrontal cortex appear to be reduced in autism, the brains of people with autism have thicker connections between certain brain regions within each hemisphere.

"At this point, we can say that autism appears to be a disorder of abnormal neurological and informational connections of the brain, but we can't yet explain the nature of that abnormality," Dr. Just said.

In the second study, published online in the journal "Brain", the researchers examined the extent to which brain areas involved in language interact with brain regions that process images. Dr. Just explained that earlier studies, as well as anecdotal accounts, suggest that people with autism rely more heavily on visual and spatial areas of the brain than do other people.

In this study, the researchers used fMRI to examine brain functioning in participants with autism and in normal participants during a true-false test involving reading sentences with low imagery content and high imagery content. A typical low imagery sentence consisted of constructions like "Addition, subtraction, and multiplication are all math skills." A high imagery sentence, "The number eight when rotated 90 degrees looks like a pair of eyeglasses," would first activate left prefrontal brain areas involved with language, and then would involve parietal areas dealing with vision and imagery as the study participant mentally manipulated the number eight.

As the researchers expected, the visual brain areas of the normal participants were active only when evaluating sentences with imagery content. In contrast, the visual centers in the brains of participants with autism were active when evaluating both high imagery and low imagery sentences.

"The heavy reliance on visualization in people with autism may be an adaptation to compensate for a diminished ability to call on prefrontal regions of the brain," Dr. Just said.

The second study also confirmed the observations in the first study -- that the prefrontal and parietal brain regions of the cortex in people with autism were less likely to work in synchrony than were the brains of normal volunteers. The second study also confirmed that the extent to which the two parts of the cortex could work together was correlated with the size of the corpus callosum that connected them.

Dr. Just and his colleagues are conducting additional studies to ascertain the nature of the abnormality of the connections in the brains of people with autism.

The NICHD sponsors research on development, before and after birth; maternal, child, and family health; reproductive biology and population issues; and medical rehabilitation. For more information, visit the Institute's Web site at http://www.nichd.nih.gov/.

The National Institutes of Health (NIH) -- "The Nation's Medical Research Agency" -- includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. It is the primary federal agency for conducting and supporting basic, clinical and translational medical research, and it investigates the causes, treatments, and cures for both common and rare diseases.

For more information about NIH and its programs, visit www.nih.gov. □

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MENTAL HEALTH NEWSDESK

New Children's Inpatient Unit at Binghamton Ready for Occupancy

Staff Writer
Mental Health News

Members of the Greater Binghamton mental health provider community recently had an opportunity to tour Greater Binghamton Health Center's (GBHC) newly renovated, 14-bed inpatient unit for children and adolescents.

"This new inpatient unit will complement the quality care that has been available to children and adolescents through the Greater Binghamton Health Center's clinic, day treatment and crisis residence programs," said Sharon E. Carpinello, RN, PhD, Commissioner of the New York State Office of Mental Health (OMH). "It will enable the facility to treat those children who are most troubled on an inpatient basis, and will complete the continuum of care available to children and adolescents in New York State's Southern Tier."

The knowledge base around psychiatric disabilities among children and adolescents continues to grow, and continues to inform providers in the field. Research has shown that: one out of ten children have a serious emotional disturbance; only 30 percent of children age14 and older with emotional disturbance graduate with a standard high school diploma; among all disabilities, emotional disturbance was associated with the highest rate of school dropout; and suicide is the third leading cause of death among children and adolescents.

Dr. Sharon Carpinello

Decades of research support the findings that: mental health problems can be recognized as early as preschool; risk factors for the development of mental health problems can be identified in childhood, and many are modifiable; failure to identify and intervene can have life-long and often devastating effects; scientifically-validated tools for early recognition exist; and a range of effective intervention service programs exist, and they have a strong science base.

"I believe that the primary locus of mental health care should be in the community, enabling children to remain at home, at work, in school, with friends and loved ones. But this does not mean that we can dismiss the need for quality inpatient care when it is needed," said Commissioner Carpinello.

"We believe it best when families are full participants in all aspects of service planning and delivery," Commissioner Carpinello said. She explained that a cooperative process helped to determine the structural design of the new unit. OMH convened a focus group during which administrators and the project's architect met with children who have been hospitalized and their families, facility staff and other area mental health providers. Together, they discussed various design elements that would enhance the recovery process, as well as those that may inhibit it. As a result, the new unit is truly designed to support recovery: it balances individual privacy and appropriate supervision, provides a safe and therapeutic environment, and is family friendly - especially in the visiting areas.

A newly-renovated hospitality house is also available for families of children who require inpatient care. The hospitality house will enable parents who live out of the immediate Binghamton area to become full partners in their child's treatment, by providing temporary accommodations for them here on the campus of the Greater Binghamton Health Center.

"I would also like to acknowledge Senator Thomas Libous for his ongoing advocacy and support for children and families served by the Office of Mental Health," Commissioner Carpinello said.

The Greater Binghamton Health Center is completing finishing touches on the building, and working with other mental health providers in the Greater Binghamton area to finalize referral procedures. The new unit is expected to open in the coming months. □

Researchers From Duke University To Evaluate Assisted Outpatient Treatment in New York State

Staff Writer
Mental Health News

Sharon E. Carpinello, RN, PhD, Commissioner of the New York State Office of Mental Health (OMH) today announced that a team of mental health services researchers from Duke University has been awarded a contract to evaluate the implementation and effectiveness of New York State's Assisted Outpatient Treatment (AOT) initiative. Established as a provision of Kendra's Law, AOT is the procedure for obtaining court orders for certain individuals to receive outpatient treatment for mental illness. The legislation is named in memory of Kendra Webdale, who died after being pushed in front of a subway train by a man with a history of mental illness and hospitalizations.

"The expertise of the Duke University researchers will provide OMH and all New Yorkers with an objective assessment of issues that are central to understanding how well AOT has been implemented and is working for recipients of mental health services," said Commissioner Carpinello. "Their work will provide an important complement to OMH's work in this area, which has found that individuals with mental illness who participate in AOT are able to make and maintain progress in their recovery. We have seen improved access to mental health services, improved coordination of service planning, and significant reductions in harmful behaviors such as arrests, incarcerations, homelessness and hospitalizations."

The Duke University research team is led by Dr. Marvin Swartz, who has a national reputation for his involvement in studies of mandated community treatment. Dr. Swartz's team includes members of the Research Network on Mandated Community Treatment, a group of national experts convened to study the use of legal mandates in community treatment. The team will begin its evaluation this summer and a final report of findings will be completed by March of 2009.

"The Office of Mental Health is pleased to have the Duke University Research Team review the use of AOT in NewYork State," said Chip Felton, OMH Senior Deputy Commissioner and Chief Information Officer. "OMH is continuously looking to improve the quality of mental health services, and this team's insight and expertise in the field of mandated community treatment will help to ensure that individuals with mental illness receive the high quality services and supports they need to live successfully in their communities."

The AOT program is designed to ensure that certain individuals with a mental illness are safely and effectively treated. The law also ensures that local mental health systems give these individuals priority access to case management and other services necessary to ensure safe and successful community living.

The original Kendra's Law statute was enacted by the Legislature and signed into law by Governor George E. Pataki in 1999, and the law was extended for another five years in June 2005. This external evaluation of AOT is a requirement of the law's 2005 extension, and the contract award announced today concludes a competitive Request for Proposals process.

Findings from OMH's evaluation of AOT's first five years are now available on the Office of Mental Health website at http://www.omh.state.ny.us/omhweb/statistics/. Up-to-date statistical data on AOT program operations, the demographic and diagnostic characteristics of AOT recipients, and outcomes for AOT recipients is also available, at the Statewide, regional and county-level. □

MENTAL HEALTH NEWSDESK

Walgreens Recruits Employees with Disabilities Through New and Highly Accessible Web Site

Staff Writer
Mental Health News

Walgreens (NYSE, NASDAQ: WAG), the nation's largest drugstore chain, has launched an innovative initiative to hire people with disabilities at its new distribution center in Anderson, S.C. and is recruiting through a new, specially-designed Web site.

Walgreensoutreach.com describes jobs available at the Walgreens distribution center and is designed to be accessible by people with sensory, physical and cognitive disabilities.

The center has begun pre-hire training and will open in 2007. Initially, Walgreens will hire more than 200 employees with plans to ramp up to more than 600 employees. Walgreens goal is to have at least one-third of the workforce consist of employees with a variety of disabilities working in a fully-integrated team. This "real work for real pay" environment will be competitive employment in which performance standards must be maintained. Job openings at the Anderson distribution center include a number of management positions.

Walgreensoutreach.com provides information to help potential employees understand what work will be like at the distribution center. The site incorporates audio messages, photos, video and a large-print text option to depict jobs and worklife at Anderson. The site also is designed to be accessible to blind and low vision individuals who use screen reader technology. Under the jobs section, videos show employees performing various jobs, and the text describes what the workers are doing. Prospective employees unsure if they can perform the essential job functions can take a self-quiz to get an idea of the tasks involved.

Randy Lewis

From the same page, a series of photos shows an employee arriving at work and going through the daily routine – going to a locker, storing lunch, walking to a work station, taking a break and ending the day.

For potential employees considering relocating to Anderson, the site also has information about Walgreens partnership with 13 local disability agencies. Knowing the difficult challenges faced by people with disabilities who want to work, Walgreens designed the Web site to address concerns such as transportation, housing and the impact of gainful employment on Medicaid, SSI or SSDI benefits.

"We know this requires more than a 'build it and they will come' attitude to be successful," said Randy Lewis, Walgreens senior vice president of distribution and logistics. Lewis, who has a son with autism, knows first-hand the challenges of everyday life for people with disabilities. "Our local partners and statewide officials have worked tirelessly in setting up a support network to make this outreach with the disability community a success," said Lewis.

Larry Kraemer, human resources manager for the Anderson distribution center, said, "This is a workforce that is underemployed and has not had the same opportunities as others. This is a chance to change that." Walgreensoutreach.com also features success stories. One is that of Chuck Studzienko, an employee with Asperger's Syndrome (a form of autism) who has worked at Walgreens Lehigh Valley distribution center in Pennsylvania since 2004. Studzienko started as a stocker and was promoted to split-case picker, where he has a 100 percent productivity rate.

Walgreens worked with The Paciello Group (TPG) of Nashua, N.H., to make Walgreensoutreach.com accessible for people with various disabilities and to meet the international Web Content Accessibility Guidelines of the World Wide Web Consortium (W3C).

The Paciello Group was founded by Mike Paciello with a mission to make information technology resources available to the full spectrum of people with disabilities. Paciello has pioneered the field of accessible interface design as a technologist, consultant, author and professional speaker. His internationally best-selling book, "Web Accessibility for People With Disabilities," remains the definitive reference for accessibility design, implementation and usability.

"The impact of this new Walgreens Web site is immeasurable," said Paciello. "It will be embraced by the disability community as a critical tool in the employment process. TPG is proud to be a part of this forward-thinking Walgreens initiative."

Walgreen Co. is the nation's largest drugstore chain with fiscal 2005 sales of $42.2 billion. The company operates 5,294 stores in 46 states and Puerto Rico. Walgreens also provides additional services to pharmacy patients and prescription drug and medical plans through Walgreens Health Services, its managed care division, which includes Walgreens Health Initiatives Inc. (a pharmacy benefits manager), Walgreens Mail Service Inc., Walgreens Home Care Inc. and Walgreens Specialty Pharmacy. More information on Walgreens is available at Walgreens.com or Walgreensespanol.com. □

Kudos on Perlman Appointments and Coalition Award Honorees

Staff Writer
Mental Health News

Perlman Receives State and National Appointments

Dr. Barry B. Perlman, the Director of Psychiatry at Saint Joseph's Medical Center in Yonkers, N.Y. and a member of the Board of *Mental Health News*, was recently appointed to the Hudson Valley Regional Advisory Committee of the Commission on Health Care Facilities in the 21st Century by Senator Joseph Bruno, the NYS Senate Majority Leader. The Commission was created to make recommendations to the Governor and legislature regarding the "rightsizing" of the hospitals and nursing homes in the state.

Recently, Dr. Perlman also was appointed as Chair, Committee on Government relations of the American Psychiatric association. He recently completed his 2nd two year term as President of the New York State Psychiatric Association. □

Dr. Barry B. Perlman

Coalition Benefit Honors Siskind, Carpinello & Moore

The Coalition of Voluntary Mental Health Agencies held its 22nd Annual Awards Benefit in June, honoring NYS Office of Mental Health Commissioner Dr. Sharon Carpinello, NY Times bestselling author Bebe Moore Campbell and Dr. Alan Siskind, Executive Vice President & CEO of the Jewish Board of Family and Children's Services, and past Chairman of the Board of *Mental Health News*.

Wide representation from the community mental health sector. elected officials and representatives from city and State government attended, including Assembly Member James Brennan (D-Brooklyn), who chaired the Assembly's Mental Health Committee for five years, and the current Chair, Assembly Member Peter Rivera (D-Bronx). □

Dr. Alan Siskind

MENTAL HEALTH NEWSDESK

Peter Campanelli Elected Chairman of the Mental Health News Board

Staff Writer
Mental Health News

As spring ushered in its' new season of growth and vitality, it also heralded a passing of the torch for Chairman of the Mental Health News Board of Directors. Dr. Peter C. Campanelli was elected to the position at the organization's June annual meeting. He succeeds Dr. Alan B. Siskind who lead the award-winning mental health newspaper since 2003.

The formal announcement was made by Janet Z. Segal, LCSW, BCD, Vice-Chairman of the *Mental Health* News Board of Directors. According to Segal, "We are so honored to have someone of Dr. Campanelli's stature, lead the *Mental Health News* Board of Directors. He is such a dedicated and respected leader of the Metro-New York mental health community."

Dr. Campanelli is currently the President and Chief Executive Officer of the Institute for Community Living (ICL), an award-winning, multifaceted and full service mental health agency based in New York City. He joined ICL as Associate Executive Director in 1986 and was named President and Chief Executive Officer in 1987.

Dr. Peter C. Campanelli

As President and Chief Executive Officer, Dr. Campanelli is responsible for the overall operation of ICL, and has led the growth of the agency to a nationally recognized agency serving over 5,000 people per year with an annual budget of $60 million.

Dr. Campanelli is a licensed Clinical Psychologist in both New York and New Jersey and is the recipient of numerous local and national awards including the Peterson Prize awarded by the Graduate School of Applied and Professional Psychology of Rutgers University, two Gold Awards from the American Psychiatric Association, as well as various congressional and legislative awards.

Prior to joining the staff at ICL, Dr. Campanelli served as Chief of Service of the Community Residential Service for South Beach Psychiatric Center, a New York State psychiatric hospital. He has served on the faculty of Pace University, Rutgers University and Metropolitan College of New York within their graduate training programs.

Dr. Campanelli is President of the Coalition of Voluntary Mental Health Agencies, an agency comprised of the majority of mental health care providers in New York City. He is also Chairman of the Board of Directors of the Association of Community Living, Inc. a statewide group of over 120 providers of residential services.

He currently serves at the pleasure of the State Commissioner of Mental Health on the Families and Children Committee of the Commissioner and is a member of the Executive Committee of the Human Services Council of New York City.

Dr. Campanelli received a Bachelor of Arts degree in Psychology from St. Francis College, Brooklyn, New York in 1972, a Master of Science degree and a Professional Diploma in Educational Psychology from St. John's University in 1974 and 1975, respectively, and a Doctorate in Clinical Psychology with specialty foci in Public Administration and Health Care Delivery and Behavioral Medicine and Health Psychology from the Graduate School of Applied and Professional Psychology at Rutgers, the State University of New Jersey.

According to Dr. Campanelli, "I am delighted to have this opportunity to lead the *Mental Health News* Board of Directors. *Mental Health News'* mission of providing mental health education to the community is a such a vital part of helping people with mental illness, and it also serves to strengthen everything we do as service providers." □

Giselle Stolper and Peter Beitchman Join the Board of Mental Health News

Staff Writer
Mental Health News

Giselle Stolper, EdM, is the Executive Director of the Mental Health Association of New York City (MHA of NYC), one of the metropolitan area's leading mental health advocacy and direct services organizations.

Since joining the Association in 1990, Giselle's leadership has brought the organization to the forefront of innovative direct service and public education models in the community. Giselle pioneered the development and growth of 1-800-LIFENET, New York City's leading mental health hotline, which has achieved national prominence through its award-winning model of information and referral services. In the wake of the 9/11 attacks, LifeNet became the official hotline for residents in the tri-state area to call if they were experiencing emotional distress. The MHA of NYC's success with LifeNet led to the award of a federal grant to develop the National Suicide Prevention Lifeline, 1-800-273-TALK, which now includes 115 crisis centers nationwide, helping callers find referrals to nearby mental health resources.

A personal experience with mental illness in her family originally fueled

Giselle Stolper, EdM

Giselle's commitment to improving mental health services for all New Yorkers. Before joining the MHA of NYC, Giselle worked for the New York State Office of Mental Health for 15 years at Manhattan's Children's Psychiatric Center. Today she is a catalyst for transformation within the city's mental health system by acting as a tireless advocate for policy change, giving

see Giselle Stolper on page 34

Staff Writer
Mental Health News

Dr. Peter Beitchman has worked and advocated within New York's mental health system for almost 40 years. He is Executive Director of The Bridge, Inc., a comprehensive multi-service agency for men and women with serious mental illness located in New York City. The Bridge operates more than 40 programs in Manhattan, Queens and the Bronx providing residential, rehabilitation, clinical and support services to more than 1100 individuals each year. In addition to serving men and women with serious mental illness, The Bridge provides specialty services to the mentally ill homeless, to those dually-diagnosed with mental illness and substance abuse, to persons with HIV/AIDS who are experiencing significant mental health problems and to persons with mental illness who have been in the criminal justice system.

Prior to assuming the position of Executive Director of The Bridge six years ago, he served as the agency's Deputy Executive Director for 16 years. Before coming to The Bridge, Dr. Beitchman held a number of key public mental health policy positions. He was a member of the Commissioner's senior staff in the New York City Department of

Dr. Peter Beitchman

Mental Health, Mental Retardation and Alcoholism Services. He was also the Executive Director of the New York State Assembly Special Subcommittee on Urban Mental Health, and was Executive Director of the Coalition of Voluntary Mental Health Agencies, the advocacy and technical assistance organization that represents New York

see Peter Beitchman on page 34

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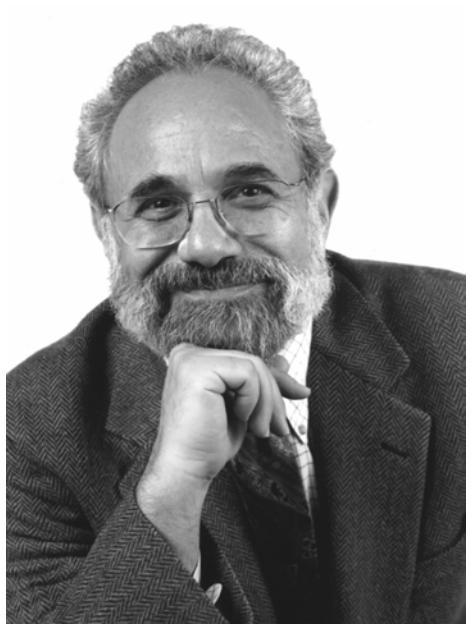
POINT OF VIEW

Advice for the Next Governor of New York State

By Michael B. Friedman, LMSW



Michael B. Friedman, LMSW

The next Governor of New York will have to confront a vast array of mental health issues. Here are a few observations I hope will be helpful.

Mental health is important to all New Yorkers and should be one of the next Governor's priorities.

50% of us will have a mental disorder in our lifetimes, and 20% will have a disorder in any given year. Most mental illnesses are not severe, but they result in substantial pain for both people with mental illness and for their families. They also take a toll on the economy. Mental illness is the leading cause of disability in the United States and the fastest growing cause of disability in the workforce. Untreated mental illness reduces productivity and costs American business over $100 billion per year.

Mental illness also drives up the cost of health care. Psychogenetic symptoms result in unnecessary testing and treatment. And, when combined with mental illness, physical illness becomes more complicated—and costly. For example, people with cardiac conditions and depression cost almost twice as much to treat for their heart problems.

A Governor committed to a high quality of life for New Yorkers and to a thriving economy should make mental health a priority. He should focus, of course, on how the public sector can promote mental health, but also should focus on helping the private sector to understand that promoting mental health is good for business.

The next Governor should commit to continued progress towards the development of a comprehensive community-based mental health system for adults with long-term psychiatric disabilities with particular attention to problems of transinstitutionalization.

A half century ago NYS passed the first community mental health act in the United States setting the stage for the nation's shift from institution-based mental health policy to community-based policy. The first step in the transition was "deinstitutionalization." It helped many people avoid unneeded long-term institutionalization, but it also resulted in the abandonment of tens of thousands of people in communities unprepared to serve them. (Fortunately, families filled the void for many of them.) A quarter century ago, NYS instituted the Community Support Program, which—over time—has addressed shortcomings of deinstitutionalization with expanded outpatient treatment, housing, rehabilitation, family and peer support, and more.

For those of us who have been around since the late 1970's, the progress is apparent—but so is continuing need. The next Governor should continue the momentum with **expanded housing** and **more services and supports oriented to recovery**, particularly for those most likely to be underserved, such as people with co-occurring mental and addictive disorders.

Continued progress will entail confronting the future of the state hospital system and the nature of "reinvestment" if more hospitals are closed. This will be among the thorniest of political issues the next Governor will have to face.

In addition, the new Governor should anticipate that the large presence of people with serious mental illnesses in adult homes, nursing homes, jails, and prisons will re-emerge as a major crisis as they did in the Carey, Cuomo, and Pataki administrations. It would be wise for the new Governor to **confront transinstitutionalization** before it confronts him. Among other things, this will entail a commitment to increase and remodel housing for people with serious mental illness.

The Governor should commit to continued progress towards the development of a community-based mental health system for children and adolescents.

Over the past quarter century, incremental progress (with a big leap this year) has been made in addressing the mental health needs of children and adolescents. This has included the development of more specialized child mental health services, the development of non-traditional services, new efforts to treat families with respect and as partners in care, strides towards integration with other child-serving systems, use of a home and community-based waiver program to reduce institutionalization, and—this year—a vast increase in screening, assessment, and treatment through Clinics Plus. If Timothy's Law passes the Senate as promised and Governor Pataki signs it into law (no word as I write this), services will also be increasingly available to those covered by employer-based health plans.

But all of these gains leave much still to be accomplished. The next Governor should commit not only to continued expansion and improvement of mental health services for kids in the public sector but should also press for increased access through workplace benefits and programs.

The march of demography calls for increased attention to the mental health needs of minorities and older adults.

Our society is undergoing major demographic shifts. Over the next quarter century minority populations will grow from 30% of the population to 43%. The population of older adults will grow from 13% of the population to 20%. Neither NYS nor the nation is prepared to meet the mental health challenges of these demographic shifts. In NYS some progress has been made. The Geriatric Mental Health Act has led to the creation of a planning council and a services demonstrations grants program. There may soon be centers of excellence in minority mental health. But so much more is needed: a workforce that speaks the language of its clientele and is knowledgeable about geriatrics, cultural differences, etc.; public education to overcome stigma; development of more mobile services providing outreach to populations unable or reluctant to seek out mental health services; integration of services, and more.

The next Governor should lead NYS into the future by laying the groundwork now for meeting the needs that will increasingly emerge as the march of demography moves ineluctably forward.

Quality of mental health services is uneven in NYS. The Governor should commit to continued support of research and the use of best practices.

Improving the quality of mental health services through the translation of research into practice has become one of the central tenets of mental health policy in NYS and in the nation. Doing so requires a research agenda that has eventual application to the real world and a commitment to support the use of best practices. New York State has been a leader in research and in the effort to improve practice. The new Governor should support these efforts.

Using Medicaid to fund mental health care has reduced NYS's costs. The next Governor needs to understand the role of Medicaid in supporting the state's public mental health system.

Without doubt, Medicaid spending will be a major target for the next administration. But Medicaid spending in NYS is extremely complex, reflecting decisions to cover more people and services than other states as well as the high costs of health care in general. The next Governor probably knows this already, but it would be surprising if he knows much about the use of Medicaid as the major underpinning of New York's mental health system and of its use to generate federal funds to supplant state and local funds. The new Governor needs to understand that cuts to Medicaid for mental health are likely to ultimately drive up the state's costs. He should support the remarkably clever state bureaucrats who have figured out year after year how to use Medicaid to preserve and improve NYS's mental health system.

The new Governor should also understand that efforts to reduce Medicaid costs by closing general hospitals can inadvertently have a devastating effect on NY's mental health system—which relies heavily on general hospitals to provide essential inpatient and outpatient services. In general, the next Governor needs to recognize that, while mental health constitutes an extremely small part of the overall Medicaid budget, Medicaid is absolutely crucial to the of the public mental health system.

Are new approaches to the way Medicaid is used to fund mental health possible? Probably, but both the Cuomo and the Pataki administrations developed brilliant ideas about how to restructure Medicaid funding for mental health, and both failed. The next Governor needs to understand why before taking off in similar directions.

Since becoming a mental health advocate, I have lived through two gubernatorial changes—Cuomo and Pataki. Both were rough for mental health because neither new Governor initially understood how delicately balanced the mental health system is. It relies on a mix of state, community, and general hospital providers. It relies on leadership by state and local governments. And it relies on a very complex mix of funding sources—federal, state, local, philanthropic, private insurance, and self-pay. The new Governor needs to keep all this in mind if the next transition is to be smoother than the previous two.

Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of NYC and Westchester. The opinions expressed in this column are his own and do not necessarily reflect the positions of the MHAs. Mr. Friedman can be reached at center@mhaofnyc.org. □

The NYSPA Report

Clinical Antipsychotic Trials of Intervention Effectiveness: A Primer for Patients, their Families, and Friends

By Leslie Citrome, MD, MPH
Director, Clinical Research and Evaluation Facility, Nathan S Kline Institute for Psychiatric Research

Research studies comparing antipsychotics have usually been conducted by the manufacturers of the medications, and have usually included only two medications, and the results are not always made publicly available. Large scale, independently-conducted, multiple-medication studies are needed. The Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) have emerged as a rich source of information from which clinicians can gather information about the relative strengths and weaknesses of the newer, "second-generation" antipsychotics. It compared them amongst each other as well as to a "first generation" antipsychotic. A list of publications and resources follows this article.

Leslie Citrome, MD, MPH

What is CATIE?

CATIE was a randomized controlled trial, not sponsored by the pharmaceutical industry, which evaluated the effectiveness of antipsychotics in approximately 1,500 patients with schizophrenia over an 18-month period. It was paid for by an NIMH contract worth over $40 million dollars awarded to the University of North Carolina for the period from 10/1/99 to 12/31/05. Over 50 different clinical centers in diverse settings across the USA participated in this project.

What is Treatment Effectiveness?

Treatment effectiveness is a broad term that includes the concepts of efficacy (ability of a medication to reduce symptoms), tolerability/safety (side effects), and treatment adherence (taking the medication). The CATIE trial measured effectiveness by seeing how long a patient remained on a medication This amount of time taking the medication reflects both the patient and the clinician's opinion as to whether or not the medication worked in reducing symptoms (such as hallucinations, delusions, anxiety) and was free of disabling side-effects for that person. The longer the time someone takes the medication, the more "effective" it was thought to be.

CATIE Was Both Inclusive and Exclusive

Much has been said about CATIE being more generalizable than the usual study because it included patients who may have needed other medications in addition to antipsychotics, and also included patients who may have had problems with alcohol or drug abuse. On the other hand, CATIE did exclude several important groups of patients: patients whose symptoms first began less than 3 years ago, patients treated with medication for the first time in the past year, patients who have a history of non-response to olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal), ziprasidone (Geodon), or perphenazine (Trilafon), patients who have been on clozapine (Clozaril), and patients who have a diagnosis of schizoaffective disorder.

CATIE Had Three Parts

CATIE's design included 3 main phases. The results of Phases 1 and 2 have been published. Phase 1 included 1493 patients who received one of 5 antipsychotics, chosen at random: perphenazine, olanzapine, quetiapine, risperidone, or ziprasidone. Patients with a history of tardive dyskinesia (abnormal involuntary movements) could not receive perphenazine, an older antipsychotic that can cause tardive dyskinesia more often than the newer medications. Patients who stopped their initial medication before the 18 months was up were offered a new medication in Phase 2, and 543 patients accepted. Those that stopped their phase 2 medication were offered treatment in Phase 3 with one or two antipsychotics. When enrolled in the study, patients were made aware that these switches were possible. Nearly half of all patients who enrolled finished a full 18 months of follow-up.

Phase 1 Results

Almost three-quarters of the patients discontinued phase 1. The most common reason for discontinuation was "patient decision" at 30% - these patients for the most part declined further participation in CATIE, and did not go on to Phase 2. The next most common reason for discontinuation was lack of efficacy (the medication did not relieve symptoms adequately) at 24% - these patients were encouraged to participate in Phase 2 in a pathway that involved receiving clozapine, olanzapine, quetiapine, or risperidone. Intolerability (side effects) was the reason given for discontinuation in only 15% of the patients – 4% because of weight gain or associated problems, 4% because of extra-pyramidal symptoms (tremor, stiffness, other abnormal movements), and 2% because of sedation. These patients were encouraged to participate in Phase 2 in a pathway that involved randomization to ziprasidone, olanzapine, quetiapine, or risperidone.

The antipsychotics differed in terms of how long patients remained on them. Patients stayed on olanzapine longer than on quetiapine or risperidone. Patients on olanzapine had fewer hospitalizations and greater decreases in their symptoms, especially at the start of treatment. However, patients on olanzapine had a higher tendency to gain weight and have increases in blood cholesterol and triglycerides. Patients receiving perphenazine discontinued because of extra-pyramidal side effects more frequently than with the other medications. Ziprasidone had little effect on weight or associated problems, and patients remained on it for as long as the other medications except for olanzapine. We still have unanswered questions – Were there differences in quality of life? Memory? Did substance abusers do better on some agents rather than others? Were hospitalized patients different in terms of their response? Was weight gain associated with improvement?

Phase 2 Results

The more popular pathway was that involving the possibility of receiving ziprasidone. Fewer patients chose to participate in the pathway where they could have received clozapine. For those that did, patients stayed on clozapine longer than they stayed on risperidone or quetiapine. For patients who participated in the other pathway where they would possibly receive ziprasidone, patients who received olanzapine or risperidone stayed on those drugs longer than those who received either ziprasidone or quetiapine. Weight gain and associated problems were more frequently seen with olanzapine, and less frequently seen with ziprasidone. Patients who had gained weight in Phase 1 were more likely to lose weight in Phase 2 if they received ziprasidone.

Phase 3 Results

Phase 3 results have not been published. Relatively small numbers of patients entered into this open-label phase

see CATIE on page 34

THE MENTAL HEALTH LAWYER

Understanding Contractual Capacity
Protecting People with Mental Illness from Credit Card Liability

By Carolyn Reinach Wolf, Esquire and Douglas K. Stern, Esqire

Carolyn Reinach Wolf, Esquire

Credit cards. We all need them. We all use them. Many people use them wisely but some fall prey to their convenience and the allure of not having to pay out cash. This is where the trouble begins and the debts start to mount. Should one be held accountable if the credit card is obtained and used during a time when that individual did not have the capacity to understand what he or she was doing?

A credit card application, like the ones that invade your mailboxes daily, is actually a contract for the provision of credit. You sign the credit card application, the company sends you the card upon approval and you begin to charge your purchases. By doing so, you agree to repay the sums charged at a pre-arranged interest rate. The assumption by the credit card company is that the individual who executes such a credit card application is 18 years of age or older and has the capacity to understand the contents of what she/he is signing. The former is quite easy to verify while the latter, under these circumstances, is nearly impossible. But what happens when an individual who is mentally ill, symptomatic and unable to understand the contents of such an application, obtains a credit card and rings up thousands of dollars in debt? The answer is not entirely clear. This article will grapple with this question, one that has come across my desk on numerous occasions over the past several years. This problem can result in lifelong credit disrepair, debt and mounting stress.

Please keep in mind that mental illness by itself does not render an individual incapable of being a party to a contract or in legal language, lacking "contractual capacity." In fact, courts have noted that mental illness alone would not be a reason to declare a contract void. In New York, contractual capacity as a legal concept has its roots in case law that is over one hundred years old. In 1892, the New York Court of Appeals (the state's highest court), held that the legal standard for determining an individual's contractual capacity is, "whether [the mind] was so affected as to render him wholly and absolutely incompetent to comprehend and understand the nature of the transaction" [1] That same year, the Court of Appeals modified this standard to include a question as to the individuals ability to, "make a rational judgment concerning [the] transaction." [2] These two factors are typically referred to as the "cognitive rule." Subsequently, courts have concluded under this cognitive rule that there must be a direct link between the "insanity" and the making of the contract.[3] Please note that the cognitive rule was created at a time when little was known about the science behind psychiatric disabilities and the terms used to describe the mentally ill were considerably more stigmatizing.

Over the next several decades, the study of mental illness was embraced by the scientific community as well as the general public. In terms of contractual capacity, judicial decisions soon reflected this greater understanding. The Court of Appeals supplemented their cognitive rule with a "motivational rule," which encompasses the concept that while a person's cognitive ability may not be impaired that person may be unable to control his conduct due to impulsive behavior.[4] However, the Court of Appeals qualified this rule by stating that there must be "nothing less than serious…medically classified psychosis" and that the other party knew or should have known of such illness at the time of the transaction.[5] If the other party did not know of the existence of the psychosis, there was still a possibility for the mentally ill party who was contracting for something to obtain some equitable relief.[6] In 1979, the Court of Appeals opened the door to the possibility that a disability defined as something less than a clinically classified psychosis may excuse an individual from having to live up to a contract.[7] It appears this is the last time our highest court has meaningfully weighed in on the topic of contractual capacity or the ability to legally enter into and be held to a contract.

What does this all mean for our credit card debtor? It appears that the current state of contractual capacity law offers little assistance in making a legal argument for the individual with a mental illness who obtains a credit card while in a decompensated state. Why? Because all of the reported cases on this topic deal with contracts that were executed at "arms length," in person. Not by mail, where the parties will never have an opportunity to see one another or meaningfully be able to assess mental state. Does this mean the credit card company wins? No.

There is hope. An argument can be made that it would be inequitable for a court to enforce a credit card contract against a psychotic, manic or impulsive individual who did not know what he/she was doing at the time of signing the contract and using the card or could not control an impulse to do same. The credit card holder would in this situation need to establish that he/she lacked contractual capacity at the time he/she returned the application and charged purchases with the card. Furthermore, proof would likely need to be shown that the purchases were not "ratified," or approved at a time when the credit card holder was mentally well. Because of its uncertainty, the judicial route may not be the choice of first resort.

A better option would be to ascertain how much credit card debt there is and from which institutions. If the debt is a small sum of money that the credit card debtor is willing and able to repay, then the credit card company should be contacted to arrange for a repayment plan. If the debt is large and/or the credit card debtor is unwilling and/or unable to repay, then consider contacting the credit card company and negotiate a reduction in the overall debt with an acceptable payment plan. If these options fail, a more assertive approach may be necessary. For example, you might apprise the credit card company of the fact that the credit card debtor lacked contractual capacity and refuse to pay. Keep in mind, however, the following caveat: the credit card company may bring a lawsuit. If this occurs, the credit card debtor would either have to claim that he/she lacked contractual capacity as a legal defense or file for bankruptcy protection. Either of these options will likely require legal representation and legal fees. Therefore, before exercising either of the latter options one should seek professional advice.

An ounce of prevention, if possible, may go a long way. A concerned relative or friend may want to approach the potential credit card applicant ("the applicant") and make arrangements for intervening prior to the application process. The applicant

see Credit Cards on page 33

The Economics of Recovery:
A Column From the Center for Career Freedom

How to Understand & Access Government Entitlements

By Donald M. Fitch, MS
Executive Director
Center for Career Freedom

The purpose of this column is to assist providers and consumers to be more effective when negotiating with local government agencies for income, health care, housing, food, transportation, job training, employment and other social services.

The focus is on single adults (18-64 years) with a mental and/or physical disability, substance abuse issues and the homeless. The information is gleaned from government websites and local, state and federal government offices.

Tips for accessing benefits are based on assisting over nine hundred persons at the Center. Our experience is supplemented by regular mystery shopper, provider and consumer surveys.

Q. I have about fifteen minutes to spend with a patient, what can I do to help stabilize them in the community?

A. If the patient has a disability that adversely affects their ability to work for the next twelve months, refer them to the Social Security Administration (SSA) at 1-800-772-1213. To prepare for the interview, they should download form #SSA-3368-BK (www.ssa.gov).

Donald M. Fitch, MS

If the patient is not disabled but needy, refer them to the local Department of Social Services (DSS) office (www.otda.stste.ny.us). To prepare for the interview, they should acquire form #LDSS-2921. Pay particular attention to the required documentation to avoid repeated visits.

Q. What is the difference between persons who are eligible for SSI and SSDI?

A. SSI and SSDI are abbreviations used by the Social Security Administration (SSA) to designate two income benefit programs for persons with disabilities. Generally, to be eligible for SSDI ($900/mo avg.), a person must have worked ten or more years (40 qtrs). SSI recipients don't require the same work history. While SSI recipients receive on average about $200 less than SSDI recipients (up to $689/mo). They are also entitled to food stamps (up to $152) and Medicaid which includes prescription drugs and dental.

Q. As a Social Worker with a caseload of thirty consumers, I regularly interact with local government units (LGU's). I often find the quality of regulatory information varies by their caseworker. Where can I go to find the "truth"?

A. Unfortunately, our "mystery shopper" (consumers interviewing their caseworkers) research at the Center confirms your experience. Our questions about Medicare Part D, Ticket to Work and Food Stamp awards average fifty percent accurate (recent surveys of IRS and VA hotlines found similar percentages). We rely on the appropriate federal/state/county/government agency websites or state/local Commissioner inquires.

Q. I spend too much time trying to decipher "government speak". Their sites and publications are vague, full of caveats and refer you to equally obtuse resources. How can I cut through this verbiage and get to the facts?

A. There are a few simple tricks I use that may be helpful:

1) Define the population carefully e.g. single adults (18-64) living alone (a major cause of confusion over the recent Medicare Part D program rules was that government, community agencies & the media kept using the terms "Seniors" and "disabled" as if these two populations were interchangeable).

2) Use the 80/20 rule i.e. you probably only need to know 20% of the sites' content because it usually applies to 80% of your population. Don't waste 80% of your time chasing down issues that apply to 20% of your population.

Q. Many of my clients don't get enough to eat, especially towards the end of the month. Aside from food stamps, where can they go for food?

A. Food pantries (see yellow pages) for 1-2 bags of groceries once-twice/month, hot/cold meals at shelters, community agencies, Drop-ins, Club Houses and a few houses of Worship, Restaurants and day old bakeries. (One enterprising young man buys rotisserie chickens for $1 around closing time)

Please send me questions for future columns to donfitch@freecenter.org. If your questions are used in the column you will receive a complimentary copy of our *Case Managers' Toolkit.* □

The NAMI-NYS 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. www.naminys.org, Families Helping Families, Helpline: 800-950-3228 (NY

Inspiration: Many Journeys of Recovery

By J. David Seay, Esquire
Executive Director
NAMI-New York State

J. David Seay, Esquire

Sitting at the keyboard waiting for inspiration to strike, it struck me that inspiration is key to what NAMI is all about. As I attended the 2006 NAMI convention in Washington this summer I heard many voices of recovery from some strikingly wonderful people – Suzanne Vogel-Scabilia, Fred Frese, Mary Raaymakers, Phil Kirschner and many more – it dawned on me that for many persons with serious mental illness, recovery is far more than a process or even an achieved state of accomplishment or achievement of potential; it is a journey. For them it is a many-faceted trip with many stops, detours and u-turns along the way. While it is no vacation, neither is it necessarily a visit to hell, although that is often one of many waypoints in the journey. I was inspired by the stories I heard and I know that this inspiration is what fuels the leadership of our NAMI movement at every level -- local, state and national.

What family members can learn from these many journeys is hope. Hope and resilience. And dogged persistence. And although we cannot literally walk a mile in their shoes, we can go along with them for the ride, at times helping them when they get lost and at others running to keep up. We can share with them their travel memories, both good and painful, and we can marvel as they play the tour guide for us as we better understand their illness, what they are going through and how we can help.

These journeys encompass many landscapes. Medication compliance is one; so are side effects, relapse and re-hospitalization. Family members and friends can help guide them along their way, and in fact, family members provide the lion's share of care management for persons with serious mental illness. The new publication ***Helping Families to Help Their Loved Ones with Serious Mental Illness: A White Paper of the National Alliance on Mental Illness of New York State,*** described in my last NAMI Corner column, is a road map for these journeys and is must-reading for anyone even remotely connected to someone with a serious mental illness, including providers at every level, family members, consumers and policy makers. The document is available at our web site www.naminys.org or copies can be obtained by calling our Help Line (800) 950-FACT (3228) or (518) 462-2000.

Yet another inspiration-giving experience comes from the ***In Our Own Voice*** program. Developed by NAMI as one its signature programs, NAMI-NYS brought ***IOOV*** to New York beginning in 2004. We work with our local affiliates to identify consumers who are willing and able to go out into the community and tell their stories of their own personal journeys towards recovery. They speak to community groups such as churches, schools, civic associations and others. They are carefully trained before launching upon this particular journey and are accompanied by a NAMI video that sets the context for the ***In Our Own Voice*** presentation. This marvelous program is both a therapeutic and enabling program for the consumer and a public awareness raising and anti-stigma campaign at the same time. Consumers are paid a small stipend for each presentation and meticulous records are kept on how many presentations were given and how many audiences were reached. In New York in just the first six months of this year, 84 presentations were given to a cumulative audience of nearly 2,000 people.

NAMI-NYS is especially proud to make this valuable and successful program available to our affiliates and their various communities as we strive to "feed the grass roots" of our movement. If anyone is interested in having an ***In Our Own Voice*** presentation made or in becoming an ***IOOV*** presenter, the person to contact at NAMI-NYS is Rachel Greco, Program and Outreach Manager, at either of the phone numbers listed above.

Excitement is already building for NAMI New York State's 24th Annual Meeting and Educational Conference ***From Research to Recovery: Improving the Lives of New Yorkers with Mental Illness***. It will be held at the Crowne Plaza Hotel in White Plains, New York November 3-5, 2006. Please mark your calendars to attend. Thanks to Conference Chair Sherry Janowitz Grenz and the entire planning scommittee, this event is shaping up to be the best ever, so plan to be there. Speakers will include Suzanne Vogel-Scabilia, MD, Xavier Amador, Commissioner Sharon Carpinello, mental health legislative committee chairmen Senator Thomas Morahan and Assemblyman Peter Rivera, plus leading mental illness researches and clinicians from the

see Inspiration on page 30

The Use of The Self in Psychotherapy

By Samuel C. Klagsbrun, MD
Medical Director, Four Winds Hospital

Psychotherapy is the most beleaguered treatment option available to us in the current climate. Certainly psychotherapy which takes time and which requires a one on one approach is expensive, long lasting and unpopular in the managed care age we're living through. In addition, the quick fixes approaches, which are favored today and aimed at symptom control, have gained enormous popularity both with patients as well as with professionals. There is no question about the fact that the focused techniques - the short-term approaches, are enormously useful, practical and often achieve their goals. In addition, the tremendous advances of pharmacotherapy have successfully eased the pain of many, many patients whose suffering has impeded their lives as well as the lives of their families for long periods of time. Progress has certainly been made.

Why then do I bemoan the loss of the person in this process? I find myself extremely concerned about the image we have created in the field of mental health, suggesting that our focus is on managing symptoms as opposed to helping a person grow and become the best he or she can be. Alleviating suffering is certainly a notable goal to reach for, but is that all that we started out to do in the beginning days of psychotherapy and psychoanalysis?

I certainly remember in my early days of training being profoundly inspired by stories of clinicians who got down in the dirt with their severely ill patients wrestling with them to bring them back into reality, not settling for just symptom control, but reaching for a meaningful and productive life for their patients. Since there was nothing essentially available in those days on a sophisticated pharmacological level, what those clinicians had was just themselves. And so today, is there a role for the use of the self in doing psychotherapy? We were all taught in early days to present a blank screen to our patients. The theory at the time had to do with allowing our patients to delve into themselves and reveal their inner feelings and thoughts…their fantasies and dreams, without being influenced by us or directed by us.

Samuel C. Klagsbrun, MD

In my own case I have over the decades moved away from being a relatively anonymous person to using parts of my own life – where appropriate- to help improve the connection between myself and my patients. In most cases for example, patients who come into therapy often feel like failures, as if they have dropped the ball along the way, some place. They often feel ashamed and embarrassed and have difficulty articulating those feelings. This is especially true if they see their therapist as a successful person who's doing well, in charge of their life, making decisions and being independent. The contrast between their self-image and the image they have of their therapist is a black and white one. I frequently use my less than successful beginnings to create a better connection between myself and my patients, as well as a realistic and truthful invitation to demonstrate people's abilities to overcome failure.

A basic sense of trust and acceptance of who I am has been helpful in managing some of the downsides of life. One might argue that the positive image I have of myself is based on a false image, but I would argue that the positive image is what helps you reach for new opportunities and persevere in reaching for goals. A positive self-image is crucial to moving on.

We have all throughout our lives identified with particular people or have been inspired by certain stories. I find that "telling stories" is enormously effective in helping people move on. Again the theme here is not symptom control but reaching for a fuller life which is what's been left aside in current therapeutic techniques.

The use of self in therapy is obviously an approach fraught with problems and difficulties. While we want to encourage open communications and create an atmosphere of profound understanding, we certainly don't want to have people mimic us, become identified with us or feel that they have to become our clones. In telling our stories therefore, we need to find a tone…an avenue, which imparts images without inviting identification. The art of offering that kind of therapy is based on the idea of encouraging our patients to take the message, but imbue it with their own unique, different and separate stories. Encouraging them to experience and try out behaviors as a result of our stories – hopefully leaves them with their own identities, their own experiences, as opposed to simply mimicking us.

My own view of profound and comprehensive therapy is that to the degree that we can help people dream again…reach for visions of their own…take chances…initiate actions…then the symptoms that they struggle with become less of an impediment to the extent that they are successful in reaching out more. Certainly any technique that lessens symptoms allows further dreams to be sought, but talking about dreams is as much a part of therapy as is biofeedback for symptoms of phobic behavior. Dreaming is part of therapy.

What works in psychotherapy? Is it really the school of thought or the technique the therapist uses? Or, could it be the relationship and the caring experienced by the patient in relationship to the therapist? For example, if you ask a patient to describe what it is that they dislike about a therapist, you frequently hear, "He doesn't seem interested. He takes notes and never looks at me." On the other hand, if you ask a patient what they like about a specific therapist, you would hear…"She understands me so well. She goes out of her way to make me feel comfortable."

So really, it is all about the relationship, not about the school of thought that the therapist adheres to. If that's true, how come volumes have been written and research has been focused on schools of thought to such a tremendous extent, as opposed to an analysis of the nature of the relationship between patient and therapist. The language used in examining the relationship uses the words, transference or counter-transference, which have the implication of taking the relationship and placing it on the shoulders of past relationships…parental ones especially…almost as a way of avoiding a real look at what goes on in the actual relationship between patient and therapist.

I emphasize that the use of the self in psychotherapy applies to our self as well as to our patients. In reviewing our own experience with our patients, in listening to our own stories, both uplifting ones as well as depressing ones, we continue to learn, to grow, to clarify and to become better therapists. □

FOUR WINDS HOSPITAL • FALL 2006

OCTOBER 2006

A COMMUNITY SERVICE

Thursday, October 5, 2006 • 2:00 - 4:00 pm

National Depression Screening Day

Free Depression Screening for Children, Adolescents and Adults

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

For information, or to schedule a confidential appointment, please call 1-800-546-1754 ext. 2413.

Free of Charge • Open to the Public

GRAND ROUNDS

Friday, October 6th • 9:30 -11:00 am

Older Adults and Addiction: Prevalence, Screening and Treatment

THE WERNER AND ELAINE DANNHEISSER MEMORIAL LECTURE SERIES

Gary J. Kennedy, M.D.
Professor of Psychiatry and Behavioral Sciences,
Albert Einstein College of Medicine and Director,
Division of Geriatric Psychiatry, Montefiore Medical Center

Addiction among the older adult community is a silent epidemic. In many cases, it advances untreated and undiagnosed. Although the health complications are corrected on the surface, the underlying addiction, which conceivably poses the greatest risk, is often overlooked.

At the conclusion of this program, participants shall:

- Gain an understanding of the epidemiology of addiction in late life.
- Understand the significance of alcohol abuse as a risk factor for psychiatric illness in late life.
- Become familiar with identification, screening and treatment options for substance abuse among seniors.

Fee: $20.^{00}$ payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

Albert Einstein College of Medicine designates this continuing medical education activity for a maximum of 2.0 category 1 credits towards the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Albert Einstein College of Medicine and Four Winds Hospital. Albert Einstein College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

These programs will be of interest to: physicians, physician's assistants, psychologists, nurse practitioners, social workers, mental health providers, EAP's, education professionals, school counselors, RN's and consumers.

OCTOBER 2006

GRAND ROUNDS

Friday, October 13th • 9:30 - 11:00 am

What are They Thinking? Identifying, Understanding and Responding to High Risk Adolescent Behaviors

Jennifer Powell-Lunder, Psy.D.
Program Director, Four Winds Hospital Child and Adolescent Partial Hospitalization Programs

We live in a society in which thrill seeking behaviors are glorified. The inconceivable is portrayed on reality TV as not only plausible, but desirable. These concepts have trickled down and the impressionable minds of today's youth are not only open to receive, but eager to participate. The media is fraught with stories which describe the dangerous results: accidental deaths, predators using the internet to target innocent youth, teenagers arrested for making bombs (instructions conveniently offered on the internet), adolescents hospitalized after overdosing on cold medicine or brews made from household plants, and the list goes on. This presentation will focus on understanding why youth are engaging in such dangerous behaviors. Specific high risk behaviors will be identified and described, and appropriate responses will be suggested.

At the end of this presentation participants should be able to:

- Identify and describe specific high risk behaviors in which many youth are engaging.
- Understand the motivations behind these risk taking behaviors.
- Respond appropriately to risk taking behaviors.

Fee: $20.^{00}$ payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

Save the Date!

Nursing Career Day

Tuesday, October 17th • 4:00 - 7:00 pm

EXPERIENCE FOUR WINDS FIRSTHAND DURING THIS INFORMAL EVENT.

JOIN A TEAM THAT USES A MULTI-DISCIPLINARY APPROACH TO TREATMENT.

Your Voice Will Make a Difference!

Refreshments, Tours, an Opportunity to Meet with Nursing Leadership

Competitive Salaries/Benefits

RSVP BY OCTOBER 10TH AT 1-800-546-1754 EXT. 2413

All of the Grand Rounds, Special Trainings and Special Events will be held at the Four Winds Hospital Conference Center unless otherwise noted.

Registration is Required for All Programs.
Please Call 1-800-546-1754 ext. 2413.

Community and Professional Education Programs

OCTOBER 2006

GRAND ROUNDS

Friday, October 20th, 9:30 – 11:00 am

The Use of Self in Psychotherapy

Samuel C. Klagsbrun, M.D.
Executive Medical Director, Four Winds Hospitals

Is there a role for the use of self in doing psychotherapy? We were all taught in the early days to present a blank screen to our patients. The theory at the time had to do with allowing our patients to delve into themselves and reveal their inner feelings and thoughts.

At the conclusion of this program, participants should be able to:

- Understand that therapy needs to be non-judgmental towards the patient.
- Explore patients' values system and their origin.
- Review with patients, areas where their values are in conflict with accepted societal values.

Fee: $15.^{00}$ payable to Four Winds Hospital

1.5 CME Credits Available

SPECIAL TRAINING

Thursday, October 26th • 9:30 am - 12:00 pm

Child Abuse Identification and Reporting

Valerie Saltz, L.C.S.W.
Four Winds Hospital

New York State recognizes certain professionals to be specially equipped to hold the important role of mandated reporter of child abuse or maltreatment. These include Mental Health Counselors, Marriage and Family Therapists, Creative Arts Therapists, Psychoanalysts, Licensed Social Workers, Physicians, Dentists, Dental Hygienists, Chiropractors, Psychologists, RN's, School Administrators, Teachers, etc. A State Education Department Certificate of Completion will be given at the end of the class.

Fee: $45.^{00}$ payable to the Four Winds Foundation, a not-for-profit organization

NOVEMBER 2006

GRAND ROUNDS

Friday, November 3rd • 9:30 - 11:00 am

In Our Own Voice: Living with Mental Illness

Presented by: Consumers of Mental Health Services

What better way to dispel myths about mental illness than to hear from people who have been there? In Our Own Voice, a program of NAMI Westchester, Inc., is a powerful anti-stigma tool that can change hearts, minds, and attitudes. People with mental illness integrate their stories into a professional presentation that includes a brief video, dialogue with the audience and distribution of printed resource information.

This program will enable participants to:

- Understand how people with serious mental illnesses cope with the realities of their disorder and are able to recover and reclaim productive lives that have meaning and dignity.
- Debunk the myths of mental illness and help break the negative and stigmatized stereotypes associated with psychiatric disorders.

Fee: $20.^{00}$ payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

NOVEMBER 2006

GRAND ROUNDS

Friday, November 17th • 9:30 - 11:00 am

Aggression in Children & Adolescents: Management and Medication Strategies

Ginny Gerbino-Rosen, M.D.
Chief of Service of the Young Adult Unit, Bronx Children's Psychiatric Center; Assistant Clinical Professor of Psychiatry, Albert Einstein College of Medicine; Boarded in Forensic, Child and Adult Psychiatry

Aggressive or impulsive behavior is both violent and unpredictable. Much of the elements in today's society pose as factors that heighten the risk of aggressive conduct in young individuals who may already be prone to such behavior. Recognition, prevention and control are important components of spreading awareness on the escalation of this condition.

At the conclusion of this program, participants should:

- Become familiar with psychotherapeutic interventions for managing violence in children and adolescents.
- Review psychopharmacological approaches and medication monitoring in the treatment of aggression in children and adolescents.
- Gain an understanding of the impact of underlying diagnostic issues in the manifestation of aggression.

Fee: $15.^{00}$ payable to Four Winds Hospital

1.5 CME Credits Available

DECEMBER 2006

GRAND ROUNDS

Friday, December 8th • 9:30 - 11:00 am

Music and the Mind: George Gershwin

Richard Kogan, M.D.
Director of the Human Sexuality Program, Weill-Cornell Medical Center and New York Presbyterian Hospital; Private Practice, New York City

In the early 20th century, there was a boy named George who was constantly getting into trouble. He played hooky from school, got into fights, and stole things. He had what today would likely be recognized as a conduct disorder. What's more, he showed a fair amount of impulsivity, inattentiveness, and hyperactivity and thus may have had attention-deficit/hyperactivity disorder as well. Then one day he discovered music. It changed his life, and George Gershwin became one of the century's great composers. Dr. Kogan, a psychiatrist and highly acclaimed concert pianist will be doing a sort of "show and tell"— not just talking about Gershwin's life, but playing some of Gershwin's music on the piano to illustrate various points.

At the conclusion of this program, participants shall:

- Recognize the psychological factors that influenced Gershwin's artistic development.
- Understand some of the fundamental concepts about creativity.

Fee: $15.^{00}$ payable to Four Winds Hospital

1.5 CME Credits Available

10 Child Mental Health Myths

By Kevin T. Kalikow, MD

Your child is hurting. You need to do something, but you're not sure what. Your first goal is getting accurate information about the psychiatric disorders of childhood and their treatment. The following are 10 common myths and what you need to know.

(1) Children are too young to have psychiatric disorders.

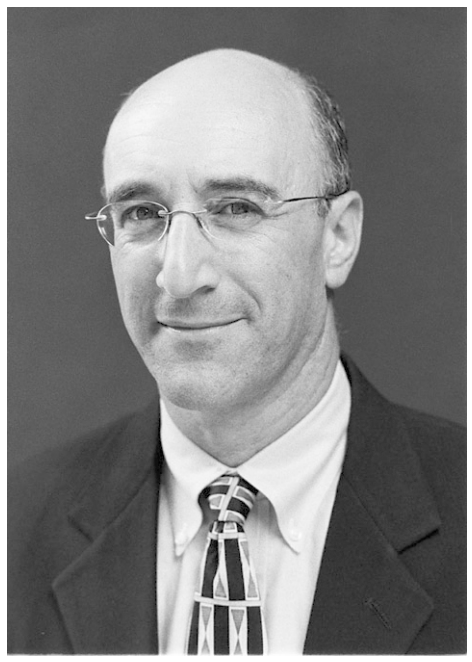
No. Many years ago it was thought that children were too young to have disorders, such as Depression. Although we have much to learn about the psychiatric disorders of children, researchers have shown that children can suffer with disorders such as Depression and Obsessive Compulsive Disorder (OCD). Illnesses, such as Bipolar Disorder, also occur in children, but their exact presentation is the subject of debate among physicians.

(2) Anyone can have a little bit of Attention Deficit or Obsessive Compulsive Disorder.

No. We all have characteristics that make us who we are. Some of us are a bit more fidgety and others more slow moving. Some are fastidious and others are a mess. But, for those with a disorder, the characteristic has become a symptom, something that significantly interferes with the person's life.

(3) Children get addicted to psychiatric medicine.

No. While some of the medicines used in psychiatry, such as the stimulants, like Ritalin, or the anti-anxiety medicines, like Xanax, are addictive when used at doses that are higher than normally used by physicians, the responsible, physician managed use of these medicines does not lead to addiction in children. In fact, research suggests that taking stimulants lowers the risk of drug and alcohol abuse among adolescents and young adults with ADHD.



Kevin T. Kalikow, MD

(4) Anti-depressants, like Prozac, make children suicidal.

Yes and No. When researchers examined whether this was true, they discovered that none of the more than 4,400 children and adolescents studied committed suicide. However, they also discovered that while 1-2% of those taking placebo (fake medicine) developed new suicidal thoughts or made a suicidal act, 3-4% of those taking anti-depressants did so. They concluded that an extra 1-2% of children and adolescent will have increased thoughts or acts of suicide from taking these medicines. Again, there were no actual suicides. So, while this is an obvious concern that mandates close follow-up of young people starting these medicines, this risk must be weighed against the risk of Depression or the other disorder that is being treated. These disorders, in particular Depression, carry their own risks, especially of suicide.

(5) Stimulants, like Ritalin and Adderall, cause the sudden death of children.

No. Although stimulants are well known to cause insignificant increases in the child's pulse and blood pressure, rarely are these side effects of clinical importance. And, even then, they are of concern in the long run, not short run. The allegations that stimulants caused sudden death are unproven and, if proven to be true, would still appear to be very, very rare. On the other hand, we must never be cavalier. While much is known about the stimulants, we can always learn more, for example, about their use in children with underlying heart deformities.

(6) Never take a medicine that has the FDA's Black Box warning!

No. A Black Box warning is the FDA's strongest way of pointing out that a medicine has a certain risk. The FDA still approves of the use of the medicine for treating a specific age group with a particular disorder. Some of the side effects that are given black box warnings are rare. The specifics must be discussed with one's physician.

(7) Anti-depressants only treat Depression and stimulants only stimulate.

No and No. There are a host of reasons that medicines are classified under a given name, like anti-depressants, but their name does not limit what they do. Anti-depressants, such as Prozac, also treat illnesses such as Panic Disorder, Social Anxiety Disorder and OCD. Stimulants do not stimulate children with ADHD, unless you want to look at them as stimulating the child's brakes. Rather, stimulants help children focus and lower their impulsivity. Interestingly, stimulants also improve the focus of children and adults who do not have ADHD.

(8) If medicine helps, it's the only treatment my child needs.

No. Research has shown that while medicine is effective for the treatment of ADHD and Depression, treatment with medicine combined with a behavioral treatment, such as Cognitive Behavioral Therapy (CBT), is more effective. For disorders such as Obsessive Compulsive Disorder, CBT has been shown to be at least equally effective as medicine and perhaps more effective in the long run. For OCD, a combination of these treatments seems best of all. Many parents also benefit from counseling that teaches them how to deal with their child's difficulties, regardless of whether their child takes medicine.

(9) My child's medicine is so easy to use that I hardly need to see the doctor.

No. Modern psychiatric medicines are often relatively safe and easy to use. However, all medicines carry risk. Also, there is often little medical information about the combinations of medicines that many children take. In addition, many children with psychiatric disorders are at risk for other difficulties that require an ongoing working relationship with a mental health professional.

(10) Too many children are taking medicines, like Ritalin.

Yes and No. Some children are given psychiatric medicine too quickly when another treatment might be more effective or when, perhaps, no treatment is needed. Other children would benefit greatly from a psychiatric medicine, but never receive one. Every parent, however, must be concerned that their child is properly treated. That means having a proper evaluation from a trusted professional with whom you can discuss the risks and benefits of medicine to decide if it is the correct treatment for your child.

In short, parents should be neither overly fearful, nor cavalier about psychiatric medicine. Rather, with their physician, parents must weigh the risks and benefits of medicine against those of other treatments and, with their child in the balance, decide the best treatment.

Kevin T. Kalikow, MD, is a Child and Adolescent Psychiatrist with a Private Practice, in Mt. Kisco, New York. He is an Assistant Clinical Professor in Child Psychiatry at New York Medical College, and is the author of "Your Child in the Balance: An Insider's Guide to the Psychiatric Medication Dilemma" □

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The Mental Health News

New York City Section

The Healing Power of Spiritual Support Groups

By Rabbi Simkha Y. Weintraub, LCSW Rabbinic Director, New York Jewish Healing Center and National Center for Jewish Healing ot the Jewish Board of Family and Children's Services (JBFCS)

In 1982, right after my ordination from the Jewish Theological Seminary, doctors decided to remove a growth on my thyroid that they had been watching throughout the year. The doctors needed to determine if the growth was benign or malignant. As it turned out, the growth was malignant. I had cancer of the thyroid.

The next day a senior colleague called to say I should tell no one of the diagnosis because I would not get a job as a rabbi if it were known I had cancer. I thanked him, hung up the phone, and plunged into the deep doubt of now what?

I was twenty-six-years old.

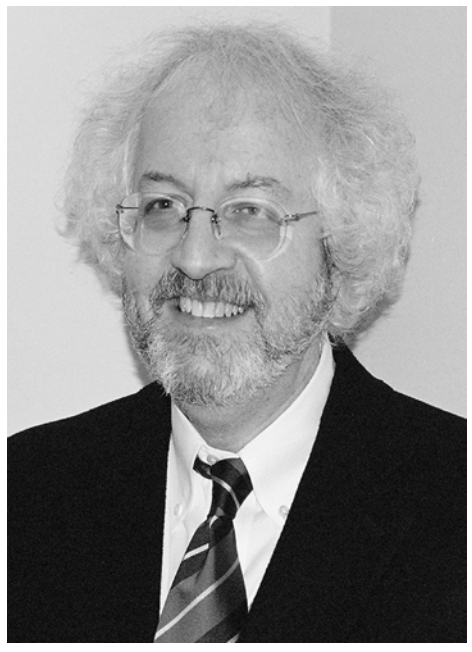
Twenty minutes later the phone rang, and it was a member of the congregation where I was working. He said, "Simkha, welcome to the club!"

"What?" I asked.

"Well, I've had stomach cancer, and another woman in the congregation had breast cancer, another member Hodgkin's lymphoma. We needed a thyroid!"

That was the best of all the calls I received following my diagnosis. Throughout the previous year of symptoms and medical tests, I had no one talk to. My best friends tried, but they didn't know how to handle it. I was lonely, isolated, in despair. Now someone had reached out who understood.

I tell this story because it creates a new narrative in a society which denies that for every human being, since creation, there's deterioration, physical pain and unpredictable physical challenges. Our culture tells



Rabbi Simkha Y. Weintraub, LCSW

us our lives should be filled with working out in the gym and eating healthy diets that allow us to live to be one-hundred-twenty-years-old, at which point we'll die a quick death without pain. It's a society that's death-denying, grief-avoidant and illness-adverse.

But if we talked about death, if we were with the dying, if they weren't stowed away in a hospital room, we'd get to know death. And if we had a better understanding of death, we might have a better acceptance of illness. That's not to say we'd rejoice in the diagnosis, but it would fit into a narrative, a way of understanding life. Right now illness interrupts our narrative of how life unfolds. People who receive a diagnosis of a serious illness are thrown into a tailspin; it's a shock.

There is a Hebrew folk saying that "The trouble of many is half a comfort." In other words, other people who are going through similar experiences can offer understanding, support and knowledge of coping strategies. We can learn from each other's difficulties. The Talmud, a collection of ancient rabbinic writings, says that "The prisoner cannot free himself from jail." In any society, at any point, a person living with a serious illness feels like they are in a prison, isolated, punished. We need other people to help us. In the Jewish tradition as in other religious traditions, there is a belief that there is no healing without other people.

Sharing strategies, insights and experiences is the core of the **Sustaining Our Spirits** group, a program of the JBFCS New York Jewish Healing Center in Manhattan for members of the Jewish community who are living with serious illness. The group meets twice a month for an hour and a half. We are not organized around a specific illness and our group includes people with multiple sclerosis, heart disease, cancer, chronic pain and more. We've found that offering different perspectives from people coping with different illnesses brings more resources for people to draw on.

The group helps people with family and personal issues and uses spiritual resources which can be everything from poetry to stories, psalms or rituals, wise sayings or ethical writings. These tools help explore meaning, faith, or hope and spark discussion and reflection. One common purpose of prayer is to give voice to expression beyond language. When there are no words to describe feelings, the group may turn to prayer.

Niggunim, wordless chanting, is another tool we use to help group members express themselves. *Niggunim* also create a relaxation response for people who need healing. Herbert Benson, MD, President, Mind Body Medical Institute and Associate Professor of Medicine at Harvard Medical School, is a researcher who coined the term "relaxation response," a physical state that alters the physical and emotional response to stress. The term grew out of Dr. Benson's research with Buddhist monks who meditated and achieved a lower heart rate following their meditation. A roomful of people draws out the power of *niggunim*.

Spiritual support groups offer insights into coping with illness, and they provide a spiritual safety net for social, psychological and emotional nurturing. It's a place where people can let their hair down, fall apart and have everybody support them. The groups also help people rebuild their life narrative which brings us back to where I began.

People who have a chronic, serious illness need a way to integrate their physical challenges into their life narrative so they can understand their experiences at a profound level. A serious illness transforms one's life story into a deeper question, what I speak of as, "*Who lives in my name*?" Spiritual support groups provide a crucial role in that transformation by allowing people to hear each other's stories, try out new ideas and learn new paths for their deep-rooted exploration.

If there's one word that summarizes healing, it's *connection*, connection to nature, to other people, to oneself, to God, to the cosmos. At **Sustaining Our Spirits**, we try to help people make the connections they need. If you or someone you know is facing a serious illness and may be right for a Jewish spiritual support group, please call us. For more information, contact the JBFCS New York Jewish Healing Center at (212) 399-2320, ext. 201. □

WLIW New York Public Television Launches Healthy Minds Series

Staff Writer
Mental Health News

One in ten Americans experience some disability from a diagnosable mental illness in the course of any given year, but for many families, the fear and shame associated with a diagnosis often leads to suffering without hope. *Healthy Minds* is a new weekly educational public television series premiering this fall on producing station WLIW that aims to remove the stigma that can prevent patients and their families from seeking help for mental disorders. Each half-hour episode humanizes a particular mental health condition through inspiring personal stories, with leading researchers and experts from institutions such as Columbia University, Rockefeller University and the Cold Spring Harbor Laboratory providing the latest information about diagnosis and treatment. Episodes will cover a wide range of topics, including anxiety, stress, insomnia, chemical dependency, post-traumatic stress syndrome (PTSD), attention deficit disorder, Alzheimer's Disease and schizophrenia, to bring the general public a better understanding of disorders that can affect anyone, at any age. The series is hosted by Dr. Jeffrey Borenstein, CEO and Medical Director of Holliswood Hospital and Chair for the Section on Psychiatry at the New York Academy of Medicine.

As Dr. Borenstein explains, "Everyone is touched by psychiatric conditions, either themselves or a loved one. Our goal is to share cutting edge information from experts along with personal experiences from people who have overcome psychiatric conditions. I want people to know that with help, there is hope."

"*Healthy Minds* reflects a core mission of public television, providing access to information that directly impacts the lives of families in the communities we serve," said WLIW President and General Manager Terrel Cass. "We hope this series will serve as a resource for families and healthcare providers to open lines of communication."

Healthy Minds will premiere in the New York metropolitan area on WLIW21 Sundays at 11:30 am beginning September 10, 2006 and air for 13 weeks. In the premiere episode, news veteran Mike Wallace and his wife Mary discuss how they dealt with his depression and reveal for the first time intimate details about his suicide attempt and ultimate recovery. Series guests also include Nobel Prize winning author and lecturer Eric Kandel and broadcast journalist Jane Pauley, who shares her personal struggle with bipolar disorder.

Healthy Minds is made possible in part by NARSAD, Value Options, New York Academy of Medicine, The van Ameringen Foundation and by the New York State Office of Mental Health.

WLIW New York is an innovator in broadcasting, production and distribution for public television. WLIW has produced a variety of programming exploring healthcare issues including *The* Other *Drug Problem*, *Pharmacists: Unsung Heroes and Healthcare: Healing the System.* For more information, visit wliw.org. □

The Psychology of Physical Illness

By Jeff Shames
MSW Intern, New York University
Institute for Community Living

The National Institute of Health (NIH) notes that since 1980 the percentage of obese individuals in the United States has doubled, from 15 percent to 30 percent of the adult population. Also, in the last 20 years the percentage of children and adolescents who are obese has doubled. This can also be seen with diabetes; in recent years the percentage of people with diabetes has increased dramatically. What was once known as adult onset diabetes is now labeled type 2 diabetes, because it now diagnosed so often in children. This is even a more serious issue for individuals with mental illness.

There is increased consciousness today about the correlation between a person's thoughts and attitudes and her/his physical health. In the 1960s, after a long career as the editor of the Saturday Review magazine, Norman Cousins became a pioneer in promoting unorthodox ways in his day, for people to deal with illness. Cousins wrote a number of books, and made use of his personal methods of dealing with physical illness as an example for others. In fighting heart disease, Cousins took massive doses of Vitamin C, and used laughter as a means of dealing with pain.

At UCLA, he founded the group that became The Cousins Center for Psychoneuroimmunology (PNI), whose website is at www.cousins.pni.org. There it is stated that Cousins believed that "a patient's psychological approach to illness could have an effect on biological states and health. He was particularly interested in the impact (on health) of positive emotions and attitudes, such as purpose, determination, love, hope, faith, will to live and festivity" PNI bridges the fields of behavioral science, neuroscience, immunology and health. Cousins' work may be seen as a forerunner for the fields of positive psychology and health psychology.

In the traditional medical model, when a person is ill he/she seeks medical treatment, in order to get cured, or fixed. The burden is on the medical practitioner to find a way to make the illness go away. The idea of utilizing the patient's inner strengths is not a part of the process.

Health Psychology is a relatively new branch of the field that examines how psychological, biological and social factors can influence illness and health. Health psychologists seek to promote healthy lifestyle habits while reducing or preventing unhealthy behaviors. They assist patients in coping with physical illness, and their quality of life during recovery. One area of the field is concerned with how people react psychologically to being diagnosed with a physical illness. It is recognized that a person's coping skills, attitude and viewpoint can affect their health. Such factors as anxiety and depression can affect the person's immune system, thus making her/him less likely to ignore self-care issues, and to seek medical assistance. An increase in physical activity and change of diet (including eating fresh foods, and whole grains, and reducing intake of white sugar) can help lead to better physical condition. Social supports can also improve a person's physical and mental health.

Similarly, positive psychology is meant to build on a person's strengths. By examining where a person falls on the scale of six virtues (wisdom and knowledge, courage, humanity, justice, temperance and transcendence) and 24 corresponding character styles, a person's strengths can be recognized and these assets can be used in dealing with life situations. (Peterson and Seligman, 2004) The goal is to better understand the range of emotions that may exist. There is a correlation that people are healthier, more successful and more socially engaged, when happiness is defined as positive emotion and pleasure, being engaged in life, and finding meaning in life. (Seligman, 2002)

I have a close friend who self-medicated with alcohol. After getting sober seven years ago, Margaret (not her real name) was diagnosed with bipolar disorder and PTSD. A number of psychotropic medications were prescribed. Her mental health is affected by her physical issues, including neurological damage that affects her balance. Margaret has had a difficult time accepting her physical limitations. She rails against her mental and physical health problems, and realizes that this may make it more difficult to accept her health concerns and take care of herself. On several occasions she has ignored or pushed past her physical limits, which then can have severe consequences. Her ataxia worsens during hot weather. While walking her dog this summer, Margaret had so much difficulty walking that she had to be helped back to the building by a neighbor. She is an example of someone who might be helped by positive psychology.

What inner strengths can a person make use of, in dealing with physical illness? In her dissertation Evelyn Torton Beck (2005) examines the work of Franz Kafka and Frida Kahlo in terms of the correlation of physical illness and "psychological woundedness." Both artists portrayed wounds that can not be verbalized but could be expressed through the medium of art. To Beck, their art became a holding environment that served to heal. These artists continued in their work in spite of the constant physical challenges in doing so.

Similarly, Tobi Zausner (1998) noted that physical illness had an impact on creativity, when examining the careers of such artists as Toulouse-Lautrec, Degas, and Henri Matisse. In these individuals a period of illness served as a time of transition into a new period of creativity and production of new art.

Another example is present day artist Lauren D (not her real name). From childhood Lauren had found a creative outlet in painting. In adulthood she had stopped painting. Lauren is a person with diabetes, and is also a consumer at a residence that is run by the Institute for Community Living (ICL).

In recent years Lauren began painting again, at the Living Museum on the grounds of Creedmoor Psychiatric Center in Queens. Her passion for art has been essential for helping her deal with the physical and mental health challenges she has faced. Lauren finds that painting provides her with a reason to get out of bed in the morning, as well as an outlet for her creative energy. In the spring of 2006 she had an art exhibit at the Living Museum.

Diabetes is a serious health issue that affects approximately 8% of the general population, a rate that has been growing rapidly in recent years. The rate among individuals with serious mental illness is estimated to be two or three times this number.

A thorough needs assessment was done by ICL, in which it was learned that a large percentage of consumers at ICL residences with serious mental illness had one or more chronic diseases. Type II diabetes ranks among the most prevalent of these chronic medical conditions, and as many as one in four consumers are thought to be diabetic.

Thanks to a grant from the United Hospital Fund, ICL is conducting a twelve-month pilot study to develop a "beta" version of a toolkit to assist these diabetic consumers in taking better care of themselves. Through its medical arm, Health Care Choices, ICL is utilizing education, support, and case management, in the hope that these individuals will better manage their self-care and overall health while reducing their healthcare costs. Such self-care factors as diet and a sedentary lifestyle are thought to be a major factor in the increase in this disease.

Being a person with diabetes can feel isolating. The daily challenges include the need to carry out a treatment regimen that it is demanding and unpleasant. One's blood sugar must be monitored, and diet adjusted accordingly. This, in a society that is so oriented around the pleasure of food consumption. Another example of self-care is that the diabetic must examine his/her feet frequently, since even minor cuts can be dangerous to the person's health. The feet must be kept clean and in comfortable shoes.

There are varying views about the challenges of living with diabetes. One view is that optimistic beliefs play a significant role in adaptation (control) to chronic disease. (Fournier, de Ridder, Bensing, 2003) The authors examine optimistic beliefs that differ in degree of controllability, which is attributed to a person's actual or perceived ability to control events. The authors contrast the issues people face in dealing with different chronic illnesses, and compare dealing with Type I Diabetes (when a person is born with the disease) and multiple sclerosis. Type I diabetes is perceived to be more controllable, since patients can improve self-care, diet, exercise, and insulin, to prevent worsening symptoms of disease. This is compared to Multiple Sclerosis, which is perceived as having a lower level of controllability. It is a progressive disease, with fewer options for improved self-care.

In contrast, Snoek (et al 1999), wrote of the difficulty of dealing with diabetes on a day-to-day basis, while living a "normal" life. "Diabetes care is considered one of the most psychologically and behaviorally demanding of the medical chronic illnesses." They felt that up to 30% of patients have difficulty keeping proper glycemic levels due to poor adherence to a treatment program. Challenges include the daily need to carry out a treatment regimen that it is demanding and unpleasant, as well as the isolation of being a person with diabetes.

Practices exist that can help diabetics face these daily challenges more easily. Motivational interviewing is a nonjudgmental client-centered style of counseling, founded on the basic principles of expressing empathy, developing discrepancy, rolling with resistance, and supporting efficacy." (La Brie, Pederson, Earleywine and Olsen, 2005) These techniques were developed from the transtheoretical model of behavior change (Prochaska & DiClemente, 1994), with stages including pre-contemplation, contemplation, action and maintenance. It is being observed if motivational interviewing techniques are effective in helping ICL diabetic consumers with serious mental illness more easily face these challenges.

Even with the strides that society has made in recent decades in medical care, the increases in obesity and a sedentary lifestyle have led to a rapid increase in diseases like diabetes. Changes in the fields of psychology, and motivational interviewing, may help in addressing these trends. □

the mental health association of new york city, inc.

The Anniversary of 9/11 and Hurricane Katrina: Shows Us That Mental Health Response is Key Part of Disaster Relief

By Giselle Stolper, Executive Director
The Mental Health Association
Of New York City

Giselle Stolper

While there are moments when it seems as if an eon has passed since the attacks of September 11, 2001, for many New Yorkers, the memory of 9/11 remains part of our current consciousness. Our reminders are constant and visceral: our forever altered skyline; the tributes on New York City's fire trucks memorializing the heroes who fought to keep others alive; the news stories about the rebuilding efforts at ground zero or the work on the 9/11 memorial.; the anguish captured in the voices of responders and 911 dispatchers, frozen in time on tape.

The fifth anniversary of the 9/11 attacks brings sadness, but also presents an opportunity to examine the mental health impact of disasters. Experience shows that a disaster is not something that happens at a single point in time and then dissipates. The psychological effects of events like 9/11 and Hurricane Katrina can be felt for months, and even years. afterwards.

Despite the fact that trauma can create psychological problems as real and debilitating as a heart attack or stroke, the consequences are not always understood by either the disaster-response community or the affected individuals themselves.

The impact is evident: the World Health Organization estimates a 7 to10 percent rate of moderate-to-severe long-term psychological distress for those exposed to a disaster. For many, early intervention improves the outcome, yet again and again we see that a sense of shame – "Why can't I move ahead with my life?" – and denial – "There's nothing wrong with me" – prevent people from seeking the help they need.

Nearly five years after 9/11, the MHA of NYC's mental health crisis, information and referrals services hotline, 1-800-LIFENET, still receives an average of 9,000 calls a month, several times the monthly volume it received before the attacks. To date, more than 10,000 participants have enrolled in the 9/11 Mental Health and Substance Abuse Program, which is funded by the American Red Cross. As the January 2, 2007 enrollment deadline approaches, increased outreach efforts are underway to ensure that people who need help are able to access it. [See the sidebar to learn more about the program.]

But that is only the beginning. While we hope there will never be another 9/11 or a natural disaster as devastating as Hurricane Katrina, we must still be prepared, and mental health must be part of relief and recovery planning both nationally and locally. For starters, we need to make sure that mental health trauma specialists are available and ready and that long-term services are in place, because we know that disaster-related problems do not always emerge immediately. We must spread information about the psychological effects of trauma to de-stigmatize the need for help and ease the way for people to come forward.

As painful as the memory of 9/11 is, we can – and should – use it as a reminder of what a caring society can do to help those whose lives are destroyed by disaster. Mental health recovery is as critically important as regaining physical health in the aftermath. It is essential that the services are in place to make sure that happens. □

A Mental Health Association of New York City Reminder: Deadline Approaching to Enroll in the 9/11 Mental Health and Substance Abuse Program

The 9/11 Mental Health and Substance Abuse Program will close enrollment on January 2, 2007. This benefit provides financial assistance for people who were directly affected by 9/11 and need help to pay for treatment. It covers services from the day of the attacks through December 31, 2007.

Please tell your friends, family and clients: now is the time to take advantage of this important program.

Available treatment includes:

- Counseling: Support, advice and education about problems you are experiencing to help change thinking or behavior.
- Medication: Can be used to treat some types of emotional problems, like depression or anxiety.
- Substance Abuse Programs: Rehabilitation and detox services for alcohol and drug abuse.
- In-Patient Care: Hospitalization and/or substance abuse treatment.
- Auricular Acupuncture: A therapy that applies acupuncture to the outer ear. It can be used for alcohol or drug abuse, or for anxiety.

Eligible participants include those who:

- lost a family member
- were physically injured
- lived below Canal Street
- worked in the World Trade Center area – whether or not they were at work that day
- were evacuated from the World Trade Center area
- attended a school near the World Trade Center or are the parent of a child who attended a school nearby
- were a rescue, recovery, or reconstruction worker assigned to a "restricted site"
- were an emergency dispatcher on 9/11 or worked in the morgues serving the attack sites
- worked south of Canal Street or at Ronald Reagan Airport, and before January 11, 2002 lost a job or earned less than 70% of their pre-9/11 income, ***or…***

if you are a family member or shared a home with any of the people whose situations are listed here.

Financial assistance for treatment is retroactive to September 11, 2001. That means if you are eligible and you received treatment after the initial attacks, your out-of-pocket costs may still be covered. □

9/11 Mental Health And Substance Abuse Program

Please tell your friends, family and clients: Now is the time to take advantage of this important program

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or 1-877-990-8585 for Chinese

Or visit our Web site

www.9-11MentalHealth.org

Inspiration from page 15

New York State Psychiatric Institute, the Nathan Kline Institute for Psychiatric Research and others. And there will be a grand total of twelve separate workshops on topics ranging from schizophrenia and bi-polar disorder to managing the co-occurring disorders of mental illness and diabetes, a consumer session on side effects and medication compliance, a workshop on implementing cultural competence plans, as well as the ever-popular "ask the doctor" and "ask the lawyers" sessions. Brochures with a full description of the conference, topics and speakers will be going out right after Labor Day.

And for your 2007 calendar, you may mark down Tuesday, February 20th, 2007 as the NAMI-NYS 2007 Legislative luncheon and conference. It will be held in "the well" of the Legislative Office building in Albany and will feature many prominent speakers from the New York State Legislature, Office of Mental Health, NAMI-NYS leaders and others. Be there and be a part of positive change to improve the lives of New Yorkers with serious mental illness. □

See Page 31 - For the Mental Health News Upcoming Themes and Deadlines Calendar

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Heart Disease from page 1

to a doctor for the first time. Nevertheless, some people have heart attacks without ever having any of these symptoms.

Risk factors for heart disease other than depression include high levels of cholesterol (a fat-like substance) in the blood, high blood pressure, and smoking. On the average, each of these doubles the chance of developing heart disease. Obesity and physical inactivity are other factors that can lead to heart disease. Regular exercise, good nutrition, and smoking cessation are key to controlling the risk factors for heart disease.

Heart disease is treated in a number of ways, depending on how serious it is. For many people, heart disease is managed with lifestyle changes and medications, including beta-blockers, calcium-channel blockers, nitrates, and other classes of drugs. Others with severe heart disease may need surgery. In any case, once heart disease develops, it requires lifelong management.

Get Treatment for Depression

Effective treatment for depression is extremely important, as the combination of depression and heart disease is associated with increased sickness and death. Prescription antidepressant medications, particularly the selective serotonin reuptake inhibitors, are generally well-tolerated and safe for people with heart disease. There are, however, possible interactions among certain medications and side effects that require careful monitoring. Therefore, people being treated for heart disease who develop depression, as well as people in treatment for depression who subsequently develop heart disease, should make sure to tell any physician they visit about the full range of medications they are taking.

Specific types of psychotherapy, or "talk" therapy, also can relieve depression. Ongoing research is investigating whether these treatments also reduce the associated risk of a second heart attack. Preventive interventions based on cognitive-behavior theories of depression also merit attention as approaches for avoiding adverse outcomes associated with both disorders. These interventions may help promote adherence and behavior change that may increase the impact of available pharmacological and behavioral approaches to both diseases.

Exercise is another potential pathway to reducing both depression and risk of heart disease. A recent study found that participation in an exercise training program was comparable to treatment with an antidepressant medication (a selective serotonin reuptake inhibitor) for improving depressive symptoms in older adults diagnosed with major depression. Exercise, of course, is a major protective factor against heart disease as well.

Treatment for depression in the context of heart disease should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the heart disease treatment. This is especially important when antidepressant medication is needed or prescribed, so that potentially harmful drug interactions can be avoided. In some cases, a mental health professional that specializes in treating individuals with depression and co-occurring physical illnesses such as heart disease may be available.

While there are many different treatments for depression, they must be carefully chosen by a trained professional based on the circumstances of the person and family. Recovery from depression takes time. Medications for depression can take several weeks to work and may need to be combined with ongoing psychotherapy. Not everyone responds to treatment in the same way. Prescriptions and dosing may need to be adjusted. No matter how advanced the heart disease, however, the person does not have to suffer from depression. Treatment can be effective.

Other mental disorders, such as bipolar disorder (manic-depressive illness) and anxiety disorders may occur in people with heart disease, and they too can be effectively treated.

Remember, depression is a treatable disorder of the brain. Depression can be treated in addition to whatever other illnesses a person might have, including heart disease. If you think you may be depressed or know someone who is, don't lose hope. Seek help for depression. □

Mental Health News and Salud Mental Upcoming Themes and Deadline Dates

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Deadline: February 1, 2007

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Theme: "Child and Adolescent Mental Health"
Deadline: May 1, 2007

Fall 2007 Issue:
Theme: "Understanding and Treating Bipolar Disorder"
Deadline: August 1, 2007

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HDSW

Human Development Services of Westchester

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.**
- ***In the Case Management Program,*** **HDSW staff provides rehabilitation and support services to persons recovering from psychiatric illness so that they may maintain their stability in the community.**

HDSW
930 Mamaroneck Avenue
Mamaroneck, NY 10543
(914) 835 - 8906

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(914) 939 - 2878

POSITION AVAILABLE
DEPUTY DIRECTOR

Westchester Residential Opportunities, Inc. (WRO) seeks a Deputy Director to assume a broad range of not-for-profit management duties. This is a new position that is being created to focus chiefly on program development, major gifts solicitation and grants writing, and will also include some program supervision responsibilities. Applicants should have a minimum of five years of progressive responsibility in not-for-profit management, strong communication and computer skills, and possess a demonstrated commitment to social justice. Knowledge of the housing field, particularly in the lower Hudson Valley, would be highly desirable.

WRO is a 38-year-old agency with strong programs in fair housing, homelessness prevention, housing for the mentally ill, senior citizen housing counseling, first time homebuying and other special projects. The agency has a staff of 20 and an operating budget of over $2 million. WRO's main office is located in White Plains, and it has satellite offices in Mt. Vernon and Yonkers.

The position will be available in mid-September, 2006. WRO offers a competitive salary and fringe benefit package.

Interested candidates should submit resume and salary requirements to:

WRO, 470 Mamaroneck Avenue, White Plains NY 10605
or by email to mdavis@wroinc.org.

Credit Cards from page 13

should give clear instructions to a trusted person as to his/her wishes for financial decisions if incapacity arises. A Power of Attorney will enable a concerned individual to deal with credit card companies or other credit providers at the onset of a period of incapacity. The recipient of the Power of Attorney, will have the legal authority to cancel credit cards at the time they are inappropriately issued or to engage in damage control at an early stage of indebtedness. If it appears that the applicant is incapacitated and there are no advanced planning tools, such as the Power of Attorney or guardianship, credit card companies, as appropriate, should be notified that they just issued a credit card to an applicant who did not have "contractual capacity." The ultimate goal is to minimize the financial and emotional impact upon an individual and their loved ones in dealing with inappropriate credit transactions.

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3. Moritz v. Moritz, 153 A.D. 147; (App. Div., 1st Dept. – 1912).

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5. id. 6. Id.

7. Padula v. State of New York, 48 N.Y.2d 366; (Court of Appeals – 1979); Blatt v. Manhattan Medical Group, P.C., 131 A.D.2d 48; (App. Div., 1st Dept – 1987). □

Giselle Stolper from page 9

testimony and serving on boards and task forces for prestigious organizations in Albany, Washington, and New York City. She serves on the National Institute of Mental Health Research Review Board and is a member of the New York City Community Services Board for many years. She has written numerous reports and policy briefs, and delivered lectures and presentations both nationally and internationally.

Giselle received her undergraduate degree from New York University. She attended graduate school at Columbia University, Teachers College, where she received her MA and Ed.M. degrees in Special Education and Program Administration.

According to Dr. Peter Campanelli, Chairman of the Mental Health News Board, "We are simply delighted to have Giselle join our board. She is key leader of the mental health community and has been an ardent supporter of Mental Health News." □

Peter Beitchman from page 9

City's non-profit mental health sector.

Dr. Beitchman received a Doctorate in Social Welfare from the City University of New York. He also earned a Masters degree in Social Work from Hunter College School of Social Work. For many years he was Adjunct Assistant Professor at Hunter College School of Social Work where he taught masters and post-masters courses in social welfare administration and public policy.

In addition to his work at The Bridge, Dr. Beitchman is a Board Member of the Coalition of Voluntary Mental Health Agencies and chairs its Committee on Co-Occurring Psychiatric and Substance Abuse Disorders. He also serves on the Steering Committee of the Urban Institute for Behavioral Health of New York City. The Institute seeks to improve quality in the City's mental health system through the dissemination of evidence-based and promising practices. Dr. Beitchman just completed a 6-year term as board member and Treasurer of the National Alliance for the Mentally Ill-New York City Metro Affiliate. He was a Vice President of the American Association for Psychosocial Rehabilitation. Dr. Beitchman has been active with the New York City Chapter of the National Association of Social Workers for many years. He currently chairs its Fundraising Committee and serves on its Finance Committee.

Janet Segal, Vice Chair of the *Mental Health News* Board said, "Peter will be a huge asset to our organization and we are so excited to have him on board." □

Cancer from page 1

side effects of medications, or other environmental factors. Whatever its origins, depression can limit the energy needed to keep focused on treatment for other disorders, such as cancer.

Cancer Facts

Cancer can develop in any organ or tissue of the body. Normally, cells grow and divide to produce more cells only when the body needs them. But sometimes cells keep dividing when new cells are not needed. These extra cells may form a mass of tissue, called a tumor. Tumors can be either benign (not cancerous) or malignant (cancerous). Cells in malignant tumors are abnormal and divide without control or order, resulting in damage to the organs or tissues they invade.

Cancer cells can break away from a malignant tumor and enter the bloodstream or the lymphatic system. This is how cancer spreads, or "metastasizes," from the original cancer site to form new tumors in other organs. The original tumor, called the primary cancer or primary tumor, is usually named for the part of the body in which it begins.

Cancer symptoms include:

- Thickening or lump in the breast or any other part of the body
- Obvious change in a wart or mole
- A sore that does not heal
- Nagging cough or hoarseness
- Changes in bowel or bladder habits
- Indigestion or difficulty swallowing
- Unexplained changes in weight
- Unusual bleeding or discharge

When these or other symptoms occur, they are not always caused by cancer. They may also be caused by infections, benign tumors, or other problems. It is important to see a doctor about any of these symptoms or about other physical changes. Only a doctor can make a diagnosis. One should not wait to feel pain; early cancer usually does not cause pain.

Treatment for cancer depends on the type of cancer; the size, location, and stage of the disease; the person's general health; and other factors. People with cancer are often treated by a team of specialists, which may include a surgeon, radiation oncologist, medical oncologist, and others. Most cancers are treated with surgery, radiation therapy, chemotherapy, hormone therapy, or biological therapy. One treatment method or a combination of methods may be used, depending on each person's situation.

Get Treatment for Depression

At times it is taken for granted that cancer will induce depression, that depression is a normal part of dealing with cancer, or that depression cannot be alleviated for a person suffering from cancer. But these assumptions are false. Depression can be treated and should be treated even when a person is undergoing complicated regimens for cancer or other illnesses.

Prescription antidepressant medications are generally well-tolerated and safe for people being treated for cancer. There are, however, possible interactions among some medications and side effects that require careful monitoring. Therefore, people undergoing cancer treatment who develop depression, as well as people in treatment for depression who subsequently develop cancer, should make sure to tell any physician they visit about the full range of medications they are taking. Specific types of psychotherapy, or "talk" therapy, also can relieve depression.

Use of herbal supplements of any kind should be discussed with a physician before they are tried. Recently, scientists have discovered that St. John's wort, an herbal remedy sold over-the-counter and promoted as a treatment for mild depression, can have harmful interactions with some other medications.

Treatment for depression can help people feel better and cope better with the cancer treatment process. There is evidence that the lifting of a depressed mood can help enhance survival. Support groups, as well as medication and/or psychotherapy for depression, can contribute to this effect.

Treatment for depression in the context of cancer should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the cancer treatment. This is especially important when antidepressant medication is needed or prescribed, so that potentially harmful drug interactions can be avoided. In some cases, a mental health professional that specializes in treating individuals with depression and co-occurring physical illnesses such as cancer may be available.

While there are many different treatments for depression, they must be carefully chosen by a trained professional based on the circumstances of the person and family. Recovery from depression takes time. Medications for depression can take several weeks to work and may need to be combined with ongoing psychotherapy. Not everyone responds to treatment in the same way. Prescriptions and dosing may need to be adjusted. No matter how advanced the cancer, however, the person does not have to suffer from depression. Treatment can be effective.

Other mental disorders, such as bipolar disorder (manic-depressive illness) and anxiety disorders, may occur in people with cancer, and they too can be effectively treated. For more information about these and other mental illnesses, contact NIMH.

Remember, depression is a treatable disorder of the brain. Depression can be treated in addition to whatever other illnesses a person might have, including cancer. If you think you may be depressed or know someone who is, don't lose hope. Seek help for depression. □

CATIE from page 12

The many choices, including combinations, and other medications such as aripiprazole (Abilify) and fluphenazine decanoate (Prolixin Depot), will make it difficult to compare the different choices.

Decisions, Decisions, Decisions

It is clear to everyone that a person may respond to one medication and not another. From CATIE we can see differences in large groups of patients who received these different medications. Olanzapine and clozapine appeared to do better in terms of decreasing symptoms. Ziprasidone appeared to do better in terms of avoiding or reducing weight gain and associated problems. When clinicians tailor a treatment strategy, information such as past history of response and ease of use of medications are important too. Ultimately the goal is reduction of symptoms, including positive (hallucinations, delusions), negative (lack of involvement in activities), depressive (sadness), and cognitive (memory, thinking, concentration), as well as the reduction of relapse or exacerbation, and the avoidance of rehospitalization. Optimizing functioning can only come from efficacious and well-tolerated medications prescribed based on an individual's clinical history and profile. The variety of advantages and disadvantages of the various antipsychotics points to the need for the clinician to have access to all of them so as to make the best fit for the individual patient being treated.

Resources

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Dr. Citrome is Director of the Clinical Research and Evaluation Facility at the Nathan S Kline Institute for Psychiatric Research in Orangeburg, New York. He is also a Professor of Psychiatry at the New York University School of Medicine in New York City. □

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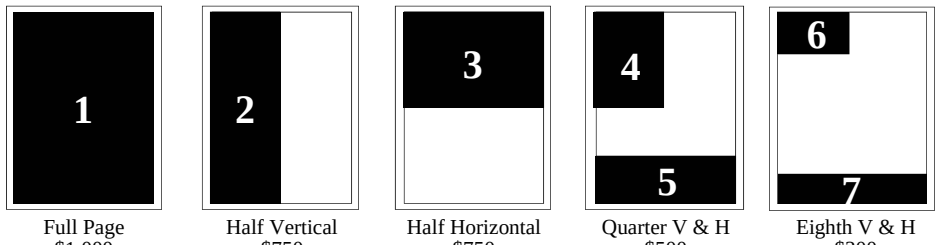

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